Public Trust Board

Thu 23 May 2024, 10:00 - 14:00

VUNHST Trust Headquarters, Nantgarw, CF15 7QZ

Prof. Donna Mead OBE, Chair

Agenda

10:00 - 10:15
15 min

1. PRESENTATIONS

1.1. Health Technology Wales Annual Report 2024

Peter Groves, Chair, and Susan Myles, Director

**To be shared at the meeting.*

10:15 - 10:30
15 min

2. STANDARD BUSINESS

2.1. Welcome and Apologies

Prof. Donna Mead OBE, Chair

2.2. In Attendance

Prof. Donna Mead OBE, Chair

2.3. Declarations of Interest

Prof. Donna Mead OBE, Chair

2.4. Draft Minutes from the previous Public Trust Board meeting held on 26th March 2024

Prof. Donna Mead OBE, Chair

2.4.0 FINAL Public Trust Board Minutes 26.03.2024(v3)_SH_LF.pdf (15 pages)

2.5. Action Log

Prof. Donna Mead OBE, Chair

2.5.0 PUBLIC ACTION LOG.pdf (2 pages)

2.6. Matters Arising

Prof. Donna Mead OBE, Chair

10:30 - 10:50
20 min

3. KEY REPORTS

3.1. Chair's Report

Prof. Donna Mead OBE, Chair

3.1.0 Chair's update Trust Board 23.05.2024-final.pdf (6 pages)

3.2. Vice Chair's Report

Stephen Harries, Vice Chair

3.2.0 23052024_Vice Chair Report.pdf (4 pages)

3.3. Chief Executive's Report

Steve Ham, CEO

3.3.0 Chief Executive's Report 23 May - final.pdf (4 pages)

3.4. Board Champion Report

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

3.4.0 Welsh language champion's report UPDATED MAY 24 Clean.pdf (5 pages)

10:50 - 10:50
0 min

4. INTEGRATED GOVERNANCE

**There are no items for discussion*

10:50 - 12:00
70 min

5. QUALITY, SAFETY & PERFORMANCE

5.1. VUNHST Risk Register

Lauren Fear, Director of Corporate Governance & Chief of Staff

5.1.0 TRR Paper -TB- May 24 -v2.pdf (11 pages)
5.1.0a INHERENT RISKS -for May TB.pdf (1 pages)
5.1.0b SAFETY RISKS 12 - for May TB.pdf (1 pages)
5.1.0c RISKS OVER 15 -for May TB - v2.pdf (2 pages)

5.2. Trust Assurance Framework

Lauren Fear, Director of Corporate Governance & Chief of Staff

5.2.0 TAF Paper - Trust Board - May 24.pdf (8 pages)
5.2.0a V60 - TAF DASHBOARD - 17.05.2024.pdf (16 pages)

BREAK 11:20-11:30

5.3. Performance Management Framework (March 2024)

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

5.3.0 Trust Board 23.05.24 MARCH PMF Performance Report FINAL version 006.pdf (68 pages)

5.4. Financial Report (March 2024)

Matthew Bunce, Executive Medical Director

5.4.0 Month 12 Finance Report Cover Paper Trust Board 23.05.24.pdf (10 pages)
5.4.0a Appendix 1 -M12 VELINDRE NHS TRUST FINANCIAL POSITION TO MARCH 2024 Trust Board 23rd May 2024.pdf (25 pages)
5.4.0b Appendix 2 - TCS Programme Board Finance Report (March 2024) - Main Report.pdf (16 pages)

12:00 - 12:20
20 min

6. PLANNING AND STRATEGIC DEVELOPMENT

6.1. Integrated Medium Term Plan 2023-2024 - Quarter 4 Update

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

- 6.1.0 Trust Board 23.05.24 IMTP 2023.24 Quarter 4 Update version 020.pdf (48 pages)

6.2. Accountability Conditions

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

- 6.2.0 Trust Board 23.05.24 Accountability Conditions Progress version 005.pdf (5 pages)
- 6.2.0a Appendix 1 EMB Run 2023-10-02 VELINDRE- Judith Paget - IMTP Accountability Letter 2023.24.pdf (3 pages)
- 6.2.0b Appendix 2 IMTP Accountability Letter 2.10.23 Quarterly Monitoring as at Q4 version 019.pdf (9 pages)

12:20 - 13:00
40 min

LUNCH 12:20-13:00

13:00 - 13:45
45 min

7. CONSENT ITEMS

7.1. CONSENT FOR APPROVAL

Prof. Donna Mead OBE, Chair

7.1.1. Commitment of Expenditure exceeding Chief Executive's Limit

Matthew Bunce, Executive Director of Finance

- 7.1.1 PUBLIC Trust Board_Commitment of Expenditure_May 2024.pdf (4 pages)
- 7.1.1a APPENDIX 1a Commitment of Expenditure NHS Resolution SLA May 2024 170524.pdf (7 pages)
- 7.1.1b - APPENDIX 1b NHS Resolution Services SLA.pdf (16 pages)

7.1.2. Digital Inclusion Plan

Carl Taylor, Chief Digital Officer

- 7.1.2 2024-05-23 SDC Digital Inclusion Plan v1.0.pdf (14 pages)
- 7.1.2a 2024-05-23 SDC Digital Inclusion Appendix 1 - Plan 2024-25.pdf (7 pages)
- 7.1.2b 2024-05-23 Appendix 2 QIA Digital Inclusion Plan.pdf (7 pages)

7.1.3. Surrender of NWSSP Leases within Companies House

Carl James, Director of Strategic Transformation, Planning & Digital and Lauren Fear, Director of Corporate Governance & Chief of Staff

- 7.1.3 Further Part 3rd Floor Companies House Deed of Surrender Board Approval Paper 170524.pdf (6 pages)

7.1.4. Amendments to Schedule 3 of Velindre University NHS Trust Standing Orders

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 7.1.4 Amendments to Trust Standing Orders - Schedule 3 - Cover Paper v2.pdf (8 pages)
- 7.1.4a APPENDIX 1 - RDI Sub-Committee Terms of Reference 2024-25 v2 FINAL DOCUMENT.pdf (9 pages)
- 7.1.4b APPENDIX 2 - SDC ToR 2024-2025 FINAL.pdf (8 pages)
- 7.1.4c APPENDIX 3a Feb 2024 Review of CFC Terms of Reference - with track changes mb.pdf (9 pages)
- 7.1.4d APPENDIX 3b Feb 2024 Review of CFC Terms of Reference - clean version mb.pdf (9 pages)
- 7.1.4e APPENDIX 3c ARC ToR_Draft_v.02.pdf (7 pages)

7.1.5. Trust Quality & Safety Framework & Quality Priorities Update

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

- 7.1.5 Quality Safety Framework Report - TB - 23.05.24.pdf (32 pages)

7.1.6. Three-yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act (2016) - for National Reporting

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

7.1.6 3 Yearly Report 2021-2024-NSA for Trust Board 23.05.24.pdf (17 pages)

7.1.7. Policies for Approval

Sarah Morley, Executive Director of Organisational Development & Workforce

- All Wales Flexible Working Policy

7.1.7 ALL WALES FLEXIBLE POLICY Cover Report_TB_May 2024.pdf (4 pages)
7.1.7a 2024_01_04 LHB Trust Chief Executives All Wales Flexible Working Policy Dec 2023.pdf (1 pages)
7.1.7b NHS Wales Flexible Working Policy.pdf (16 pages)
7.1.7c NHS Wales Flexible Working Policy Cymraeg.pdf (16 pages)
7.1.7d Flexible Working Policy (NHS Wales) EQIA v3.pdf (15 pages)

7.2. CONSENT FOR NOTING

7.2.1. Public Quality, Safety & Performance Committee Highlight Report (09/05/2024)

Stephen Harries, Independent Member (in the absence of Vicky Morris, Independent Member and Chair of Quality, Safety & Performance Committee)

7.2.1 Public QSP Highlight Report 9th May 2024.pdf (11 pages)

7.2.2. Public Audit Committee Highlight Report (12/01/2024 and 12/3/2024) (including Audit Committee Annual Report)

Gareth Jones, Independent Member and Acting Chair of Audit Committee

7.2.2 Audit Committee Part A Public Highlight Report 12 January 12 March 2024 and 21 March 2024-LF(GJ).pdf (5 pages)
7.2.2a Appendix 1 - Audit Committee Annual Report Jan - Feb 2024 Draft updated-LF.pdf (16 pages)

7.2.3. Public Strategic Development Committee Highlight Report (21/03/2024)

Stephen Harries, Vice Chair and Chair of Strategic Development Committee

7.2.3 PUBLIC - Highlight Report SDC March 2024_SH.pdf (6 pages)

7.2.4. Public Charitable Funds Committee Highlight Report (20/02/2024) (including Charitable Funds Committee Annual Report)

Professor Donna Mead OBE, Chair of the Charitable Funds Committee

**Highlight report to follow*

7.2.4b VUNHST Charity Annual Report CFC 2023.23-compressed.pdf (66 pages)

7.2.5. Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report (18/04/2024)

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

7.2.5 Trust Board Highlight Report Public 18.04.2024.pdf (3 pages)

7.2.6. Joint Commissioning Committee (JCC) Reports (09/04/2024 & 23/04/2024)

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

7.2.6a JCC Briefing (Public) 9 April 2024.pdf (2 pages)
7.2.6b JCC Briefing (Public) 23 April 2024.pdf (5 pages)

7.2.7. NHS Wales Shared Services Partnership Committee Assurance Report (21/03/2024)

Lauren Fear, Director of Corporate Governance & Chief of Staff

7.2.7 SSPC Assurance Report 21 March 2024.pdf (5 pages)

7.2.8. Trust Seal Approval Report – (26th March 2024 – 22nd May 2024)

Lauren Fear, Director of Corporate Governance and Chief of Staff

7.2.8 Trust Seal Report 26.03.24-22.05.24.pdf (6 pages)

7.2.9. Trust-wide Policies Update

Lauren Fear, Director of Corporate Governance and Chief of Staff

7.2.9 TRUST WIDE POLICIES UPDATE May 2024.pdf (4 pages)
7.2.9a APPENDIX 1 - PP 01 Trust Fire Safety Policy v.5.3_140524.pdf (11 pages)

13:45 - 13:45
0 min

8. ANY OTHER BUSINESS

Prof. Donna Mead OBE, Chair

**Prior approval required by Chair*

13:45 - 13:45
0 min

9. DATE OF NEXT MEETING

Tuesday 30th July 2024 at 10:00h

13:45 - 13:45
0 min

10. CLOSE

Prof. Donna Mead OBE, Chair

The Board is asked to adopt the following resolution:
That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

13:45 - 13:45
0 min

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

- BECS Outline Business Case
- Chair's Urgent Actions Report
- Commitment of Expenditure exceeding Chief Executive's Limit
- Claim Approval
- Private Quality, Safety & Performance Committee Highlight Report (09/05/2024)
- Private Strategic Development Committee Highlight Reports (21/03/2024 & 30/04/2024)
- Private Charitable Funds Committee Highlight Report (20/02/2024)
- Private Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight Report (18/04/2024)

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

PRESENT	
Stephen Harries	Vice Chair *(Acting Chair)*
Vicky Morris	Independent Member
Professor Andrew Westwell	Independent Member
Hilary Jones	Independent Member *(attending remotely)*
Gareth Jones	Independent Member *(attending remotely)*
Sarah Morley	Executive Director of Organisational Development and Workforce
Carl James	Executive Director of Strategic Transformation, Planning & Digital
Nicola Williams	*(deputising for Steve Ham)* Executive Director of Nursing, Allied Health Professionals & Health Science *(attending remotely) (in part)*
Jacinta Abraham	Executive Medical Director
ATTENDEES	
Lauren Fear	Director of Corporate Governance and Chief of Staff *(attending remotely) (in part)*
Kyle Page	Business Support Manager *(Secretariat)*

1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies noted:** • Professor Donna Mead OBE, Velindre University NHS Trust Chair • Steve Ham, Chief Executive Officer • Matthew Bunce, Executive Director of Finance • Amy English, Deputy Regional Director, Llais Cymru • David Cogan, Patient Representative It was noted that Alan Prosser, Director of Welsh Blood Service, would join the meeting as soon as possible, following a prior appointment.	
1.2.0	**In Attendance** The Vice Chair extended a warm welcome to the following additional attendees: • Katrina Febry, Audit Lead, Audit Wales • Steve Wyndham, Audit Manager, Audit Wales *(remotely) (in part)* • Chris Moreton, Deputy Director of Finance (deputising for Matthew Bunce) *(remotely)* • Phil Hodson, Deputy Director of Planning & Performance *(in support of items under section 5) (remotely)* • Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience *(deputising for Nicola Williams) (in part)*	

	• Rachel Hennessy, Interim Director of Velindre Cancer Service *(in part)* • Alan Prosser, Director of Welsh Blood Service *(in part)* • Susanna Whawell, Associate Independent Member • 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 January 2024 and Extraordinary Public Trust Board meeting held on 7th February 2024** Gareth Jones raised the following points: **Minutes from 30thJanuary 2024 item 2.3.0 (Chief Executive's Report)** – The minutes stated that the Chief Executive's Report "was not discussed in detail"; it was felt that this should read "The Chief Executive's Report was discussed". This will be amended appropriately. **Minutes from 30th January 2024 item 4.1.0 (Risk Register)** – The minutes stated that further review of risk 2515 (Brachytherapy) would take place at the February 2024 meeting of the Executive Management Board and Gareth Jones requested an update. Rachel Hennessy advised that while the risk had been reviewed and still remains, she was not in a position to comment on potential discussions at Executive Management Board (as she had not been present). As Lauren Fear experienced loss of connection with the meeting, it was agreed to confirm outside the meeting whether this had been addressed at February's Executive Management Board. Rachel Hennessy also advised that an update would be provided at today's meeting under item 4.1.0. Subject to the minor amendment to item 2.3.0 and further clarification on risk 2515 (Brachytherapy), the minutes from the public Trust Board meeting held on 30th January 2024 and extraordinary public Trust Board meeting held on 7th February 2024 were accepted as an accurate reflection of proceedings.	**Secretariat** **LF**
1.5.0	**Action Log** The Trust Board was content that all actions marked as closed was an accurate reflection. The Trust Board reviewed the status of open actions arising from the January 2024 meeting: **3.1.0 – Executive Team to discuss how Committee Highlight Reports can be used more effectively to summarise discussions and resulting actions to avoid repeat discussions at Board meetings –** The Board noted that this is to be discussed at the 4th April 2024 Executive Management Board meeting and that Executive Leads would then action with respective Committee Chairs. **4.3.0 – Include detail of action taken to increase capacity within Pharmacy and non-emergency SACT treatment in Performance Management Framework** – This is to be addressed later in today's meeting under item 4.3.0. **4.3.0 – Clarify % increase in SACT referral rate noted in Performance Management Framework** – This is to be addressed later in today's meeting under item 4.3.0.	

	5.1.0 – Board to be kept up to date regarding rollout of plan to embed Trust Values – Sarah Morley advised that the development phase of the Behaviour Framework (to align with the Values) had begun and an initial iteration of this, including graphics, had been developed. Following completion of a communications video outlining the new Values, more detail will be made available upon completion of the Framework. **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** – It was noted that the minutes incorrectly stated that an update would be received at the March 2024 Trust Board meeting; this should read May 2024 and will be amended accordingly. All open actions remained as such.	**Secretariat**
1.6.0	**Matters Arising** There were no matters arising that were not covered by today's agenda or the action log.	
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. In the Chair's absence the Vice Chair highlighted the following: • Gareth Jones (Independent Member - Legal) and Hilary Jones (Independent Member - Estates) had been offered and accepted a second four year term of office by the Minister for Health and Social Care. Congratulations were extended to both. • Participation of the Trust in the Job Shadowing Initiative (led by the Public Appointments Unit), to provide successful applicants with a job shadowing opportunity for potential Independent Members. A pilot programme has been established, to attract individuals from diverse backgrounds in particular. Stephen Harries had agreed to mentor Susanna Whawell, Associate Independent Member (in attendance) for this initiative. • Arrangement for the appointment of two further Independent Members (Finance, and additional Independent Member resulting from the requirements set out in the Health and Social Care (Quality & Engagement) (Wales) Act are in progress. Lastly, thanks were extended to Martin Veale (former Independent Member Finance) on behalf of the Board, for his contribution to the Board over the past seven years. The Board wished him well for the future. 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. The Trust Board **RECEIVED** and **NOTED** the content of the Vice Chair's Update Report and no comments were raised.	
2.3.0	**Chief Executive's Report**	

	Carl James, in the Chief Executive's absence, highlighted the following key matters: • Industrial Action – Following February's Industrial Action by Junior Doctors, confirmation of further action from the 25th – 29th March 2024 had been received, for which appropriate planning is in place. It is anticipated that planning will continue, in order to accommodate the planned Industrial Action by Consultants due to take place from 16th – 18th April 2024. A level of concern was expressed in relation to the potential impact on services. The planning, support and professionalism of staff was recognised as they continue to work together to bridge the gaps resulting from this Action. • Recognition of the significant contribution that Cath O'Brien had made to the Trust, both in her role as Director of Welsh Blood Service and latterly as Chief Operating Officer. It was noted that Cath had left the Trust earlier in the month to undertake a new role at Digital Health and Care Wales. The Trust Board **NOTED** the content of the Chief Executive's Update Report.	
2.4.0	**Board Champion Report – Welsh Language** The Trust Board **NOTED** that the Board Champion Report had been deferred to the May 2024 public meeting of the Trust Board.	
3.0.0	**INTEGRATED GOVERNANCE**	
3.1.0	**Audit Wales Annual Audit Report 2023** Steve Wyndham provided an overview of the Annual Report 2023, presenting a summary of both the financial and performance audit work undertaken over the past 12 months. **Financial** – An unqualified opinion for the Trust had been issued for 2023, summarising the final outcome of audit accounts work. While the audit fieldwork in relation to the Trust's Charitable Funds accounts is almost complete, it will not be possible to finalise the accounts until after March 2024 due to the delay in the receipt of independent assurances from the Fund's Investment Management Company, Brewin Dolphin. These assurances are expected imminently and it is anticipated that certification of the accounts till be concluded during early April 2024. It was also advised that the 2023 Audit Plan had set out a proposed audit fee of £243,111; however the actual fee for the year was £252,111. This was owing to the additional time required to complete the audit of the Trust's financial statements. **Performance** – Katrina Febry advised that the report set out the findings of the Structured Assessment Review, which had been outlined at the previous Trust Board meeting. The report also included the main findings from the Workforce planning work, which was completed and shared with the Trust during Autumn 2023. Two elements of audit work for the year 2022-23 remain outstanding (due to commence shortly) relating to Financial Efficiencies and setting of Wellbeing Objectives. Additionally, the audit plan for the year 2023-24 is currently being prepared and will be shared with the Trust over the coming weeks.	

	Gareth Jones indicated that the report had been discussed in detail at Audit Committee and while some concern had been expressed in relation to timely responses to enquiries made by auditors it was recognised that staff within the Trust had been working under difficult circumstances over recent months and no significant concerns had been identified for escalation to the Board. Vicky Morris referred to point 50 of the report, which referenced that the Board Assurance Framework had not been reviewed by the Board for more than six months. Vicky Morris advised that this had been discussed at both Audit Committee and Quality, Safety & Performance Committee and following formal escalation to Trust Board, significant progress had been made. In terms of comments within the report regarding Workforce arrangements / strategic Workforce planning, the Vice Chair acknowledged that Executive Colleagues are currently focusing on strengthening strategic Workforce planning and that this would be discussed further during items later in today's agenda. The Trust Board **NOTED** the content of the Audit Wales Annual Report.	
4.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
4.1.0	**VUNHST Risk Register** The Trust Risk Register informed the Board of the latest position of reportable risks in line with renewed risk appetite levels and progress against the Risk Framework and how these are currently managed across the Trust. Lauren Fear advised that following discussion at the joint extraordinary Quality, Safety & Performance and Audit Committees which had taken place on the 21st March 2024, it was agreed to re-open and revisit the action to review underlying risk related to administration systems and processes (previously closed in January 2024) given ongoing issues evident as a result of this risk root cause. This had been detailed in section 4 of the report. Vicky Morris highlighted the following: • **Risk 2515 (Brachytherapy Services)** – During discussion at the above-mentioned joint extraordinary Committee, Vicky Morris queried the reduction of the risk score to 12, given the known fragility of the service. It had been advised that the Executive Management Team requires further rationale to support the reduction and as such, the risk would be discussed further during the April meeting of the Executive Management Board. • **Risk 3337 (new) (Risk that patients are missed as a result of multiple lists being used to manage booking)** – This had also been discussed at the joint extraordinary Committee as this relates to **Risk 3230 (Risk to patient safety resulting from variation on / multiple access routes for new referrals)**. It was agreed to align the two risks given the common root cause of the systems being used for referrals. Gareth Jones raised the following questions: • **Risk 2198 (Risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department)** – While the risk had been reviewed and reduced during February as a result of progress in relation to recruitment, the report noted that an update would be received by Trust Board due to its inclusion in the risk reporting at Board level. Rachel Hennessy advised that a suite of posts is required in this area	

	and the reduction in the risk score reflected successful recruitment into a number of these to date. Gareth Jones wished to receive indication of when these posts commenced and the resulting positive impact on the current workforce. Carl James advised that detail for each phase of the recruitment programme could be provided via Vicky Morris as Chair of the Quality, Safety & Performance Committee. • **Risk 3338 (Risk that Velindre Cancer Services are unable to meet demand for SACT provision as a result of lack of Pharmacy capacity)** – Rachel Hennessy indicated that SACT continues to present challenges due to the significant increase in service demand evidenced across all SACT centres; this is expected to continue over the next 5 years. The predominant limiting factor for the Trust is capacity within Pharmacy and work around optimisation is ongoing as a matter of priority. A number of key pieces of work (in addition to the drafting of an improvement plan) are underway, with weekly monitoring undertaken by the division and in conjunction with the Executive Team. Nicola Williams advised that Gold Command – SACT Escalation continues to meet on a weekly basis, with a number of additional actions having been identified at today's meeting. The purpose of Gold Command is to monitor the comprehensive delivery plan that has been developed and to identify where further support may be required. To date, it has been determined that a full review of how systems and processes interlink and how SACT is delivered is required. Nicola Williams suggested providing a formal Gold Report to Trust Board in addition to the Quality, Safety & Performance Committee for the time being, as a number of other matters and factors require attention, aside from core issues. In terms of increasing Pharmacy capacity, Andrew Westwell questioned whether there could be opportunity to reach out to Cardiff University's School of Pharmacy, given the significant number of Pharmacy graduates (approximately 100 annually) wishing to remain in the south Wales area. Jacinta Abraham advised that clinical placements and training for Pharmacists has evolved and that the Trust would receive a number of Pharmacists as part of this. Andrew Westwell queried the current status of the TrAMs programme (Transforming Access to Medicines, an NHS Wales programme to set up a shared Pharmacy Technical Service for Wales), given its connection with SACT delivery. Jacinta Abraham advised that regular comprehensive updates had been requested from NHS Wales Shared Services, including timelines and potential impact of any delays to these. It was noted that the programme is running slightly behind its expected delivery date, however, the Board was assured that arrangements would be implemented to ensure the Trust is still able to purchase services. Gareth Jones reiterated the importance of SACT services and as updates are provided to Trust Board (and the Quality, Safety & Performance Committee) on a bi-monthly basis only, more frequent updates should be received given the high score of the risk (20). Carl James that a mechanism would be implemented for doing so in a structured way given the critical importance of the service and that the frequency of updates would be agreed outside of the meeting. The Trust Board: • **NOTED** the risks level 15 and above, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and	**RH** **CEO report** **CJ/VM/SHa**

	highlighted in this paper. • **NOTED** the on-going developments of the Trust's risk framework.	
4.2.0	**Trust Assurance Framework (TAF)** In Lauren Fear's absence (due to technical issues), Vicky Morris advised that the Trust Assurance Framework had been presented to the joint extraordinary Quality Safety & Performance and Audit Committee on the 21st March. The following was noted: • A number of actions and timeframes set out in Section 2, relating to ongoing developments of the TAF. • Discussions at the extraordinary Committee had outlined a number of gaps in relation to updates. • Section 3 of the TAF had inaccurately stated no risks within Workforce. • Several areas of the TAF will be refined to ensure that all risks are addressed and mitigated. • Section 5 of the TAF now represents a more comprehensive picture, including risk profiles and action plans. • Delivery of the Trust's Strategic Objectives are triangulated with the TAF and various discussions are underway to explore how this can be progressed subsequent to discussions at Committee level. **Risk ID 3.0 (Strategic Risk of an optimised workforce supply and shape in order to effectively delivery quality services and achieve our medium to long term objectives)** – Following reference made by a number of paragraphs within the Audit Wales Annual Report (item 3.1.0) to arrangements to strengthen workforce planning, the Vice Chair requested an update regarding associated activities currently underway to address matters raised within the Audit report. Sarah Morley advised that a multifactorial approach will be taken due to the number of elements involved and that the description within the TAF will continue to evolve as this progresses. In addition to a number of localised actions, it is the intention to align high level work such as the Strategic Plan with the development of the Clinical and Scientific Strategy and People Strategy Implementation Plan. This will allow the Trust to identify the future shape of its workforce. Gareth Jones expressed concern regarding the extended timeframe for completion of development of the Strategic Workforce Plan (September 2024). As issues with workforce have been known for some time, Gareth Jones queried the possibility of receiving the Plan prior to this date. Sarah Morley advised that this would be presented as a document to be taken through the governance process, collating a number of completed pieces of work already underway. This was therefore considered a realistic timeline given interdependencies with a number of pieces of work. Hilary Jones expressed the importance of completing section 5 of the TAF comprehensively in order to provide the required assurance regarding action plans and mitigation of risks. It was suggested that most recent narrative/updates could be inserted in italics. The Trust Board **DISCUSSED** and **NOTED** the Trust Assurance Framework, including comments and concerns raised.	**LF**
4.3.0	**Performance Management Framework (January 2024)**	

	The paper provided an update on the performance of the Trust for the month of January 2024, against a number of national targets. Alan Prosser reported the following in relation to Welsh Blood Service performance: • Following the blue alert (a colour coded system to inform hospitals that certain blood groups are running low and requesting a temporary reduction in their inventory requirements to allow prioritisation) issued in December 2023 to support the Christmas holiday period, stock levels had recovered and the alert had been lifted on the 25th January 2024. • Donor satisfaction continued to perform strongly and remained above target (at 96%). • Introduction of bespoke 'swab' sessions for bone marrow recruitment had seen a positive response and an increase in new bone marrow volunteers is anticipated from February onwards. Engagement with a variety of community groups, in particular BAME groups, has seen encouraging results over recent months. Alan Prosser expressed his thanks to the team for their efforts during the period of blue alert, in addition to successful progress regarding bone marrow recruitment within the BAME community to date. Rachel Hennessy reported the following in relation to the Velindre Cancer Service performance: • A slight reduction in Radiotherapy performance during January 2024, however this trend is usual due to the December holiday period. Performance has since improved. • Planned additional capacity to compensate for the two imminent spring bank holidays, including running extended days. • Improvement in targets (from 88% to 95%) for emergency Radiotherapy treatment commencing within the required timescale. • SACT – All patients received emergency SACT within the required timescales. However, following discussion at today's meeting around a number of areas of concern, a weekly SACT demand planning group has been established to increase capacity across the service as a matter of urgency. As previously mentioned, Pharmacy provision continues to be the predominant constraining factor. • A number of additional areas will be explored as part of the delivery plan, including maximising the contract with the Medicines at Home provider and potential buy-in of pre-prepared SACT, subject to reconfiguration of the Aseptic Unit following receipt of capital funding. It is also anticipated that TrAMs will also provide increased long term resilience. • An increase in the number of falls during January 2024 (8 patients fell against an average of 4 falls per month), however no patient harm was identified and all falls were investigated by the falls scrutiny panel. All had been deemed unavoidable. **Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience, joined the meeting to deputise for Nicola Williams.* Gareth Jones referenced the section of the report which noted the proportion of the workforce which had declared that they speak or understand Welsh, noting that this is marked as green, despite there being no target to report against. Sarah Morley agreed that the report requires refining in this respect and that this may be caused by a template issue. In terms of patient and donor experience and two associated surveys ('Friends and Family' and 'your Velindre experience'), the report had included a very small number of responses in comparison to the large	

	number of patients treated at Velindre. The Vice Chair also queried the CIVICA target of 85% for "good or above" ratings. He expressed concern that this in effect meant we had an agreed target for "not good or poor" ratings of 15%, which did not seem satisfactory. Tina Jenkins advised that the target is set by CIVICA, but agreed to explore this (and the national target) further. The Trust Board**:** • **DISCUSSED** and **NOTED** the January 2024 Performance Management Framework • **NOTED** the targeted work being undertaken through business continuity arrangements in respect of the delivery of SACT.	**TJ**
4.4.0	**Financial Report (January 2024)** In presenting the report outlining the financial position for the period ended (Month 10) January 2024, Chris Moreton highlighted the following key points: • It is anticipated that the Trust will deliver against its 3 statutory Financial Targets and duties at year end, including the projected breakeven position. • The Trust remains above its Public Sector Payment Performance administrative target of 95%, at 97.8% year to date. • Capital Spend is forecast to breakeven; whilst there was a gap in relation to capital funding costs in relation to the new Velindre Cancer Centre, this risk has now been removed as Welsh Government has agreed to provide coverage for this. • Long Term Agreements (LTAs) / Commissioning arrangements with Health Boards are predominantly driven by the additional demand seen within the cancer services. The Trust's income associated with LTA contracts is in excess of what was expected at the start of the year and is expected to cover the cost of the capacity investments made to date. • Trust response to NHS Wales Financial Pressures – the internal review process has sought to identify areas of additional cost savings internally to enable continued contribution back to the system, with the intention of easing the national financial pressures at the end of the year. The Trust's contribution is expected to be approximately £2m. The Trust Board **NOTED** the content 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.	
5.0.0	**PLANNING AND STRATEGIC DEVELOPMENT**	
5.1.0	**Integrated Medium Term Plan (IMTP) 2024-2025 – 2026-2027** Following confirmation of the Trust's Integrated Medium Term Plan (IMTP) from the Welsh Government (July 2023), there is a requirement for the Trust to update and refine the approved plan for the period covering 2024-25 – 2026-27; Trust Board approval of this is required prior to submission to the Welsh Government by 28th March 2024. CJ highlighted the following key points: • The plan is presented on the basis of an approved plan from last year; this is the first year it has been possible to fully align this with the Trust's strategic direction of travel. • An additional set of national requirements / other areas (e.g. Value Based Healthcare, regional working, broader social values,	

decarbonisation) exist alongside elements that the Trust intends to achieve. Clear narrative on how these will be delivered will be included in the plan.

- Planning assumptions – A number of services are currently operating under pressure across NHS Wales, with demand outstripping supply. The Trust's planned assumptions have been tested to the best of our knowledge.
- The next 12-18 months will mainly focus on supporting and sustaining Quality & Safety core service delivery and standards, in addition to the delivery of key transformation and infrastructure programmes (e.g. Blood Futures, Velindre Futures).
- An Equality Impact Assessment (EQIA) had been undertaken on the overall plan and 4 associated Quality Impact Assessments (QIAs) had been attached to the plan.
- A range of elements within the plan are yet to be wholly approved and will also be subject to QIAs prior to any final decisions.

Financial Assumptions and risks – Chris Moreton advised that the savings plan exceeds the previous year, reflecting the challenge faced in terms of current overall system pressures. The key area in terms of assumptions (still to be formally finalised) is the 3.67% risk regarding recurrent discretionary funds, issued by Welsh Government. It is assumed that the Trust will receive this from Commissioners, however at this stage the Trust does not have signed Long Term Agreements (LTAs) with Health Boards; formal agreement will be summarised within the LTAs, signoff of which is required by the 28th June 2024 at the latest. The Trust reached out to Health Boards during January 2024 around planning assumptions, in addition to working with the collective Commissioners' Group to review the plan in detail. LTAs have been issued to Health Boards. Signed LTAs are currently not in place.

Hilary Jones queried the potential impact of outstanding signed off LTAs. Chris Moreton advised that this sequence of events is not unusual and that the IMTP had been approved the previous year prior to signing of the LTAs. Mitigating arrangements have been implemented to ensure communication with Health Boards is clear in terms of the Trust's assumptions, to enable resolution of any issues ahead of time. An additional letter had been received from the Director General of Finance of Welsh Government, confirming that the 3.67% discretionary allocation would be passed through to providers. Therefore, there is confidence that this arrangement remains extant.

Vicky Morris indicated that the Board had not received the flowchart of what is expected for QIAs to have progressed through before coming to Board. Despite stipulation in the document that 3 signatures are required for QIA signoff, no signatures were present in the 3 QIAs relating to the Welsh Blood Service. The Board agreed that it was not appropriate for unsigned QIAs to be presented to Board as this does not provide the required assurances from Executive clinical colleagues. Jacinta Abraham advised that the lack of signatures was not due to concerns preventing signing of QIAs, rather processes and that this would be rectified appropriately.

The Vice Chair re-iterated, for clarity, that in order to achieve a balanced IMTP for 2024-25, there is an assumption of **£1.179m** planned savings to be achieved, in addition to **£1.427m** income generation, which will involve a significant amount of work.

Gareth Jones queried whether there was confidence that the savings schemes with a RAG rating of Red (totalling £934k) is realistically

	achievable. Chris Moreton advised that the figure was inaccurate and would be amended to the correct figure of £660k. It was confirmed that plans are in place across divisions to identify schemes to bridge this gap. It was agreed that all the figures in this section of the document would be amended to increase the Amber and Green rating figures accordingly. Based on discussions noted above, the Trust Board **APPROVED** the Trust's IMTP 2024-25 – 2026-27 for submission to Welsh Government, which included: • Service plans for the Welsh Blood Service and for the Velindre Cancer Centre; • The Trust Financial Plan; • Plans for or enabling functions e.g. digital services. The Vice Chair re-iterated the governance route through which the paper had progressed and amendments were **NOTED**. The Board also **NOTED** the requirement for the Trust to submit a fully approved IMTP on the 28th June, in doing so, recognising that two LTAs remain unsigned but that this is usual process. Carl James advised that a more digestible 10 page summary would be available for public consumption during the first weeks of April 2024. Gareth Jones questioned when a Welsh translation of the document would be available. Phil Hodson advised that as per standard process, the document would be fully translated into Welsh, before publishing both versions simultaneously. Phil Hodson also confirmed that translation of the condensed document would also be undertaken.	**CM**
5.2.0	**Accountability Conditions** Following approval of the Integrated Medium Term Plan (IMTP) 2023-24 to 2025-26, an Accountability Conditions letter had subsequently been received during October 2023 from the NHS Wales Chief Executive, stipulating the requirement for the Trust to report progress against the Conditions on a quarterly basis. Appendix 2 provided an outline of progress to date and there was confidence that all accountabilities set for the Trust would be discharged within this financial year. No questions were raised and the Trust Board **NOTED t**he progress update against the Welsh Government Accountability Conditions in **Appendices 1 and 2.**	
5.3.0	**Integrated Medium Term Plan (IMTP) 2023-2024 Quarter 3 Update** The report provided an update of progress against actions included within the IMTP for 2023-24, as at Quarter 3. Carl James drew the Board's attention to the following two amber rated actions contained in the report: • **Implementation of the national Transforming Access to Medicines (TrAMs) Model across Velindre Cancer Services –** It was noted earlier in the meeting that the TrAMs programme is currently running	

	behind schedule. Whilst this is out of the Trust's direct control, close monitoring and Trust engagement with the programme continues. • **Implementation of the approved Full Business Case for the development of the new Velindre Cancer Centre (nVCC) by 2025/26 –** Carl James advised that the Full Business Case is currently awaiting Welsh Government approval. Whilst the update provided information to the end of Quarter 3 only, it was noted that a forecast trajectory had been undertaken in terms of the position as at March 2024, which will form the basis of the IMTP for the coming year. An update on items not achieved will be provided at the next meeting. The Trust Board **NOTED** the progress made in the delivery of the agreed IMTP (2023-2026) actions as at Quarter 3, for the Velindre Cancer Service, the Welsh Blood Service and Trust-wide initiatives.	
6.0.0	**CONSENT ITEMS**	
6.1.0	**CONSENT FOR APPROVAL** Gareth Jones requested removal of item 6.1.4 (Charitable Funds Committee Terms of Reference) from the consent agenda, to allow for further discussion.	
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.	
6.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chair's Urgent Actions taken between **23/01/2024** and **19/03/2024.**	
6.1.3	**Strategic Equality Plan 2024-2028** Vicky Morris queried which Committee would be responsible for the monitoring of the Strategic Equality Plan. Sarah Morley advised that a detailed Smart action plan would be monitored via the Quality, Safety & Performance Committee. The Trust Board **APPROVED** the Strategic Equality Plan and Objectives.	
6.1.4	**Charitable Funds Committee Terms of Reference** This item was removed from the consent agenda to allow for further discussion. Gareth Jones noted that sections 2 (Background) and 3 (Assessment) of the cover paper had not been completed. Vicky Morris noted that a significant amount of narrative in relation to the Advancing Radiotherapy Cymru (ARC) Programme Board had been introduced into the Terms of Reference and therefore attention should have been drawn to material changes such as this in the cover paper. Gareth Jones noted that there was no information contained in the Terms of Reference in relation to the running of the Advancing Radiotherapy Cymru	

	(ARC) Academy, including arrangements between the Trust and other cancer centres regarding ARC management, which is essential information. Andrew Westwell advised that now chairs the new ARC group, which succeeds the Advancing Radiotherapy Fund (ARF) Advisory Group. The Terms of Reference for the ARC group currently remain under development. The paper was **NOT APPROVED** by the Trust Board and was withdrawn for reworking on the basis of the queries noted above. It was agreed to include further content and context within the cover paper, in addition to appending the Terms of Reference for the Advancing Radiotherapy Cymru (ARC) Programme Board. It was agreed that this should be progressed via an appropriate governance route for out of Board approval.	**LF**
6.1.5	**Velindre University NHS Trust Food Mission** The Trust Board **APPROVED** the Velindre University NHS Trust Food Mission set out in Appendix 1 and **NOTED** that actions arising from the Strategic Development Committee (March 2024) in relation to the Quality Impact Assessment will be completed in April 2024 and incorporated within the Food Mission Action Plan.	
6.1.6	**Surrender of Lease Part Ground Floor Matrix House Swansea** The Trust Board **APPROVED** the Lease to be surrendered for the Trust to sign and seal on behalf of NHS Wales Shared Services Partnership (NWSSP).	
6.1.7	**Deed of Rectification with Toast (Mail Order) Limited** Gareth Jones noted that the Trust had been incorrectly named in the document. The Trust Board **APPROVED** the signing of the Deed of Ratification, subject to the amendment noted above.	
6.1.8	**Tenancy at Will Agreement for the Du Pont Building** Gareth Jones noted that the Trust had been incorrectly named in the document. The Trust Board **APPROVED** the signing of the Tenancy at Will for the Du Pont Building, subject to the amendment noted above.	
6.1.9	**NWSSP Companies House & Charnwood Court to Cefn Coed, Nantgarw proposed relocation** The Trust Board **APPROVED** the new lease prior to signing and sealing on behalf of NWSSP.	
6.2.0	**CONSENT FOR NOTING**	
6.2.1	**Trust-wide Approved Policies Update** The Trust Board **NOTED** the policies that had been approved during the period **February 2024 to March 2024.**	

6.2.2	**Public Quality, Safety & Performance Committee Highlight Report (14/03/2024)** 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 (12/03/2023)** **This paper was not received.	
6.2.4	**Public Charitable Funds Committee Highlight Report (20/02/2024)** **This paper was not received.	
6.2.5	**Remuneration Committee Highlight Report (14//03/2024)** The Trust Board **NOTED** the content of the report.	
6.2.6	**Local Partnership Forum Highlight Report (08/03/2024)** The Trust Board **NOTED** the content of the report.	
6.2.7	**Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report (25/01/2024)** The Trust Board **NOTED** the content of the report.	
6.2.8	**Public Welsh Health Specialised Services (WHSSC) Committee Briefing (30/01/2024 & 27/02/2024)** The Trust Board **NOTED** the content of the reports.	
6.2.9	**Emergency Ambulance Services Joint Committee (EASC) Briefing (30/01/2024)** The Trust Board **NOTED** the content of the report.	
6.2.10	**NHS Wales Shared Services Partnership Committee Assurance Report (18/01/2024)** The Trust Board **NOTED** the content of the report.	
6.2.11	**Trust Seal Approval Report – (31st January 2024 – 25th March 2024)** The Trust Board **NOTED** the content of the report.	
7.0.0	**ANY OTHER BUSINESS** The Vice 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 23rd May 2024 at 10:00h.	
9.0.0	**CLOSE**	

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	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**
4.3.0	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.	**CLOSED**
4.3.0	Clarify % increase in SACT referral rate noted in Performance Management Framework.	Acting Director of Velindre Cancer Service	**23/05/2024**	Update to be provided at May Trust Board.	**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**	**Update 16/05/2024** – The Values and Behaviour Framework including a Communications Plan went to Executive Management Board on 29.4.24 and is timetabled for Quality, Safety & Performance Committee and Trust Board on 30.7.24. The formal launch of the Values will take place on 5 June 2024 with an All Staff Briefing led by Executive Directors.	**OPEN**
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	**23/05/2024**	**Update 14/05/2024 -** This is on the agenda for the May 2024 Board meeting.	**CLOSED**
ACTIONS ARISING FROM 26/03/2024					
1.4.0	Confirm that Risk 2515 (Brachytherapy) was addressed at February 2024 Executive Management Board.	Director of Corporate Governance & Chief of Staff	**23/05/2024**	Update to be provided at May Trust Board.	**OPEN**

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

4.1.0	Detail for each phase of recruitment programme for Radiotherapy Physics Department to be provided via Vicky Morris / Quality, Safety & Performance Committee.	Acting Director of Velindre Cancer Service / Chair of Quality, Safety & Performance Committee	~~**23/05/2024**~~ **30/07/2024**	**Update 14/05/2024 -** IRS project board has been tasked with this and a summary will be shared at the July Trust Board meeting.	**OPEN**
4.1.0	Discuss mechanism to enable more frequent updates to Board and Quality, Safety & Performance Committee regarding risks associated with SACT services.	Director of Strategic Transformation, Planning and Digital / Chair of QS&P Committee / Vice Chair	**23/05/2024**	Update to be provided at May Trust Board.	**OPEN**
4.2.0	Most recent updates / narrative to be inserted in section 5 of Trust Assurance Framework for ease of visibility.	Director of Corporate Governance & Chief of Staff	**23/05/2024**	Update to be provided at May Trust Board.	**OPEN**
4.3.0	Explore national and CIVICA set targets for "Friends and Family" and "Your Velindre Experience".	Interim Deputy Director of Nursing, Quality & Patient Experience	**23/05/2024**	**Update 14/05/2024 -** National Targets set at 85%. Velindre agreed an internal target of 95%.	**CLOSED**
5.1.0	Figures to be amended within saving scheme section of March 2024 IMTP / Financial Plan.	Deputy Director of Finance	**23/05/2024**	**Update 14/05/2024 –** The Summary of the Financial Plan table and commentary on the savings plan were updated in line with feedback provided by Independent Members. The Medium Term Financial Plan was then submitted with the IMTP to Welsh Government in time with the deadline.	**CLOSED**
6.1.4	Background and Assessment sections of cover paper for Charitable Funds Terms of Reference to be completed, including context for inclusion of narrative in relation to ARC Programme Board. Terms of Reference for ARC to be appended to Charitable Funds Terms of Reference.	Director of Corporate Governance & Chief of Staff	**23/05/2024**	Update to be provided at May Trust Board.	**OPEN**

TRUST BOARD

CHAIR'S UPDATE REPORT

DATE OF MEETING	23rd May 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.
- Private Trust Board meeting 26th March 2024.
- Independent Members.
- Chair's Appraisal with Minister – 18th March 2024.
- WBS Donor Awards – 19th / 20th March 2024.
- WBS Donor Awards – 23rd / 24th April 2024.
- VE Day Celebrations – 8th May 2024.
- Nursing Conference – 13th May 2024.
- The Learned Society of Wales.
- Recycling of walking aids at Velindre Cancer Centre.
- Retirement of Chief Executive Officer.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Board Development Sessions

No Board Development Sessions took place during the period.

3.2 Private Trust Board meeting 26th March 2024

Discussions at the private meeting of the Trust Board which took place on the 26th March 2024 addressed the following items:

- Minutes of previous extraordinary Trust Board meetings.
- Chair's Urgent Actions.
- Highlight Reports from recent private Committees.
- Renewal of All Wales NHS Building for Wales Frameworks.
- Infected Blood Inquiry and next steps.

3.3 Independent Members

The Trust is delighted to welcome the appointment of Lindsay Foyster as Independent Board Member for Equality, Diversity and Inclusion. Lindsay's distinguished career in the charity sector in Wales and previous roles of Corporate Diversity Lead for Mind and the Non-Executive Board Diversity and Equality Champion at Audit Wales will bring a wealth of experience to the remit of the Board.

The Trust has also recently welcomed the appointment of Dr Susanna Whawell as Associate Independent Board Member. Her role will see her contribute her skills and expertise across a number of areas, assisting the Board in overseeing the governance system. Susanna's experience in overcoming barriers to the successful implementation and use of systems will bring many benefits to Velindre.
Arrangements to recruit an independent member with a finance background are progressing

3.4 Chair's Appraisal with Minister – 18th March 2024

The Chair attended an appraisal meeting with the Minister during March and has subsequently received objectives for the coming year. The Chair is in communication with the Minister's office regarding ensuring the objectives capture some key developments and when finally agreed, these will be shared with Independent Members and the Executive Team.

3.5 WBS Donor Awards – 19th / 20th March 2024



The March Welsh Blood Service Donor Awards welcomed 111 milestone donors over two nights to the Village Hotel, Cardiff, to celebrate their 50, 75 and 100 blood donation milestones. The evening was also attended by a number of 50, 100, 200, 350, 500 and 1,000 platelet donors and 7 very special bone marrow donors. Also in attendance were our community partners The Football Association Wales, to receive the special recognition award for their outstanding work on the 'Blood, Sweat and Cheers' campaign, which has potentially saved over 3,000 lives to date. Professor Andrew Westwell and the chair were in attendance.

3.6 WBS Donor Awards – 23rd / 24th April 2024



The April Welsh Blood Service Donor Awards welcomed 98 milestone donors over two nights at ceremonies in the Ramada Plaza, Wrexham and Celtic Royal Hotel, Caernarfon, to celebrate their 50, 75 and 100 blood donation milestones.

Across the two ceremonies, the donors had collectively saved up to 20,325 lives as a result of their continued commitment to regular blood donation. Several attending donors had reached their 100 donation milestones.

3.7 VE Day Celebrations – 8th May 2024

Victory in Europe (VE) Day occurred on May 8th, 1945. To celebrate this important occasion and to shine a light on the collaborative work that the Welsh Blood Service has undertaken with military services and personnel over the years, a very special piece of artwork was unveiled. The Chair, The Chief Executive and Director of Welsh Blood Service were in attendance.

Armed Forces Veteran, Stephen Roberts, who works in Digital Services across the Trust, has been working with a local artist, Doug Leech, to bring this to life in the form of a painting, now on display in the Welsh Blood Service in Talbot Green. The VE Day project demonstrates the Trust's appreciation of the service of our Veteran staff, donors and supporters and we were pleased that members of Valleys Veterans and 203 Wales Field Hospital were also in attendance.



3.8 Nursing Conference – 13th May 2024



On International Nurses' Day, 2023, the Trust hosted its second Nursing Conference, providing registered nurses, health care support workers and clinic collection assistants from across the Trust with an opportunity to celebrate past successes and plan future achievements. This year's Annual Nursing Conference, attended by the Chair, Chief Executive, IMs and other members of the Executive Team was held at Cardiff City Stadium and included inspiring talks, interactive workshops and networking opportunities. The conference also celebrated the vital role nurses play in shaping the future of healthcare and driving positive change.

3.9 The Learned Society of Wales



Four Colleagues from across Velindre University NHS Trust have been honoured with a prestigious accolade. The Learned Society of Wales has awarded Fellowships to Professor Mark Taubert (Clinical Director for Palliative Medicine), Dr Seema Arif (Consultant Clinical Oncologist), Professor Peter Groves, Chairman of Health Technology Wales) and Professor Andrew Westwell, Independent Member. This is an outstanding achievement.

3.10 Recycling of walking aids at Velindre Cancer Centre

A new scheme has been launched by Velindre Cancer Centre Therapies Department to recycle hundreds of walking aids a year. Many patients supported by the Cancer Centre require walking aids (sticks, crutches and Zimmer frames) during their cancer journey and the new scheme calls on patients and their families to return the walking aids they no longer require so they can be refurbished for future patients. The aids can be dropped of anonymously. Reusing a walking aid is on average 98% lower in



carbon emissions than ordering new. Walters, a partner in the enabling works for the new Velindre Cancer provided the materials and Mens Sheds Lisvane built the structure. Mens Sheds Lisvane was established after a VCC workshop delivered with community partners, Ray of Light, where they first learned their woodworking skills.

3.11 Retirement of Chief Executive Officer



After almost 15 years with the Trust, including 10 years as Chief Executive, Steve Ham will be retiring at the end of June.

Steve has led the Executive Team through a number of challenges and very recently, the Trust has achieved a number of milestones following an unprecedented period of challenge and change.

Arrangements are underway to appoint an Interim Chief Executive from July 1 2024, for a four month period. It is hoped that a new Chief Executive will be appointed in early August 2024.

As chair, I wish to acknowledge the support Steve has given me during my tenure as chair. It has been immense.

4 IMPACT ASSESSMENT

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

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

5 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

VICE CHAIR'S UPDATE REPORT

DATE OF MEETING	23rd May 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
- 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 chaired the following Committee and Sub-committee meetings:

- TCS Scrutiny Sub-Committee, Public and Private Meetings – 16 May 2024
- Strategic Development Committee, Public and Private Meetings – 15 May 2024

I have attended the following Committee meetings:

- QSP Committee, Public and Private Meetings – 9 May 2024

External Meetings

On 8 April 2024 I met with the Chair and Chief Executive of City Hospice for a tour of the VCC.

On 8 May 2024 I attended a Meeting of Vice-Chairs of Health Boards and Trusts.

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.

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 undertaken the additional role of IM Mentor to the Mentee assigned to the Trust as part of a Welsh Government pilot programme aimed at "developing and supporting applications for public appointments from a more diverse range of backgrounds and life experiences".

Stephen Harries

Vice Chair

TRUST BOARD

CHIEF EXECUTIVE'S UPDATE REPORT

DATE OF MEETING	23rd May 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:

- Infected Blood Enquiry
- Successful Financial Close
- Joint Executive Team
- CEO's Final Meeting

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Infected Blood Inquiry

Established in 2017, the independent public statutory Inquiry has examined the circumstances in which men, women and children, treated by the NHS, were given infected blood and blood products, in particular in the 1970s, 80s and early 90s.

I attended the launch on Monday 20th May with Alan Prosser and Edwin Massey from the Welsh Blood Service. It was a humbling experience for us, and you will have seen the coverage in the press and on the television.

The Trust has also published the statement below:

Statement by Velindre University NHS Trust, of which the Welsh Blood Service is an operational national service:
"We acknowledge and sincerely apologise for the tragic hurt, pain and loss of everyone infected and affected by blood and blood products.

We take full responsibility for the failings outlined in the report that relate to the Service's actions. Lessons have been and will continue to be learnt in the interest of public and patient safety.

To the infected and affected, we thank you for your courage in sharing your experiences. They will not be forgotten and will underpin our approach to patient safety.

We would also like to thank Sir Brian Langstaff and the Inquiry team for all their work. Expert, detailed analysis has been undertaken with compassion and given a voice to personal experiences that were kept quiet for too long.

We will work with our colleagues across NHS Wales, the Welsh Government and UK Blood Services on our collective response to the report's findings to ensure that the events it describes cannot happen again. We will also continue work in every and any way possible to support the continued work of the Inquiry.

Today, the blood supply chain in Wales is highly regulated and blood services and blood safety have evolved considerably since the tragic events investigated by the Inquiry."

As the statement highlights, we are already working with colleagues across blood services, government and NHS Wales to coordinate our response to the report's recommendations. We will continue to keep you informed about developments and will arrange opportunities to consider what the report means for us all.

It has been a time for reflection. Reflecting on the tragic stories of those infected and affected by contaminated blood and blood products which resulted in pain and loss for so many.

2.2 Financial Close

On 28th March 2024, the final agreement was signed between the Trust and Acorn consortium to design, build and maintain the new Velindre Cancer Centre, scheduled to open in 2027.

Our new cancer centre will enable us to deliver the best possible care and treatment for future generations as more of us are diagnosed with cancer.

Thank you to my Trust Board colleagues for the work we completed together in setting the strategy for this important development for generations to come and the in-depth scrutiny and assurance processes over many years.

2.3 Joint Executive Team

The Trust Executive team met with the Welsh Government Executive team on 14th May. The agenda was:

- Delivery against 2023/2024 plan
  - Strategic
  - Organisational
  - Frontline services

- Transforming our services
  - Velindre Futures/ Transforming Cancer Services programmes
  - Welsh Blood Service Futures

- Delivery in 2024/2025
  - Deliverables
  - Key risks/issues

  The full slide pack will be distributed to Trust Board members under separate cover.

2.4. CEO's Final Meeting

This will be my last Trust Board meeting after almost 15 years with the Trust, including 10 years as Chief Executive. It has been an honour to serve on this Board with all current members and with our colleagues over the years. We have achieved so much together in the service of our patients, donors and staff. I will be reflecting more in thanking the organisation, of which we are all so proud, over the coming weeks but for now I wanted to specifically thank you as a Board.

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.

Gweithredu Gwasanaeth Ddwyieithog / Delivering a bilingual service

Welsh Langugage Champion Annual Report

23 May 2024

1. Purpose of the report

1.1. This Annual Report provides an opportunity to take stock of our progress in embracing the Welsh language, including the progress we have made in meeting our legal requirements and also fulfilling our cultural aspirations. Specifically, this report provides an update on the governanace, compliance and divisional activity relating to the development of a bilingual service for patients and donors.

2. Introduction

2.1. The Welsh Language Standards (Standards) were introduced by The Welsh Language Standards (No. 7) Regulations 2018 and became applicable to the NHS in November 2018. These were implemented under the Welsh Language (Wales) Measure 2011.

2.2. Velindre University NHS Trust (the Trust) currently monitors its compliance against each of the Standards by using a RAG rating system. Most Health Boards and Trusts use this system with some minor differences.

2.3. There are 118 Standards which apply to the Trust and as of April 2023, our self-assessment reflected 68.6% compliance. This will be reassessed during 2024, particularly in light of the Investigations currently being undertaken by the Welsh Language Commissioner.

2.4. Currently, there are 139 Welsh speakers within the Trust who can hold a stable conversation in Welsh with a patient or donor. This figure represents 8.4% of the total Trust workforce.

3. Welsh Language Cultural Plan

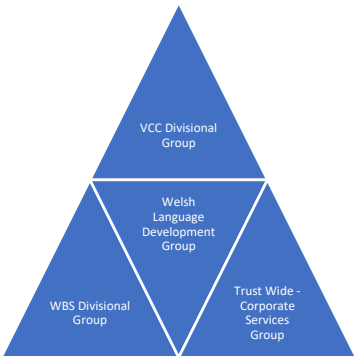
3.1. Our Executive Management Board has agreed the principles of the Welsh Language Cultural Plan and was keen to see it run alongside the development of the new Trust values which were approved in January 2024. Consultation on developing the values highlighted the importance of developing initiatives with a bilingual mindset from the outset, not just translating from English at the end of the process.

3.2. Moreover, our Strategic Equality Plan for 2024 – 2028 includes an action to ‘Truly implement the Active Offer for Welsh speakers and comply with the Welsh Language Standards Framework’.

3.3. The Trust has a Welsh Language plan which includes actions to respond to feedback from the Welsh Language Comissioner, as well as the development of skills, raising confidence and developing the information and reporting mechanisms that allow us to understand our linguistic profile.

4. Governance

4.1. Since 2023 our Governance structure around the delivery and monitoring of the Standards has been strengthened significantly. We now have three divisonal groups that feed into the Trust wide Welsh Language Development Group. This group meets quarterly and highlight reports are shared.



Welsh Blood Service

- The divisonal group has a strong membership and recently added a representative of the collections teams which is extremely encrouraging.
- Focus for this group has been about embedding the language in all aspects of the service.
- The Active offer has also been discussed in this group and will be the next priority as we look at collections and the ability to respond to Welsh language needs. This will be done via awareness training and offers of language training.
- The Group has set up a specific Welsh Language intranet page utilising the Trust wide information and making it specific to their needs, developing standard procedures for basic responses to requests etc.
- They have been proactive in supplying positive input into the Trust's Clinical Consultation Plan.
- Training for reception staff and staff answering telephone calls has been identified and a process agreed.
- Awareness training has been provided by the Trust's Welsh Language Manager in response to an investigation led by the Welsh Language Commissioner.
- A network of departmental Welsh Language Champions is being considered.

The WBS Group is extremely proactive with the promotion of Welsh Language events and celebrations and putting a calendar of events together for staff.

Velindre Cancer Centre

Embedding the new structure took some time at the Cancer Centre due to clinical priorities however the group is now fully established with cross departmental membership.

Its main priorities are to look at:

- Patient accessibility to the language and the collection of patient feedback.

The Active offer is a principle outlined in the Welsh Governement framework, 'More than just Words' and its aim is to offer Welsh langauge services without a patient having to ask for them. This is a principle that means Welsh Language services have to be visible to patients and donors and the service then needs to respond to the need. The main challenge is that the Cancer Center does not have the staff currently with the Welsh language skills required to respond to the need.

- Radiology took this priniciple and worked with the Welsh Language Manager to think of simple yet effective ways of responding to the need should it arise. Separate patient information boards were provided asking patients in both langauges to identify themselves and what they required.

This was the first time the department had done this as previosuly no patient had asked for treatment or information in Welsh. The result has meant that for the first time the department has seen an increase in Welsh language requests and subsequently they have been able to offer a Welsh language service to patients that need it.

A really important step for Cancer services

- Following on from this success Radiology are now focussing on their 'known' Welsh language patients and putting together a pilot to establish what services they would require and look at the prioritisation of services against specified need. This will work in the form of a small survey aimed at providing exactly what patients require and not what the service 'thinks' they would like. The Welsh language Manager is working with the department to focus on priority setting.

  Should this be successful it will be discussed further at the divisional group and the intention is to collect valuable information to move the workforce planning aspects forward.

- Radiotherapy are now working on the same principle and the intention is to roll out the service across all departments, working on language skills needs and address training requirements.

Other focus has been:

- Translation of consent forms
- Collecting language needs of patients through CIVICA – this is the first time we have been able to assess our services in this way and it is already proving useful to identify areas that need further awareness training
- Awareness raising with reception staff and the need to use bilingual greetings – training has been provided
- Raising confidence training is also underway with front line staff. Provided by Newport adult learners and funded by Welsh Government.

Corporate Services

- Translation of policies has been high on the agenda here and a process has been established for future translation as they are uploaded to the Trust website.
- Staff training has been provided to individuals responsible for answering the telephone.
- Resources have been assigned for simultaneous translation and Public Board meetings for 2024-25.

5. 'More than Just words...' Welsh Government framework

5.1. More than Just Words is a strategic framework for Welsh Language Services in Health, Social Services and Social Care launched by Welsh Government in March 2016. At the heart of the framework is the concept that being able to use your own language is an integral part of care.

5.2. The framework has been refreshed on a number of occasions and we are now in a Five Year Plan from 2022-2027.

5.3. The Trust is required to report on compliance against the framework every July. This is a framework and not a legal structure and does not come with penalties for non-compliance.

5.4. The Active offer is the main principle but this version 5 (the current version) also comes with personal performance objectives for Chairs and Chief Executives to ensure that the Active Offer is embedded in and cascaded throughout organisations throughout Wales. The timeline for introducing these objectives was 2023 so that they should be in place already.

6. Embedding the Welsh Language and Culture in our Workforce planning

6.1. Over the last year, the Trust been working towards a fully bilingual approach to worforce planning. Assessing Job roles to ensure we consider the Welsh language and not use a blanket approach or 'desirable' approach to all roles was the first priority. The successful process now follows a simple pathway:

1. Consider the language skill requirements of the role
2. Establish the baseline within the team – at least 10% of Welsh Language Skills required
3. Complete a basic form and share it with the Welsh Language Manager
4. Discussions are held should there be any queries around the decision for either a Welsh Language 'Desirable' post or an 'Essential' post

6.2. To date it is proving extremely useful. In much the same way as the Equality impact assessment process, staff are more aware of why language skills are important and discussions with the Welsh Language Manager has changed perspective in some areas, meaning a role has been changed to 'Essential', thus increasing the Trust's ability to provide a bilingual service.

6.3. Translation of job descriptions was the next priority. Last year 219 job descriptions were translated. An increase from the previous year of 24.

7. Welsh Language Commissioner Investigation

7.1. The Trust recieved its first formal investigation in November 2022 and responded within the time scale agreed. Response to the Investigation was received in March 2023 from the Welsh Language Commissioner.

7.2. The information provided to the Commissioner gave an assurance of:

1. Training for telephone users : This has been provided
2. Training opportunities to be circulated to staff: Complete
3. A Welsh Language awareness dash board developed to monitor take up: Complete
4. Confidence raising training is currently underway. This is an 8 week programme delivered by an external language provider and financed by Welsh Government

7.3. An action plan has been agreed and the Trust has one year to complete a number of actions.

7.4. A second Investigation was recieved in November 2023. The timescale for this compliance with this investigation is shorter, giving us three months to respond and rectify a number of changes to the Trust and Velindre Cancer Centre website.

7.5. An Action plan has been drawn and we are already working on a number of changes around translation and continued monitoring of the sites.

8. Complaints and Resolutions

8.1. As the demand for Welsh Language services increases we have seen the number of complaints rise. In 2023-24, three complaints have been recieved outside of the formal investigation.

8.2. These were focussed on the equality of access to website information.

8.3. All complaints were resolved and measures put in place to recify the translation of pages and policies. The Communications team have since developed a process that reqires a formal agreement to uploading Welsh and English content on to the website at the same time as this should rectify the publishing issues.

9. Summary and Moving forward

9.1. We will continue to focus our efforts on providing a bilingual service for our patients and donors and doing so without them having to request it.

9.2. There is so much to do still especially around capability to provide a clinical consultation in Welsh but we are moving positively toward this. We have a clinical consultation plan that will be monitored by the divsional groups.

9.3. We also have a strengthened SLA with Shared Services to provide translation support to the Trust.

9.4. Our Welsh language team are working with Welsh Government on a number of initiatives including looking at a terminology for Welsh translation and we are actively involved in the development of a National website for sharing best practice on Welsh language initiatives.

9.5. The Welsh Language Standards and the More than just Words framework, continue to be our main focus and our aim is to increase our compliance against the actions set. It is extremely encouraging to note that the work being undertaken to date has provided positive steps in helping us fulfil our objective of improving our compliance. However, over and above that, we are determined that the Welsh language should be embedded in our culture as an organisation and it has been pleasing for me and the Board to witness the huge steps we have taken towards that goal. We are confident that this positive progress will be continued with the updating of the Welsh Language Cultural plan and the workforce planning for 2024 onwards.

Gareth Jones
Independent Member and Welsh Language Board Champion
15 May 2024

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	23RD MAY 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 Trust Board 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 Trust Board is 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	29 April
Quality, Safety & Performance Committee	9th May
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Quality, Safety & Performance Committee considered the April version of the risk register. To note that there was an error in the Committee cover paper which stated that 3094, 3095, 3247 and 2200 were new risks – this was not the case and has been corrected in this paper. An updated paper for Quality, Safety & Performance Committee record will also be loaded.	

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

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

APPENDICES	
1-4	Current risk register data.

1. SITUATION

The report is to inform the Trust Board of the status of risks reportable at Board, in line with the Board approved risk appetite levels. In addition, the report will update on progress on the development of the risk framework.

2. ASSESSMENT

2.1 Trust Risk Register

There are a total of 12 risks to report in line with the Trust's risk appetite during this reporting period. This includes 8 risks with a current score over 15 and 4 risks with a current score of 12, reported in the 'Safety' domain. The information is an extract from Datix 14.

2.2 Updates following May Quality, Safety and Performance Committee

It was discussed in Quality, Safety and Performance Committee in May, and since further with the Committee Chair, that going forwards there will be clearer layout in the register to show change since the last report. This is in addition to the cover paper continuing to highlight key points.

It was also discussed that the format of the attached registers had become cumbersome to read easily given the level of detail included. Since the Quality, Safety and Performance Committee, there has been some initial improvements made in this respect and this will be further considered in the next reporting cycle.

2.3 Changes since the previous reporting cycle

- ***3094*** *- There is a risk that we will not meet IRR17 regulatory compliance as a result of insufficient activity or resources to deliver the relevant risk assessments and subsequent actions leading to reputational risk and potential risk of inappropriate radiation to patients and staff (Score 20)*

  Score reduced to 9 – Given programme of risk assessment underway through the Radiation Protection Group. The management of regulatory compliance for and on behalf of the employer related to IRR17 and Ionising Radiation (Medical exposure) Regulation (Ir(Me)R) determined.

- ***3095*** *- There is a risk that HSE will issue a non-compliance order or enforcement notice on VCC as a result of lack of compliance with IRR17 regulations and risk assessments leading to reputational damage and potential radiation risk. (Score 16)*

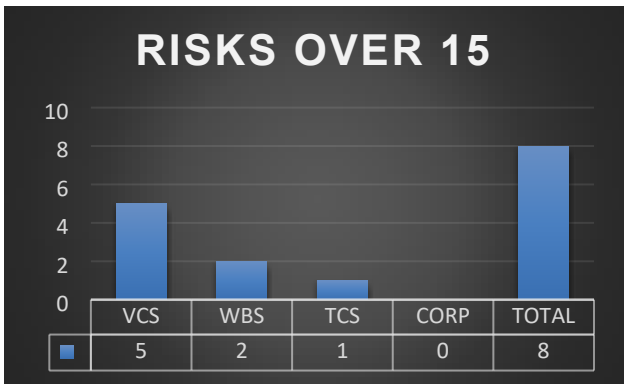
  Score reduced to 9 - Health and Safety advisor now recruited and in post. Radiation risk assessment work plan managed through Radiation Protection Group and on target.

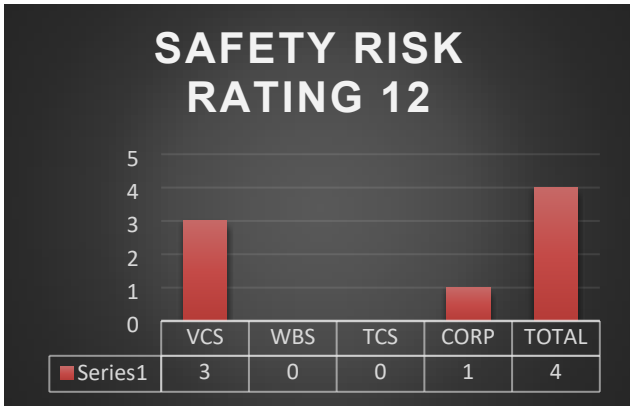
- All other risks have remained at consistent scoring for the period.

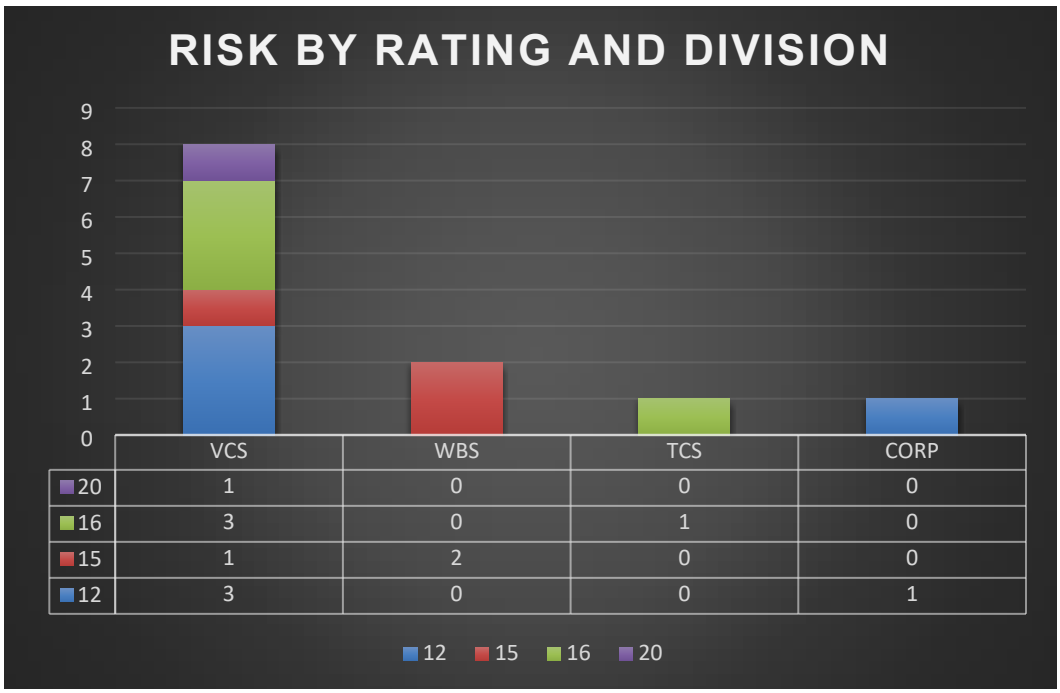
- To also note that for risk ***3227*** regarding new Velindre Cancer Centre financial stability remains on Datix for the April extract. However, following Financial Close for the new Velindre Cancer Centre, all associated risks have been undergoing review in line with the Trust Board approved Full Business Case Management Case and then the new risk profile agreed through the governance cycle. These papers are being considered in the new Velindre Cancer Board in May and June and will then be reported through the Committees and to Trust Board.

2.4 As a new addition, all risks which have a residual score of more than risk appetite levels and new for April are included in separate appendices – there are 4 risks. This is to provide visibility for assurance purposes that the quality of the control framework is in line with the residual scoring.

2.5 As a further addition, the split of risks is shown below for Board reporting levels:







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

3.1 All Wales Datix module

Work is progressing and the Trust will need to make a decision on next steps over the summer. This is being coordinated at an All-Wales level and since March 2024 chaired by the Velindre Director of Corporate Governance & Chief of Staff.

3.2 Other development and improvement work tracker is below. The matters that were agreed as closed in the March Trust Board have been removed from the table.

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe/ Update	Status
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	July reporting cycle	Deep dive work underway for July 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	Propose to close – implemented in this report
10	Risk report to track overall number of risks at different scores in Datix	To action for March reporting cycle	May reporting cycle	Propose to close – implemented in this report
11	Risk Register format	The format of the attached risk register has become difficult to read given the level of detail	May reporting cycle	Initial improvements made for May Trust Board report. Further development for July report.
12	Timing of the cycle of risk review	Review timing of the cycle of risk review and oversight between the Divisional Senior Leadership	July reporting cycle	Requires further input from IMs – to confirm for July reporting.

		Teams, Executive Management Board, Committees and Trust Board.		
13	Management of risk reviews in timely way	Review all risk review dates in a structured way through management and governance	July reporting cycle	July report.

4. 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.

5. 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 Type	Opened	Division	RR - Current Controls	Risk (in brief)	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Risk Decision	Controls in place	Adequacy of Controls	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	Description
3326	There is a risk to staffs health as a result of Repetitive strain injury leading to potential claims and staff sickness.	Safety	06/02/2024	Corporate Services	ESR online mandatory training (no renewal) Face to face assessments picked up by the H&S Advisors and Compliance Manager. (informal arrangement) Revision of the Trust DSE policy May 2023 to include home self assessments SLA with Cardiff & Vale Occupational Health for ill health referral (does not include DSE assessment provision)	It is not yet known if the Covid-19 pandemic and working from home arrangements, including hybrid working and ad hoc hot desk arrangements will result in personal injury claims, given that repetitive strain injuries can take a while to develop. There is therefore a requirement to ensure that health and safety requirements have sufficiently been met to comply with health and safety legislation and ensure that there is adequate provision for safe systems of work to prevent staff from sustaining injury that could otherwise have been prevented. To comply with regulation our policy states: • Suitably trained DSE Assessors are available to provide advice on DSE assessments and to refer to health and safety teams or Occupational Health where the issues are beyond their capacity. • Processes are in place to ensure	Probable - Will probably occur/reoccur but will not be a persistent issue.	3 - Moderate	12	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	Treat - actions agreed to reduce the level of risk which will be implemented		Inadequate	Possible - May occur/reoccur at some time / occasionally.	2 - Minor	6	30/03/2024	
3346	There is a risk that the continuation of safe patient care and financial income	Safety	26/02/2024	Velindre Cancer Centre	1. Appointments not processed on WPAS reviewed and processed.	Outpatient Oncology Notes (OON) have not been created/created correctly or processed in a timely	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8	Treat - actions agreed to reduce the level of risk which will be	1. Staff training and awareness on the accurate processing of patient activity.	Adequate	Unlikely - Not expected to occur/reoccur but there is some possibility.	3 - Moderate	6	28/06/2024	Implementation of Medical Secretarial Service Model
3367	There is a risk to PERFORMANCE, SERVICE SUSTAINABILITY and SAFETY as a result of the termination of the current contract for Chemocare in October 2024, leading to a failure to safely deliver SACT treatment within VCC.	Multiple Risk Domains	04/04/2024	Velindre Cancer Centre	Work is already underway nationally, led by NWSSP, to secure an extension to the current contract for the 5 NHS Wales organisations (including VUNHST) who use Chemocare. The aim is to secure a 5-year extension of the current contract, to include provision to establish a single, national instance of Chemocare during the period of the new contract.	The current contract for the VCC instance of Chemocare expires in October 2024. Chemocare is used to support the administration of SACT chemotherapy treatments in VCC - an essential tool to safely and effective schedule and track SACT treatments for VCC patients.	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be implemented		Adequate	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	4 - Major	4	04/06/2024	
3373	There is a risk to Quality and patient safety as data integrity of the cold chain monitoring system may be impacted because the primary server needs to be replaced.	Quality	12/04/2024	Welsh Blood Service	1. A manual backup of the data has been saved for the system that becomes the roll back to option to restore data. 2. Each Datanode includes one weeks data on the system. 3. Step 1 describes the extraction of a sample data set for verification of integrity during process "Risk Domain""Ref No""Item / Function/ Risk Summary""Potential Failure Mode(s)""Potential Effects of Failure/Impact of failure""Initial Impact""Potential Cause(s)/ Mechanism(s) of Failure""Initial Likelihood""Current Design Controls (Preventative/ Detection Actions)""Initial Detection""Initial RPN""Risk Treatment Plan & Recommended Actions""Responsible Person & Target Completion Date""Impact Current""Likelihood Current Detection Current""NEW RPN	background Following a RCA INV973 the primary server on the cold chain monitoring system is to be replaced. Situation The following process has been designed in collaboration with the SME from the supplier, with SME from across the WBS including, digital, Validation, System admin, System owner. Operational leads, the RP and QA Systems have been informed of the process throughout this investigation. Aim: The aim is to design a process that supports the safe replacement of the primary server whilst ensuring service continues for users and the validation status and data integrity are maintained. Method statement to be completed by the supplier: Method statement to be completed by the supplier and written into the validation documentation that will be provided on completion. Purpose	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	5 - Critical	5	Treat - actions agreed to reduce the level of risk which will be implemented		Adequate	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	5 - Critical	5	11/04/2025	

ID	Risk Title - New	Risk Type	Opened	Division	RR - Current Controls	Risk (in brief)	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Risk Decision	Adequacy of Controls	Likelihood (Target)	Impact (Target)	Rating (Target)	Review 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.	Safety	09/12/2022	Corporate Services	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.	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	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	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 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, cas 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	Safety	19/10/2023	Velindre Cancer Centre	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	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	Inadequate	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	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 Digital Officer New Patient Waiting List Referral Discussion with Health Board Colleagues Establish Workstream - Referrals and Referral Process Transformation Fund - Planned Care
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.	Safety	14/09/2020	Velindre Cancer Centre	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.	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	Expected - Will occur/reoccur and likely to be frequent.	5 - Critical	25	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be implemented		Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8	31/05/2024	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	Safety	05/11/2021	Velindre Cancer Centre	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal	There is a risk of severe harm due to the excessive use of email both internally and externally to the	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	Unlikely - Not expected to occur/reoccur but there is some	2 - Minor	4	28/06/2024	

RISKS OVER 15

ID	Risk Title - New	Risk Type	Opened	Division	RR - Current Controls	Risk (in brief)	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Risk Decision	Adequacy of Controls	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	Description
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	Quality	08/09/2023	Welsh Blood Service	"Respond to change notifications Collaborate with other UK Services in groups such as The Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO). 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 "□	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.	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Treat - actions agreed to reduce the level of risk which will be implemented	Adequate	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	5 - Critical	5	13/05/2024	Review/update review/update Review/update
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.	Financial Sustainability	16/10/2023	Transforming Cancer Services	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	changes during the design development process lead to a design which costs more overall, increasing project costs.	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	Treat - actions agreed to reduce the level of risk which will be implemented	Adequate	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	31/10/2023	Increasing Costs
3247	There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times.	Workforce	08/11/2023	Velindre Cancer Centre	Clinic review as part of the preparation process. Audit of consultation room utilisation. Controls and risk mitigation to be developed.	Increased patient demand leading to clinics being overbooked, increasing Consultant and Clinical workload	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	Tolerate - the level of risk is tolerated where there are no safe alternatives and any action(s) considered would increase the level of risk	Inadequate	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	29/03/2024	Group Review of Risk for Acceptance and Escalation to SLT Implementation of a virtual consultation hub Conversion of OP office space to Consultation Room Business Case to be developed to create 4 Consultant Roomss Baseline of clinic start/end times Establish Workstream - Demand and Capacity Amendment to Clinic Start/End Times Amendment to clinic templates
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.	Multiple Risk Domains	21/12/2023	Velindre Cancer Centre	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.	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.	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	Tolerate - the level of risk is tolerated where there are no safe alternatives and any action(s) considered would increase the level of risk	Adequate	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	Safety	13/02/2024	Velindre Cancer Centre	daily escalation meetings take place to ensure that patients are identified and managed appropriately	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	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	Treat - actions agreed to reduce the level of risk which will be implemented	Inadequate	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	Safety	13/02/2024	Velindre Cancer Centre	daily escalation meetings outsourcing more product to suppport capacity within pharmacy	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.	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Treat - actions agreed to reduce the level of risk which will be implemented	Inadequate	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	04/06/2024	

3350	There is a risk to performance and service sustainability due to the Welsh Blood Service transport function being unable to deliver services due to operating an ageing fleet of commercial vehicles	Performance and Service Sustainability	04/03/2024	Welsh Blood Service	Daily vehicle checks/Robust defect reporting system Annual service/MOT Resilience vehicles Rotation of vehicles to manage mileage and extend operating life of vehicle Transport office staff available to assist during normal working hours as well as on call cover	A risk assessment was undertaken to determine the risk associated with operating an ageing commercial fleet of vehicles and how this could impact on the ability of the transport function to deliver the required levels of service to both internal and external customers. The risk assessment took into account the impact of specific vehicle failures (minibuses, delivery vans, lorries and support vehicles and the MDC combination) and the overall risk of not replacing the vehicle fleet within the appropriate timeframe.	Expected - Will occur/reoccur and likely to be frequent.	3 - Moderate	15	Expected - Will occur/reoccur and likely to be frequent.	3 - Moderate	15	Tolerate - the level of risk is tolerated where there are no safe alternatives and any action(s) considered would increase the level of risk	Inadequate	Probable - Will probably occur/reoccur but will not be a persistent issue.	3 - Moderate	12	12/06/2024	Reiew risk assessment 3350 - review date 12/06/2024
2200	There is a risk to the performance of the radiotherapy service as a result of insufficient capacity within the current linear accelerator fleet, leading to the radiotherapy service being unable to meet the current and anticipated demand. See Risk assessment attached for full details.	Multiple Risk Domains	01/05/2011	Velindre Cancer Centre	UPDATED 3/4/2024 - Ongoing monitoring of capacity and demand. - Ongoing monitoring of breaches of waiting times targets. - Extended working hours are in place on the treatment machines and in many other areas of the service. - Machine replacement program initiated, improving the age and capability of the linac fleet but not linac configuration.	There is a risk to Performance and Service as a result of insufficient capacity within the current linear accelerator fleet, leading to the radiotherapy service being unable to meet the current and anticipated demand. The lack of sufficient capacity within the Radiotherapy service has had the following consequences:- Compliance risk -An inability to maintain waiting times compliance. -Creation of waiting lists. -Inability to meet RCR clinical guidelines. Patient safety risk -Patients will wait longer to start treatments resulting in possible poorer clinical outcomes, lack of symptom control and poor patient experience. Reputational risk -Limited service developments with a corresponding delay or inability to meet IMTP objectives. -Restricted ability to participate in clinical trials or research projects. -Issues with recruitment and retention of staff.	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Expected - Will occur/reoccur and likely to be frequent.	3 - Moderate	15	Treat - actions agreed to reduce the level of risk which will be implemented	Inadequate	Unlikely - Not expected to occur/reoccur but there is some possibility.	3 - Moderate	6	28/06/2024	

TRUST BOARD

Trust Assurance Framework

DATE OF MEETING	23RD MAY 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	This paper summarises provides the latest view of the Trust Assurance Framework.
RECOMMENDATION / ACTIONS	The Committee 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
Quality, Safety & Performance Committee	9.5.24
Executive Management Board	17.5.24

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Quality, Safety and Performance Committee on 9th May considered the April iteration of the Trust Assurance Framework.

Executive Management Board (Shape) which considers the Trust Assurance Framework each month met on 17th May and therefore this Trust Board paper includes that updated version.

APPENDICES	
1	Trust Assurance Framework

1. SITUATION

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

2. ASSESSMENT

2.1 There are two specific matters which were discussed in the Executive Management Board on 17th May to also highlight for the Trust Board:

2.2 Firstly, it was discussed which two risks were recommended for deep dive in the July Quality, Safety and Performance Committee. The conclusion was:

- TAF 06 Governance - *"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."*

  The discussion in the Quality, Safety & Performance Committee can form an important part to the progression of the 'Governance, Assurance & Risk - Phase two' through the governance cycle in July also.

- TAF 05 Digital – *"There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security."*

  An overview of Digital risks was considered in the January 2024 Quality, Safety & Performance Committee. A further discussion in the July Committee on TAF 05 would therefore provide an opportunity for the matters raised to be updated and further assurance provided.

2.3 Secondly, there has been further work on the approach of the integration of the Integrated Medium Term Plan with the Trust Assurance Framework.

In the July version there will be an additional section in the Trust Assurance Framework template to include the relevant Integrated Medium Term Plan actions. This mapping will be completed following a series of meetings between the Executive Directors and Director Corporate Governance with support from the Strategic Transformation team.

The longer term approach will be to re-orientate the Trust Assurance Framework according to strategic objectives. The template and approach for this to be agreed by October, in order to allow the development of the 2025-2028 Integrated Medium Term Plan and Trust Assurance Framework to progress on this basis during Quarter 3 and 4.

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.	Although issue with lack of risk/assurance resource continues, it has been possible to progress the development work is complete and there is a usable version of the

			dashboard on SharePoint. Next steps are to migrate the dashboard through the Power Automate Exporting Tool. Expect to be available to start migration by end June.
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Full update in paper in section 2.2 above	Phase 1 – July reporting cycle. Phase 2 – aligned to 2025/6 Integrated Medium Term Plan development
4	Deep dive of two risks at Quality, Safety & Performance Committee going forwards	Following reporting of refresh framework of strategic risks, this will recommence from the next reporting cycle.	Complete – included in 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 c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions	July 2024 - in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

		and responsibilities. This may include further Board development time etc.	
6	Tracked changes	Tracked changes will be highlighted more clearly to show recent updates. In addition, the cover paper will be developed to include clearer commentary of key changes.	July reporting cycle – This will be automated based on migration to Power BI template as per improvement action 1 above.

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)	**Choose an item** All Strategic Risks are related.

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). 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 / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual Service Level Agreement meetings with Health Boards to review supply. Benchmarking against National and International standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Regular meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	PA	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plans	PA	Welsh Government Quality, Planning and Delivery Review Internal Audit, Wales Audit Office, regulator audits.	PA
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	PA	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	PA	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government Emergency Preparedness, Resilience and Response (EPRR) for Health, Local Resilience Forum - Strategic Coordinating Group. Internal Audit, Wales Audit Office, regulator audits.	PA
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB to review.	PA	QSP committee and Board and external stakeholders if required. Internal Audit, Wales Audit Office, regulator audits.	PA
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			E	Horizon scanning and representation at key forums including UK Forum, Joint Professional Advisory Committee (JPAC) for UK blood services, The UK advisory committee on the Safety of Blood, Tissues and Organs (SaBTO). Regular liaison with Blood Policy and Tissue, Cells and Organs Policy team in Welsh Government.	Not Assessed	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	Not Assessed	QSP, SDC	Not Assessed
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed
C7	Demand and Capacity Plan for each service area of VCS	Director VCS	X	X		PE	Service area operational planning meeting	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ 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 C&V in light of new supplier for All Wales LIMS solution.	18.4.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
A1.1	Working with DCHW to support the Blood Transfution Module of the new All Wales LIMS 2.0 , Track Care Lab Enterprise (TCLE).	Lee Wong	**IA**		Discussions ongoing about funding solutions for blood tracking/fating to patient,	18.4.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
A2	Blood Health National Oversight Group key work streams are underway identifying inappropriate use of blood.	Lee Wong	**PA**		Ongoing work under the remit of the BHNOG to support patient blood management initiatives, including	18.4.24	All Wales programmes which will ensure equity of care for patients.	
	review of outpatient activity to determine what could be repatriated back to Health Boards relasing capacity within the outpatient facility and providing care closer to home for the patient	Head of Medical Services			report to be received			
	formal demand and capacity operational group to be established to provide oversight of current and future plans, manage D&C plans and identify areas of concern with mitigations for escalation as appropraite	Head of Medical Services			Key objective for Head of Service onow commenced in role - as at Dec 2023			

SECTION 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)

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

SECTION 3

Overall Level of Effectiveness: **RATING** **PE**

Overall Trend in Assurance THIS WILL HAVE A GRAPH

KEY CONTROLS

SOURCES OF ASSURANCE

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

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line and second lines of defence assurance are in place to a certain extent	1.9; 1.7; 1.8
Establishment of new commissioning national commissioning function (WHSSC/EASC) regarding blood service commsissioning and specialsit cancer commissioning	Replace of CCLG not in place yet so no regioanl assurance regarding strategic alignment etc	1.9
Agreement of need for improved regionsal cancer commissiong (core services)		1.6; 1.8
Need for improved data/quality metrics to track perforamance	Provision of improved metrics to EMB; QSP and Trust Board	1.3; 1.4

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.4	Phase 1 complete. Development of Phase 2 of PMF with additionalperfromance measures/quality metrics commenced - delivery dates require firming up. Phase 2 elements commenced with a range of new quality indicators proposed for WBS and wider quality dimensions - approved by EMB in May 2024 - for consideration by SDC in May 2024. Progress made on provision of outcome measures/resource utilisation dashboard for all Site Specific Teams in VCS and resource utilisation (may 2024)	Carl James	Mar-24	Design stage commenced and a revised programme has been developed to support the delivery of phase 2.	14/05/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce	Programme outputs to be confirmed	Programme established and staff on-boarded. Progress being made on a number of projects (Food mission; cancer dashboards etc. Progress made on provision of outcome measures/resource utilisation dashboard for all Site Specific Teams in VCS and resource utilisation (may 2024)	11/04/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	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). Still no commencement date. Further regional discussions at the regional summit on 6 june 2024	14/05/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase
1.7	WG review of NHS Wales strategic management / accountability arrangements will potentially identify how strategic alignment across the healthcare system can be stregthened. When completed the Trust will review and identify any actions which strengthen alignement	Carl James	April/May 2024	Trust received request to feed into the review process. Review in progress - NHS organisations have not received any further information at this stage. No further update received on the findings of the national review	14-May-24	Unknown at this state	The level of assurance should increase
1.8	Trust included in SE Wales regional strategic planning programme (for wide range of services i.e. not only cancer (e.g. diagnostics etc)	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. Regional programme working through implementation phase. Regional clinical summit on 6 June 2024 to discuss future regional plans	14-May-24	Anticpated it will reduce the level of risk regarding strategic mis-alignment between the Trust/partners and the wider healthcare system.	The level of assurance should increase
1.9	Establishment of new national commissioning body (bringing WHSSC/EASC together)	Welsh Government	#####	Implementation of new commissioing body well progressed. New Commissioning Body established and LIVE	14/05/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments	Action complete: increased level of assurance increased as national body with clear commissioning scope and powers

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		PE
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			E
C3	Workforce planning - skills development	Susan Thomas	X			PE
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE
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
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
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE
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
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

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
Provide operational managers with skills and capabilities to undertake effective	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
Evaluation sheets	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
Staff Meeting to feedback on implementation plan	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	IA
Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	IA
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
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
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		
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	**PA**	COMPLETE	The Healthy and Engaged workplan 2024-25 was agreed at the Healthy and Engaged Steering Group on 09.03.2024. The Healthy and Engaged Workforce Steering Group reports quarterly to EMB.	14.05.2024		Impact on assurance level was updated in the Supply and Shape paper presented to QSP on 09.05.2024.
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	**PA**	COMPLETE	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	21/12/2023	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	
1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	**IA**	COMPLETE	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.	
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	**PA**	COMPLETE	A plan to implement the People Strategy will be presented to EMB in December.	21/12/2023	Presented to EMB Shape	
1.5	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	14/05/2024	The Clinical & Scietific Strategy is still under dvelopment. Work underway in the interim is described in the Workforce Supply & Shape Paper was presented to QSP Committee in May 2024	
1.6	Development of a Trust Retention Plan	Susan Thomas	**IA**	Jun-24	Retention plan is bening developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly. Paper on the plan to be presented to EMB in May	14.05.2024		
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							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			E	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycles of business	PA	To be completed as per compliance/ reg tracker updates	PA
C2	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	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
C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training steering group	PA	Highlight Report to EMB from Education and Training Steering Group on a quarterly basis	PA	Internal Audit Reports	IA
C4	Values to be reviewed and Behaviour framework to be considered	Susan Thomas	X			PE	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
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group	IA	Reported through EMB to QSP	IA	Internal Audit Reports	IA
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health and Wellbeing Steering Group	PA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Workforce and OD steering groups and internal governance	PA	Steering Groups' highlight reports to Executive Management Board	PA	Internal Audit Reports	IA
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Workling Group	PA	Exucutive Management Board	PA	Internal Audit Reports	IA
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	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		
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture		

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	PA	Jun-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 May 2024. This paper also proposes that the conversations continue as routine in person and virtually.	14/05/2024	The outputs from the WT Sessions are being mapped into the Refresh of the Building Our Future Together Organisational Development Approach. New Sessions are now being scheduled which will cover staff across the bases in Wales	
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley	PA	Jul-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	14/05/2024	We received the Trust level data from the 2023 staff survey with the more detailed dahsboards following in May. This data will be used to over lay with other feedback. The areas of data have been mapped onto the current workstreams and management groups to ensure that this will enusre action is taken under the appropriate workstream.	
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	PA	COMPLETE	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023.	21/12/2023		
1.4	Promotion of the Speaking Up Safely Framework	Sarah Morley	PA	COMPLETE	The initial task and finish group to establishe the Speaking up Safely Framework in Velindre has been completed. Communication and governance processes are in place.	14/05/2024	Initial programme completed - ongoing work to trianguate with wider cultural work	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

	LIKELIHOOD	IMPACT	TOTAL			LIKELIHOOD	IMPACT	TOTAL			LIKELIHOOD	IMPACT	TOTAL	
INHERENT RISK	4	4	**TOTAL**	**16**	**CURRENT RISK**	3	4	**TOTAL**	**12**	**TARGET RISK**	2	4	**TOTAL**	**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 inclusion in wider community	Chief Digital Officer	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales	PA
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			PE	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting Digital Programme Board	PA	EMB Shape / EMB Run / Cyber Action Plan	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	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		E	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	PA	EMB Shape / EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS	PA
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE	Digital Programme Board Digital Design Authority being established	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE**
Agreed Digital Inclusion plan - C4,C7 - This has now been agreed by EMB/SDC and is no longer a gap in control	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 -	
C9 - Change Advisory Board needed		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
92	There is a risk to COMPLIANCE as a result of the inadequate oversight of supplier contracts, procurement governance etc., leading to difficulties in complying with internal governance for contract management, renewals and procurement activity.	12	Risk trend is increasing with capacity constraints in the procurement teams supporting the Trust
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 in place - risk closed from TAF
3193/3197 (BECS)	There is a risk to QUALITY as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform leading to degredation of critical WBS (NHS Wales) supply chain activities	15	Outline Business Case at EMB/SDC in April '24

R008 (WHAIS)	There is a risk that the LIMS solution will not support the required interactions between WHAIS and WBMDR because commercial H&I solutions are not designed to support an integrated donor registry. If no workaround is identified this would prevent WHAIS from being able to maintain its current HSCT clinical services.	20	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. This includes identifying the future relationship between WHAIS and WBMDR. Appropriate requirements will be stimulated in the URS.
2651	There is a risk to Financial Sustainability as a result of the introduction of a new interfacing policy by MAK-System for devices connected to ePROGESA, leading to organisational cost pressures, reputational damage and/or delays in realising IMTP and other strategic benefits.	12	Additional funding needs to be made available for a Blood Establishment Computer System re-procurement through to 2027

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer	PA	Complete	Digital Programme has now been established from Oct '23 Now meets on a bi-monthly basis	May-24	As the Programme continues to develop the overall level of risk should reduce by reducing the likelihood scores	The level of asurance should increase.
1.2	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 Digital Strategy has now been published and a draft insfrastructure strategy (reference architecture) is available.	May-24	Terms of reference for the Digitial Programme include the creation of Digital Design Authority which is in the process of being stood up in Q4 23/24. Digital Design Authority is still to formally meet.	The level of asurance should increase.
1.3	Approve the Digital Inclusion plan so that it can be used as the control point	Chief Digital Officer	IA	Complete	Plan approved at EMB/SDC Quality Impact Assessment Completed and Approved	May-24	improvement in the position on C7	The level of asurance should increase.
1.4	C13 - Embed new Head of Cyber Security	Chief Digital Officer	IA	Complete	Head of Cyber Security has been appointed from Dec '23	May-24	Dedicated post now in place to lead on cyber - will still be a single point of failure - Request into Trust reserves for a second post - no funding decision provided	C13 to move to Effective
1.5	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Chief Digital Officer	IA	Jun-24	Data and Insight formative paper presented at April EMB Shape / Strategic Development Committee	May-24	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	May-24	Will start with identification of standards for Digital Service (through new ITSM tool) and Cyber Security IT Infrastructure Library (ITIL) will form the basis of standards for Digital Service Cyber Essentials will be used for Cyber plan alongside Cyber Resilience Unit review	May-24	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	Jun-24	To be reviewed at May EMB	May-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice
1.7	Introduce a Change Advisory Board (CAB) to manage digital changes to service.	Chief Digital Officer	IA	Jun-24	Scope fror CAB has been established and will meet for the first time in May	May-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice, around C9

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)	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	Jun-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	14.5.24	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	14.5.24	Requirement for C7 to be put in place	
3.0	Revised reporting mechanism to be developed	Lauren Fear	4	Jun-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.	14.5.24	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	14.5.24	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	Jun-24	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	14.5.24	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	May-24	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	14.5.24	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**	**TOTAL**	**16**	4	**4**	**TOTAL**	**16**	2	**4**	**TOTAL**	**8**
CURRENT RISK												
TARGET RISK												

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	PE	VCS Quality & Safety Group / VCS SLT	PE	Integrated Quality & Saefty Group / Executive Management Board	PE	Quality, Safety and Perfromance Committee	PE

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Service level to Board monitoring of national standards delivery eg. NICE	Quality & Safety Tracker continues to be refined - not at its optimum	A1
Service level to Board intergrated dashboards	Quality Metrics under development	A2
Patient reported outcome measures across all SSTs, with service level to Board reporting	PROMa not in place	A3
Robust and consistent administrative processes for referrals and bookings		A4, A5, A6,A7

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors.- key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	15	Risk Stable

2465	Number of emails medics are receiving, especially those related to clinical tasks.	16	Risk Stable
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	15	Risk Stable
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	15	Risk Stable
2612	Acute Oncology Service (AOS) Workforce Gaps	15	Risk Stable

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
Actions also aligned with TAF 01 re capacity and demand mapping and service reconfiguration								
A1	An electronic mechanism to be introdcued to monitor compliance with relevant national standards and guidance, including NICE, delivery plans and national frameworks.	Interim Director VCC	0	Sep-24	Q-pulse being procured. Options appraisal to be undertaken to consider Blue light, Q-Pulse and AmAT systems and agree on which system would be the most effective and efficient	14.5.24	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	14.5.24	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	14.5.24	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	14.5.24	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		14.5.24	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	14.5.24	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	14.5.24	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	14.5.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced control and assurance
A10	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	Aug-24	Benchmarking undertaken and Trust process have been reviewed based on benchmarking outcomes and review of national standards	14.5.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced assurance
A11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corportae Governance	1	Mar-25	Project group being established, project leads identified. Trust wide Q-Pulse system procured	14.5.24	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		14.5.24	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. Long Term Management Support to be secured.	15.05.2024	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effectve prioritisation and decision making.	Enhanced control
A14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Exec Medical Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	Strategy under development following extensive engagement. Draft strategy will be developed to commence consultation in may 2024. Long Term Management Support to be secured to drive forward delivery of the startegy (same post as one described above)	15.05.2024	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	Enhanced control
A15	Undertake a review of the manaement of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	0	Aug-24	Regional working group established and proposals due to VCC SLT & EMB in May 2024.	15.05.2024	Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways	Enhanced control

SECTION 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. Opportunity Pipeline presented at April 2024 EMB Shape identified 4 potential initiatives to take forward. These require further development including identification of Senior Responsible Officers to take accountability at Exec level to oversee the development and delivery.	22.04.24	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. Finance and Investment Enhanced Monitoring reporting continues with key risks highlighted regarding Long Term Agreements.	22.04.24	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. Financial Control Procedure update plan and pipeline for review in development.	22.04.24	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	Presentation made to April 2024 EMB Shape for the development of criteria for assessing investment opportunities. This included Strategic Fit, Deliverability and Value and Sustainability. Next steps are to develop criteria aligned to the 3 areas identified.	22.04.24	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	Jun-24	Cardiff Cancer Research Hub market engagement exercise completed. Programme plan drafted and in the process of being reviewed. Private patient cash collection and pricing continues to be developed and progress being made in the backlog of cash collection.	22.04.24	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. A Scheme of Delegation and Governance Framework is being developed for nVCC, which will integrate findings from DLA Piper and PwC reviews. Progress to be taken forward through the nVCC Taskforce established in April 2024.	22.04.24	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	tbc

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Trust Board

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

Date of meeting	**23/05/24**
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 MARCH 2023/24 ARE:** **Velindre Cancer Service** **SACT Services:** • At present it is not possible to confirm end of March position. SACT non-emergency performance continues to be challenging. In response to this business continuity plans have been initiated. A weekly VCS SACT demand planning group has been established reporting to a weekly SACT GOLD, chaired by Executive Director of Nursing. It is anticipated that these plans will positively affect performance by July 2024. **Radiotherapy Services:** • Radiotherapy performance for March was 94% for Scheduled, 85% for Urgent, 100% for Emergency and 100% for elective delay. All against a 100% compliance target. Improvement continues to be sustained. **Welsh Blood Service:** • All clinical demand was met in March. However, a pre-amber alert was issued on 2nd April following the two Easter Bank Holidays due to pressures on red cell stock and was lifted on 9th April. The service has stood up a Task & Finish Group that is examining key constraints to help stabilise supply and is considering workforce, on boarding/training of new staff, demand and supply, community venues and screening related pressures in the collection clinic model. • The recovery plan for bone marrow volunteer recruitment is showing encouraging results again for March since our launch of buccal swab drives in late January. Performance increased from 735 to 969 for March (against a target of 333). • Since January 2024, 2,022 new stem cell donors have been recruited. Of those who shared their ethnicity, 447 were classed as black, Asian, mixed, or from a minority ethnic background (21% against current population ethnicity data in Wales of 5.8%). **Financial Performance:** • The Trust reported a year end underspend revenue position of £0.030m for 2023-24, achieved the Capital CEL target by spending £31.002m against the £31.005m allocated, and achieved the PSPP target by paying 97.7% (target 95%) of non-NHS invoices within 30 days.

RECOMMENDATION / ACTIONS	**The Trust Board is asked to:** • **NOTE and DISCUSS the March 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 April 2024**
VCS SLT / Performance Review	**20 April 2024**
Executive Management Board – Run	**29 April 2024**
Quality Safety and Performance Committee	**9 May 2024**
Summary and outcome of previous governance discussions **The report has been considered and endorsed at the VCS and WBS Performance Review meetings and EMB and is presented to the QSP Committee 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 MARCH 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 March 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

94% of patients referred for scheduled radiotherapy treatments began treatment within 21-days of the decision to treat in March, a significant improvement in performance from 80% in February 2024 against a target of 100%.

Compliance with the 7-day time-to-treatment target for urgent symptom control radiotherapy treatment dropped from 88% in February 2024 to 85% in March 2024 against a target of 100%.

100% of patients requiring emergency radiotherapy treatment began treatment within required timescale (target 100%).

The implementation of the IRS has had an impact on capacity with the replacement of La5 concluding in March 2024, a planned increase in capacity for LA5 is scheduled through March and April, where the implementation of the Halcyon treatment unit breast solution will be fully deployed. The commissioning of LA5 provides resilience to the Halcyon fleet and increases capacity available from 12 hours per day to 22 hours per day by May 2024. As of 29/1/2024, La3 replacement programme commenced in readiness for installation of the first Ethos treatment unit planned for April 2024, thus reducing capacity on the Elekta units from a maximum of 44 hours per day to 34 hours per day.

A further reduction in Elekta capacity is planned from 1 May 2024 where La1 becomes end of life, thus reducing Elekta capacity to 24 hours per day. Plans are in place to mitigate the impact of the linac replacement programme, but this is expected to be challenging for the service.

There will be a stepped increase in Varian capacity as of August 2024 when La3 Varian Ethos becomes clinical.

Where developments/ upgrades, such as Aria 18 (April 2024), Elekta CCP or Identify version 3 are likely to impact on capacity a risk assessment is undertaken identifying appropriate mitigations to reduce the risk of breaching time to radiotherapy targets.

Where demand exceeds capacity, all referrals are submitted through escalation where prioritisation and clinical harm assessment is undertaken and are booked according to clinical priority. Patients are prioritised and offered the first available appointment in response to the clinical urgency of their pathway- whilst considering the patients' needs and in accordance with the Access to treatment procedure.

All failures to meet WG time to radiotherapy targets are investigated at pathway level to identify maximum wait and delay reasoning

Through the All Wales Cancer Performance Management group, it has been established that the three Cancer Centres in Wales have historically utilised inconsistent data definitions for the Emergency Time to Radiotherapy measures. The agreed future definition will include measuring the 24 hour timescale from the point of receipt of the referral to radiotherapy. Velindre Cancer Centre has always adopted this measure, however other centres were measuring the time from when a patient arrived at a respective treatment centre.

SACT

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

We are not yet able to report the March 2024 position due to the pressures on day-to-day management of patients, therefore data to support the end of March position has yet to be fully validated and is expected to be available towards the middle of May 2024. The position at the end of February 2024 showed an improved position against January 2024. Emergency patients were all treated within the target of 5 days maintaining the 100% performance of the last 12 months. Non-emergency patient performance improved from 64% compliance to 79% compliance, with a drop in breaches from 160 to 95. This was delivered against a background of a continued increase in referrals with 457 patients referred in February, the highest single referral number in month ever recorded by the service. The January 2024 number of 443 referrals was the previous highest. Daily escalation meetings are taking place and patients are being clinically prioritised and will undergo a harm review where deemed clinically appropriate.

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 and reports into a GOLD command meeting chaired by Executive Director Nursing, to give Executive oversight and support in respect of SACT performance. It is anticipated that these plans will positively impact performance by July 2024. Work is continuing with Digital Insight team to understand the demand for individual components of the service including oral and parental SACT, pharmacy, nursing and booking.

The greatest risk to achieving and sustaining our required level of performance relates to SACT Pharmacy provision. 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. The team have been speaking with other SACT providers in Worcester and Swansea as part of a benchmarking exercise and have identified a number of key target areas of service redesign and process review to support improvements in pathway management and reduce waiting times for patients.

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

Pressure Ulcers
No pressure ulcers avoidable or unavoidable were reported for the second consecutive month.

Health and safety incidents
There were three Health and safety incidents for the second consecutive month which is the lowest since May 2023.

Delayed pathways of care
There was one patient with a delay of 19 days due to awaiting a nursing home placement.

Sickness Rate
The sickness rate dropped to 3.89% in the month of March, which is under the Trust 4.7% target.

1.2 Welsh Blood Service Overview

All clinical demand was met in March, however, a pre-amber alert was issued on 2nd April due to pressures on red cell stock and was lifted on 9th April. A Task & Finish Group has been established that is examining a number of areas in the collection clinic model.

Performance in quality incidents closed within 30 days continues to exceed target at 94% against a target of 90%. Two adverse events were submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in March.

1. **SABRE 117: Datix 16313** – A donation unsuitable for use inclusion in a pooled platelet was mistakenly bled into a pack that permits processing into a platelet pool. There was no risk to patient safety as eProgesa prevented the pack from being processed. This restriction was introduced following a system update on 28/01/2024. As part of the incident investigation, it was identified that there were 16 occasions during 2023 when donations were inappropriately included in a pooled platelet, due to being bled into the wrong pack type. There have been no reports of adverse events relating to recipients and the WBS Consultant in Transfusion Medicine has concluded that there was no necessity to conduct a lookback on the affected donations or to notify hospital clinicians.

2. **SABRE 118: Datix 16440** – A donor advised WBS that they had previously declared cancer of the kidney but had been allowed to donate when a permanent donation deferral should have been activated. The permanent deferral is now in place. The investigation into root cause is ongoing and includes a holistic review of SABRE reportable events to analyse trends in root cause.

Donor satisfaction continues to perform strongly in March and remained at 97% (95% target). 6,567 donors were registered at donation clinics and 3 informal concerns were raised (0.04% of all donors registered). All 3 informal concerns were managed as early resolutions and responded to the donor's satisfaction within 48 hours.

All clinical demand for platelets was met representing a strong performance against this metric. Platelet wastage remains on target at 10%. There has been sustained improved performance against the platelet wastage target over the last 12 months which will be further supported by the review of the Platelet Strategy currently underway as part of WBS Futures.

At 1,573, new donor recruitment figures did not meet the quarterly target of 2,750. Throughout this quarter there have been prolonged periods of time where red blood cell stock of certain blood types has been below optimum levels. As such, the service has continued to prioritise regular blood donors with known blood groups to ensure continuity of supply. The result is a reduction in appointment availability for new first-time donors whose blood type is not known.

The total stem cell provision for the service in March was 5 (4 stem cell collections from Welsh donors and 1 cell product imported for Welsh patients) which was just below the service target of 7. The service continues to see a gradual increase in activity for the year with a final total of 53 (48 stem cell collections and 5 lymphocyte collection at year end) against a target of 80.

With the launch of the buccal swab drives in late January, the recovery plan for bone marrow volunteer recruitment is building. Performance increased to 969 for March (against a target of 333). The swab drives and online recruitment together resulted in 827 volunteers being added to the database with another 142 from blood donation sessions.

Reference Serology performance increased in month but remained slightly below target (80%) at 72% for March. Training and development of junior staff continues to influence performance against this measure as not all staff are fully operational to date. Training of 2 recently appointed staff is due to be completed in April 2025 and once completed is expected to have a positive impact upon performance for this measure.

1.2 Workforce and Wellbeing

Sickness

Current rolling sickness absence is 5.17% to March 2024, which is above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%. A number of interventions to manage sickness are in place to mitigate the risk to staff wellbeing and there has been a downwards trend in sickness absence over the last 12 months. Work is ongoing with service managers to support staff.

PDAR's (staff appraisals)

Trust wide PADRs this month is 72% (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.

A full summary of workforce interventions to mitigate workforce risks and to support effective Supply and Shape of the workforce is summarised in the Supply and Shape Paper February/March 2024

1.3 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys. In March performance against 'Would you recommend us?' was 96% and 'Your Velindre experience?' was 94% both set against the 85% target.

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

1.4 Digital Services

Limited change in performance in March 2024 when compared with previous months.

Target met (85%) in respect of % of IT incidents resolved within agreed response times. However, slight fall in performance in respect of the resolution of IT service requests, which fell slightly below target (83%).

Digital Service Desk improvement plan agreed – further improvements anticipated through 2024/25. Planning for implementation of a new IT Service Management tool has commenced. Deployment should improve performance across a range of service areas through efficiencies, task automation etc. as well as improve various regulatory and administrative activities – e.g. asset management.

Performance against rolling 12-month position for the number of significant IT business continuity incidents fell slightly in March 2024, increasing from 10 to 11. Overall trend is positive, however further work required to achieve target (6 incidents in a 12-month period). Work remains ongoing to remove / replace legacy IT infrastructure and improve the resilience across both the WBS and VCC sites. However, a significant number of legacy (Windows 7) client devices were removed in Q4 2023/24.

Reporting of performance in respect of the % of employees clicking on internal phishing campaigns/exercises has re-commenced, following the re-start of simulated phishing campaigns in March 2024. A regular calendar of simulated phishing campaigns has been established – data from 3 runs will be used to inform the PMF metric in terms of baseline, target etc.
Reporting arrangements for one indicator are still in development:

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

A number of new metrics have been drafted, to demonstrate Trust performance against the various objectives set out in the recently-published Digital Strategy. Two **new indicators** are presented this month. A further three indicators will be introduced over subsequent months – see below:
The 5 measures are as follows:

- **% of outpatient consultations performed virtually (DIG.70)**
- **% of donors booking online (DIG.71)**
- % compliance with cyber security statutory & mandatory training – to be reported from May 2024 (April data)
- % of Trust expenditure in digital – to be reported from May 2024 (April data)
- Hours saved through digitisation / automation of paper-based manual processes – to be reported from June 2024 (May data))

1.5 Estates Infrastructure and Sustainability

March has been a busy month Planned Preventive Maintenance (PPM) and reactive tasks which are currently listed as under benchmark of 95% due to a number of staff sickness absences and staff taking end of year annual leave, furthermore the team has been supporting end of year capital works in Velindre Cancer Centre which were time critical for end of year financial spend.

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 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.

Health & Safety Incidents are being reviewed for the annual plan where a pareto analysis is being developed. The item to note is 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 with a SMART action plan to address this area. Also, we have a downward motion this month for Violence and Aggression as we have fallen 10%. However there is work being completed to identify which divisions need targeting.

1.6 Finance

The overall final revenue position against the profiled revenue budget for 2023-2024 was underspent by **£0.030m.**

The final approved Capital Expenditure Limit (CEL) for 2023-24 was **£31.005m**. This represents all Wales Capital funding of **£29.322m**, and Discretionary funding of **£1.683m.** The Trust reported actual total Capital spend of £31.002m ensuring that the Trust CEL target was achieved for 2023-24.

During March ’24 the Trust (core) achieved a compliance level of **98%** of Non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **97.7%** for 2023-24, and a Trust position (including hosted) also of **97.7%** compared to the target of 95%.

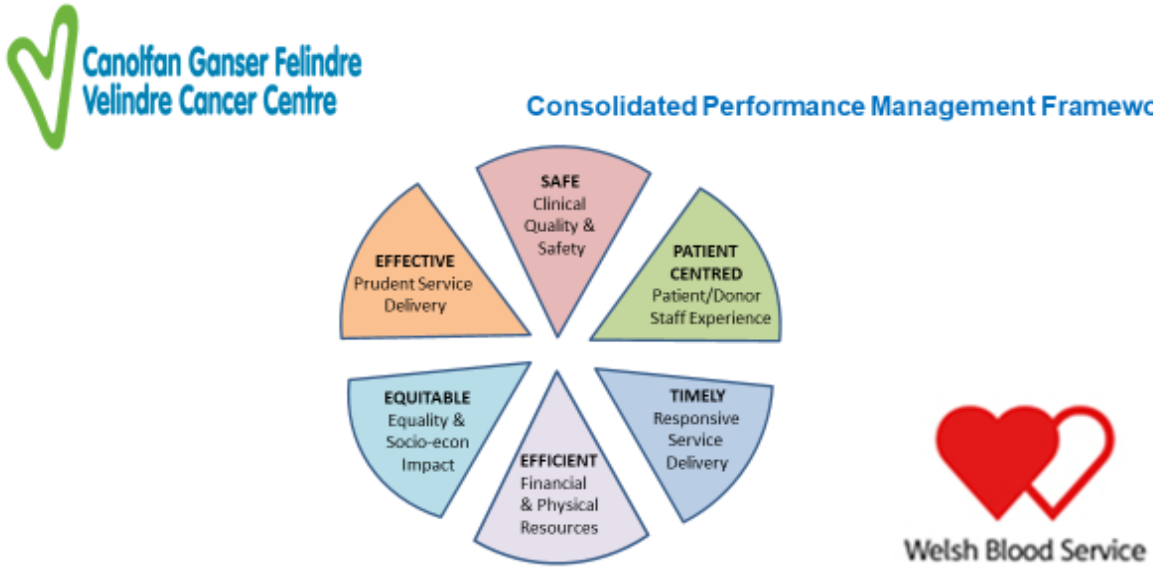
The Trust fully achieved the savings target of £1.8m during 2023-24, however, during July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status.

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 £2.5m during 2023-24 which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit.

2. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION
VELINDRE NHST PERFORMANCE SCORECARDS FOR MARCH 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 March (Month 12) 2023/24

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 12 (March 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	1	✗	→	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	1	✗	→	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	1	✗	→	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	2	✗	↓	KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	14	✗	↑↓	H&S.55
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	205.7 C/m3 Dec	137.4 C/m3 Dec	✓	→	EST.06

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 12 (March 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	1	✗	→	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	94%	✗	↓	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0%	✓	↑	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	121%	✓	↑	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	10%	✓	↓	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	5	✗	↑	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.17%	✗	↑	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	72%	✗	↑↓	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	95%	96% 94%	✓	→	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	97%	✓	↑	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	→	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	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%	17% 94%	✗	↓	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	11% 85%	✗	→	KPV.15
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	94% 100%	✓	↑	KPV.16

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 12 (March 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%	100% 100%	✓	↑	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days **February position**	National	Monthly	98%	98%	79%	✗	↑↓	KPV.20
	% Patients Beginning Emergency SACT within 5 days **February position**	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%	97%	✓	↑	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.030 m	✓	→	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£31.005m	£31.002m	✓	→	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.543 m	£0.775 m	✗	→	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.8m	£1.8m	✓	→	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	N/A	N/A	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	TBA	5.96%	✓	→	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	TBA	5.74%	✓	→	WOD.80
	% of Workforce not declared Welsh Language Listening/Speaking capability	National	Quarterly	11.63%	0%	7.50%	✓	→	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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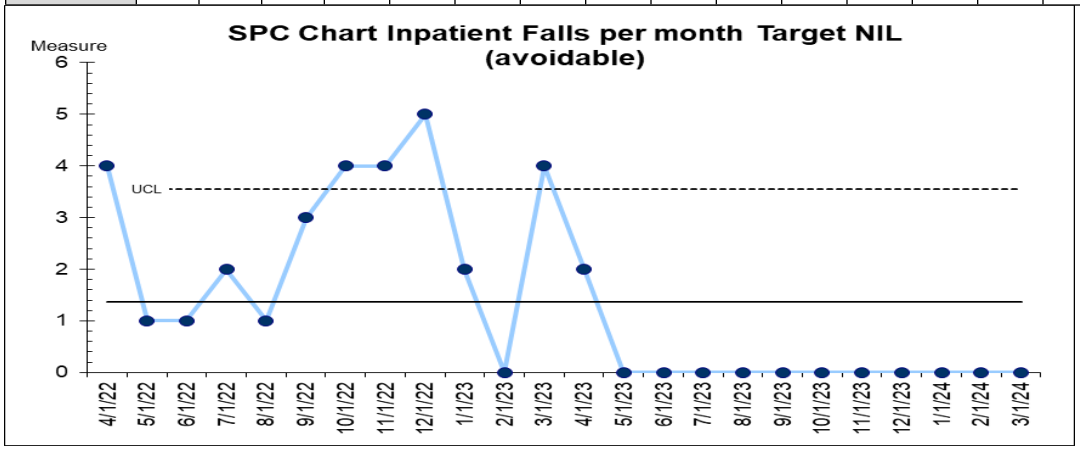
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Feb 24	Mar 24
Actual Number	2	0	4	2	0	3	5	5	3	5	3	6	8	2	5
Avoidable Falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



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 March 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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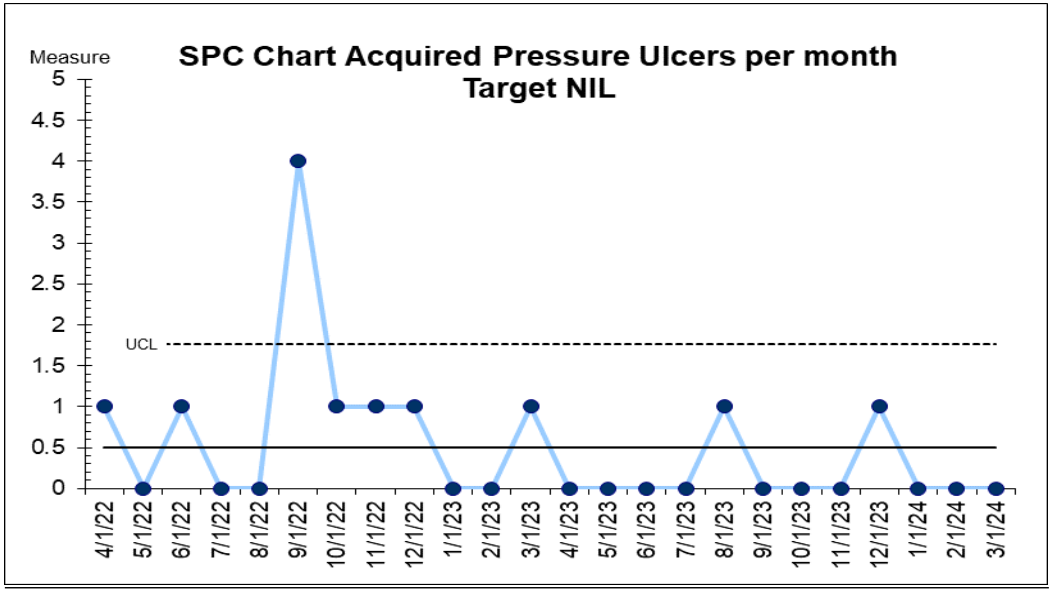
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Feb 24	Mar 24
Actual Number	0	0	1	0	0	0	2	2	3	0	2	2	1	0	0
Avoidable Ulcers	0	0	0	0	0	0	0	1	0	0	0	1	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, apart from Sept '22 over the last 15 months

Performance

There were 0 avoidable pressure ulcers in March 2024.

Service Improvement Actions – Immediate (0 to 3 months)

-Identified members of the nursing team to receive individual teaching/updates by the TVN. -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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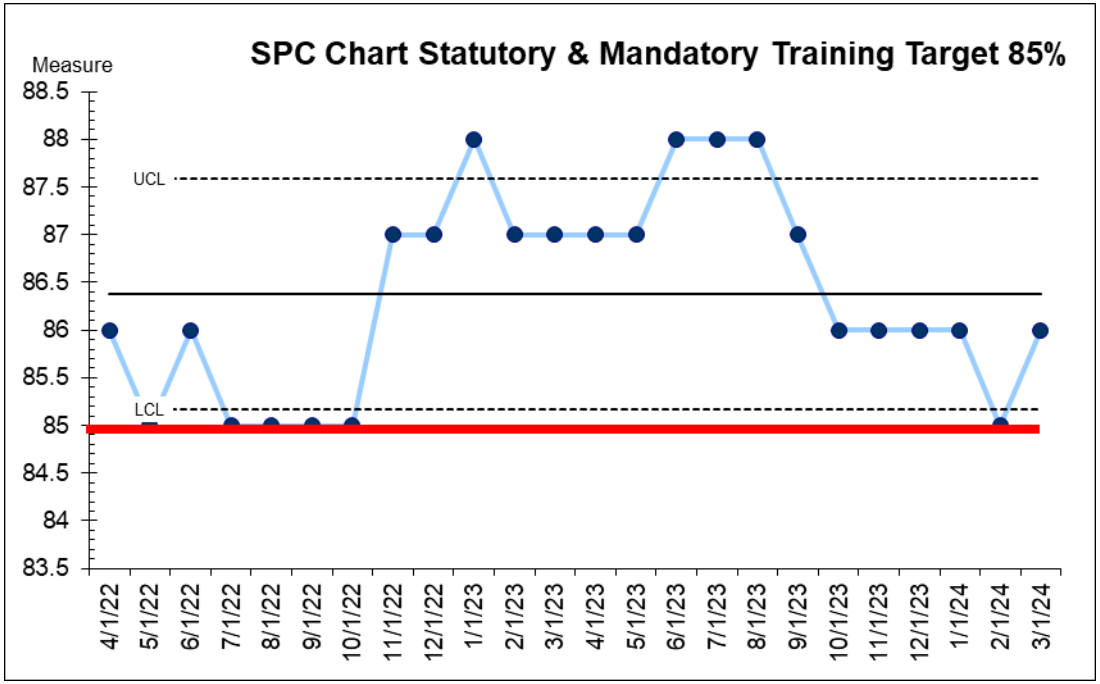
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	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	Feb 24	Mar 24
Actual %	88	87	87	87	87	88	88	88	87	86	86	86	86	85	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	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	Feb 24	Mar 24
Hospital Acquired Thromboses	0	0	2	1	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

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 Jan 2023 to March 2024

VCC	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	Feb 24	Mar 24
C.diff	1	0	0	1	0	0	0	0	0	1	0	1	0	0	0
MRSA	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
E.coli	3	1	0	1	0	1	1	0	1	0	0	0	0	0	0
Klebsiella	1	0	0	1	1	0	1	1	0	0	0	0	0	0	1
Pseudo Aerugi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg	4	1	0	3	1	1	3	1	1	1	0	0	0	0	1

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	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	Feb 24	Mar 24
VCS Hand Hygiene						100 %	100 %	99%	99.6 %	100 %	99%	100 %	97.5 %	98.9 %	98%
WBS Hand Hygiene						100 %	99.2 %	99%					99.8 %	99%	100 %
Trust Hand Hygiene						100 %	100 %	99%					98.6 %	99.4 %	99%
IPC Validation						100 %	100 %	100 %	99.4 %	100 %	96%		100 %		99%
Target l00%	0	0	0	0	0	100 %	100 %	100 %	100 %	100 %	100 %		100 %	100 %	100 %

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

Plus Infection Prevention Control Team Validation Audits % compliance

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

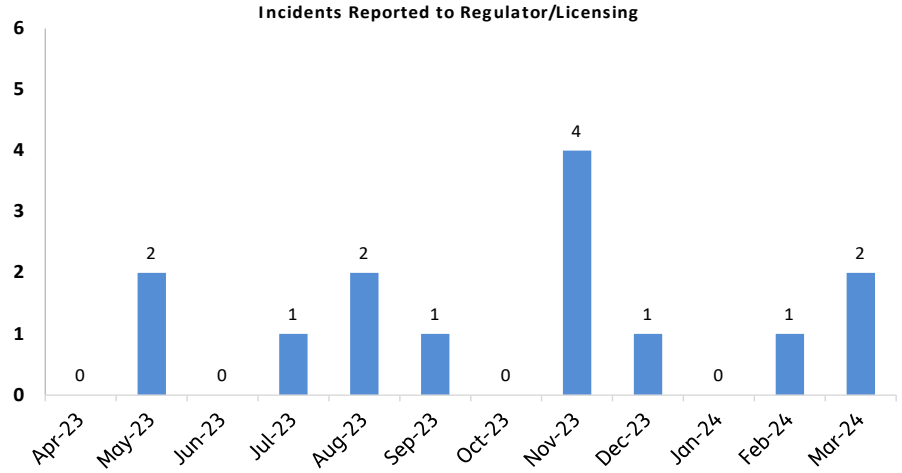
Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

Performance

	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	Feb 24	Mar 24
Actual	0	2	0	0	2	0	1	2	1	0	4	1	0	1	2
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Assessment of current performance, set out key points:

Two adverse events were submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in March.

SABRE 117: Datix 16313 – A donation unsuitable for use inclusion in a pooled platelet was mistakenly bled into a pack that permits processing into a platelet pool. There was no risk to patient safety as eProgesa prevented the pack from being processed. This restriction was introduced following a system update on 28/01/2024.

As part of the incident investigation, it was identified that there were 16 occasions during 2023 when donations were inappropriately included in a pooled platelet, due to being bled into the wrong pack type.
There have been no reports of adverse events relating to recipients and the WBS Consultant in Transfusion Medicine has concluded that there was no necessity to conduct a lookback on the affected donations or to notify hospital clinicians.

SABRE 118: Datix 16440 – A donor advised WBS that they had previously declared cancer of the kidney but had been allowed to donate when a permanent donation deferral should have been activated. The permanent deferral is now in place. The investigation into root cause is ongoing and includes a holistic review of SABRE reportable events to analyse trends in root cause.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
The completion of Corrective Actions and Preventative Actions (CAPA), in respect of SABRE and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & Safety Hub. Operational Managers are exploring opportunities to share learning through formal staff engagement sessions, to promote discussion	Progress is reported Monthly into the WBS Integrated Quality & Safety Hub.	Peter Richardson

	Expected Performance gain – immediate - N/A		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve Actions have been/will be introduced as outcome of Root Cause Analysis of these incidents is known.	**Timescale:**	**Lead:**
	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

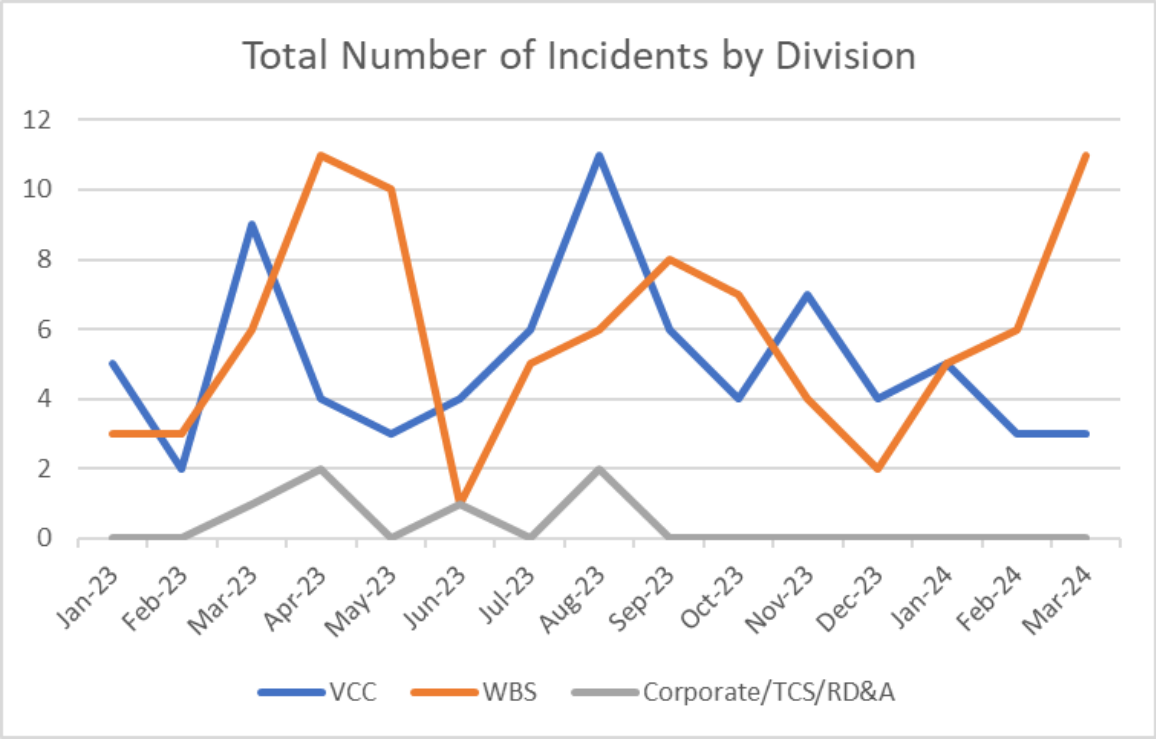
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

Performance - remains stable

	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	Feb 24	Mar 24
VCC	5	2	9	4	3	4	6	9	6	4	7	4	5	3	3
WBS	3	3	6	2	10	1	9	6	8	7	4	2	5	6	11
Corporate	0	0	0	2	0	1	0	2	0	0	0	0	0	0	3



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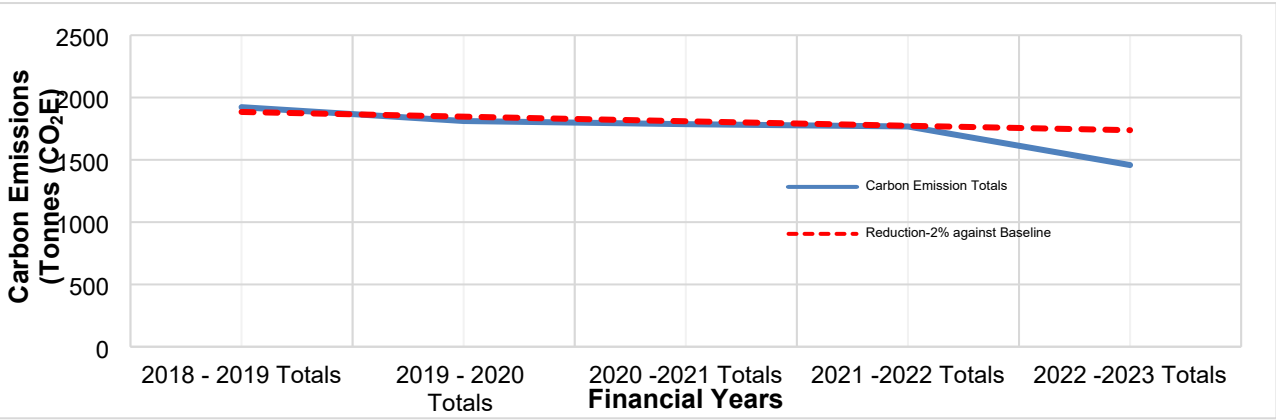
% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline

Target: -16% by 2025

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	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	Feb 24	Mar 24
Actual Number	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)	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

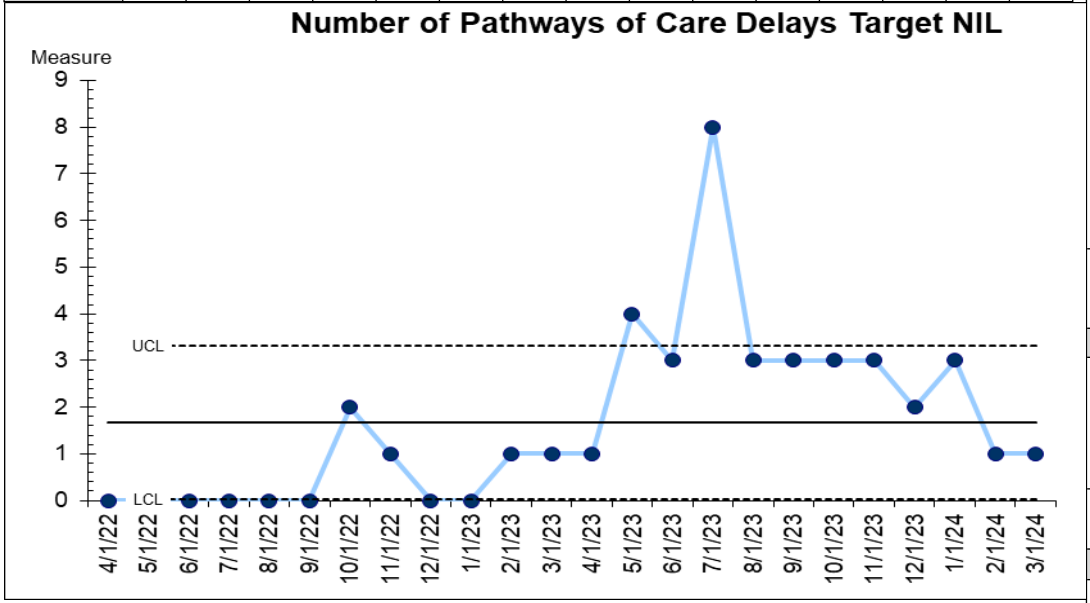
Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Performance

VCC	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	Feb 24	Mar 24
Actual PoCDs Number	0	1	1	1	4	3	8	3	3	3	3	2	3	1	1
Days Delayed							32	19	43	73		5			19
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.

Assessment of current performance, set out key points:

There was 1 Pathway of Care delay reported in March2024

Patient 1: Delayed Transfer of Care with a delay of 19 days due to awaiting a nursing home placement.

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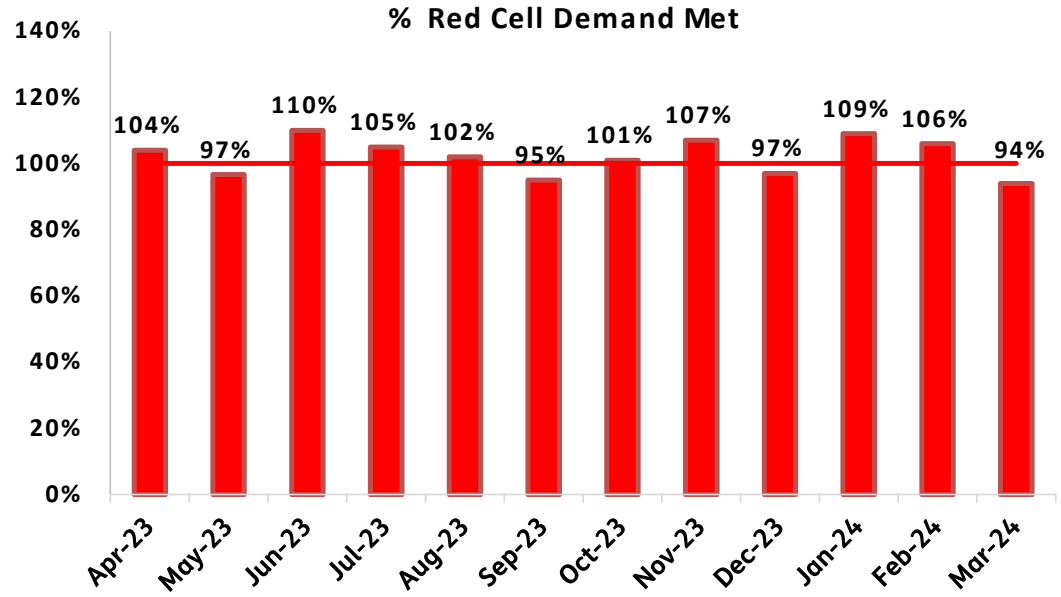
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	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	Feb 24	Mar 24
Actual %	106	103	104	104	97	110	105	102	95	101	107	97	109	106	94
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

Performance reduced and was below target in March and is attributed to insufficient collections against demand. Factors affecting performance include a single exceptionally high demand week and the Easter bank holiday.

The average weekly demand in March was 1391 compared to February average of 1343 units per week.

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

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**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.

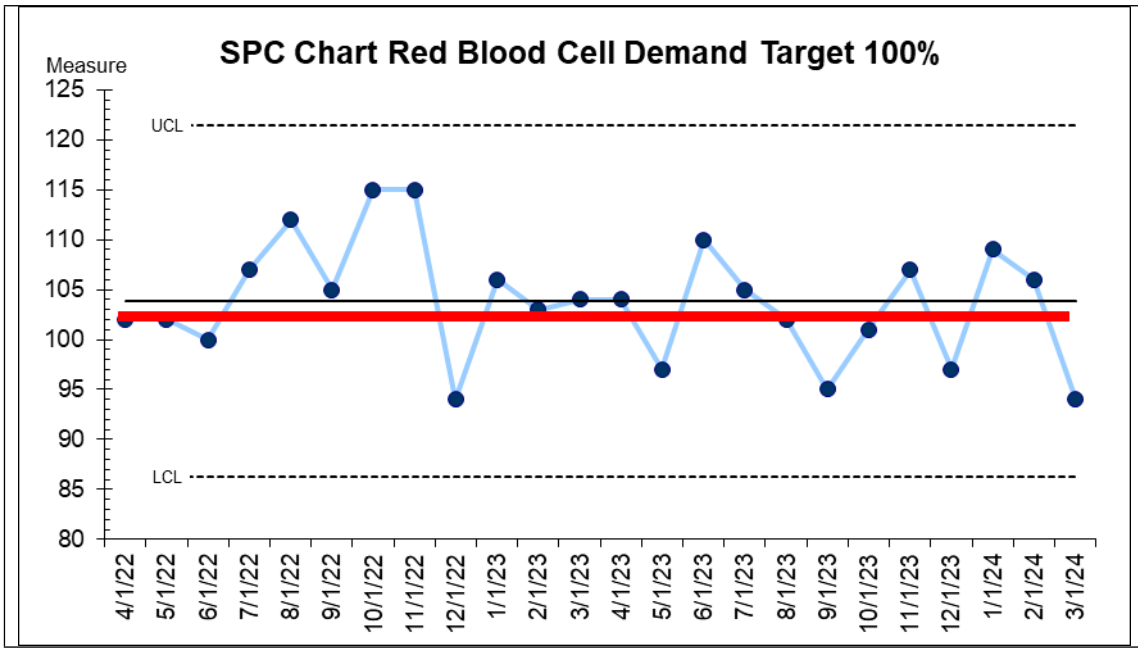
Service Improvement Actions – tactical (12 months +)

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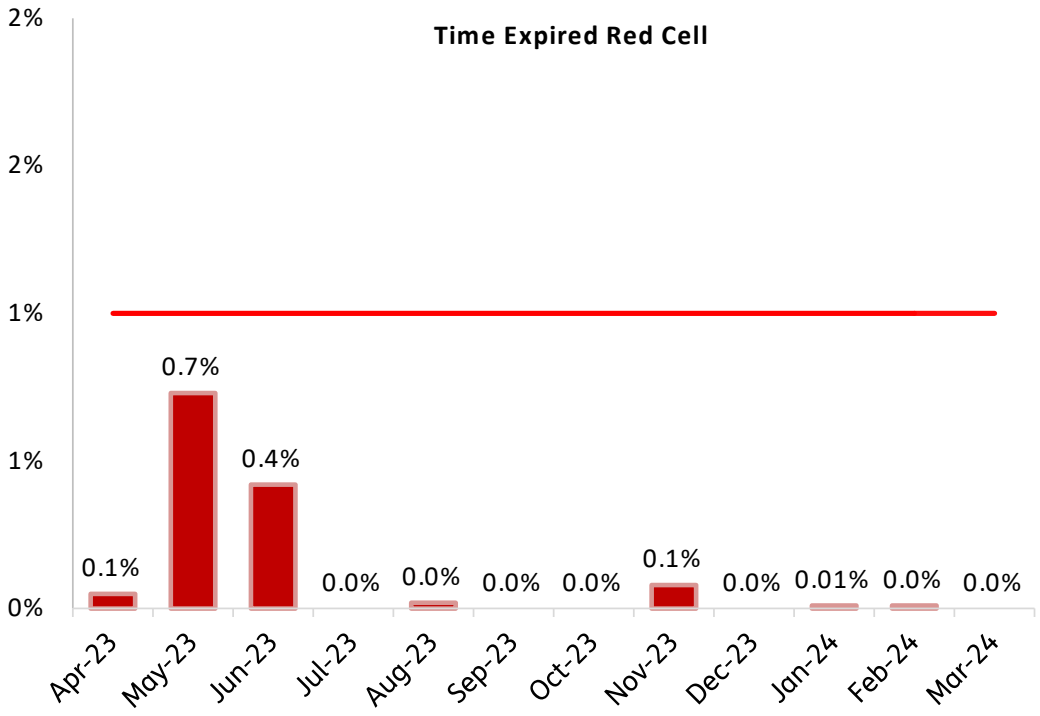
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	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	Feb 24	Mar 24
Actual %	0.21	0.05	0.02	0.05	0.7	0.42	0	0.02	0	0	0	0	0.01	0.01	0
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0



Performance

Assessment of current performance, set out key points:
There was excellent performance of this metric in March 2024, with no 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

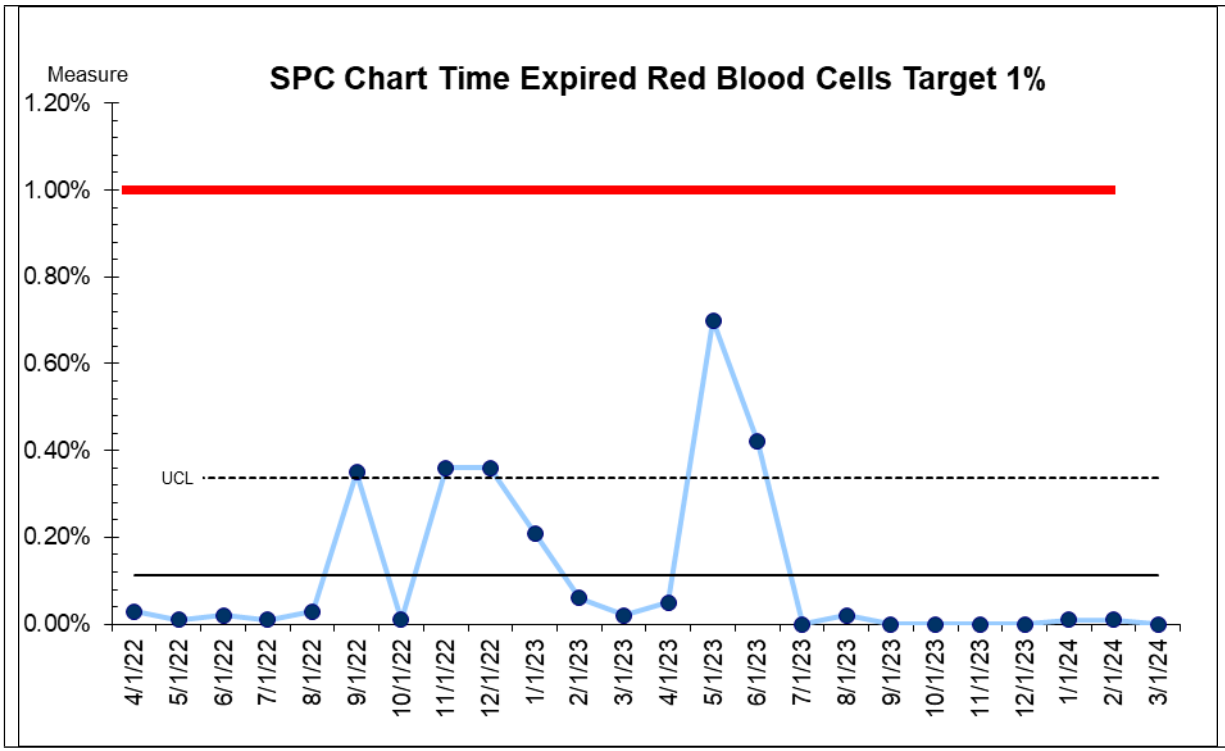
Expected Performance gain - immediate.
Continued effective management of blood stocks to minimise the number of wasted units.

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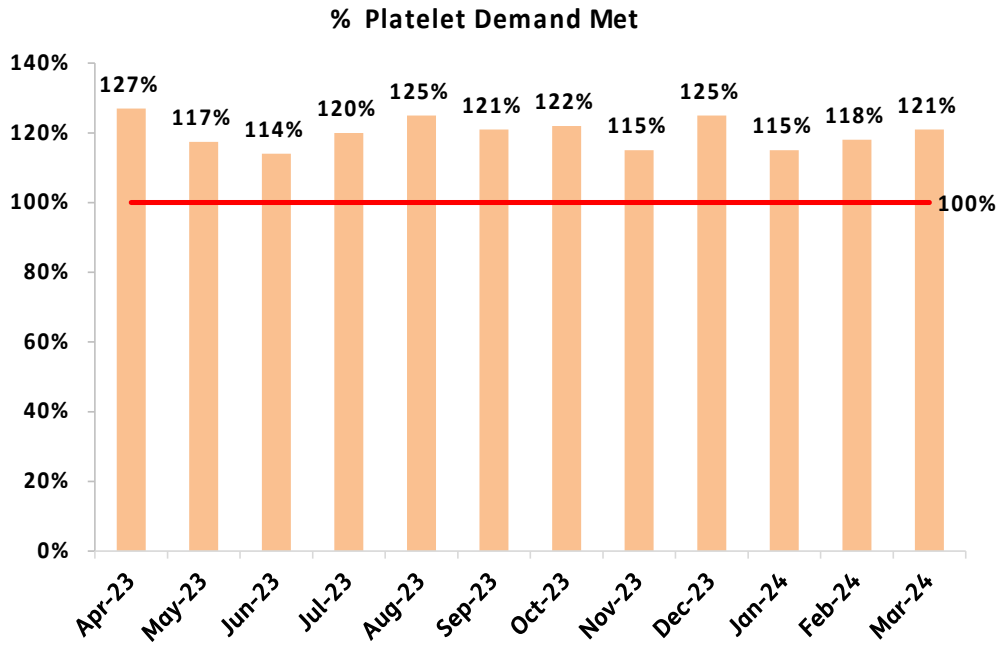
Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	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	Feb 24	Mar 24
Actual %	141	168	133	127	117	114	120	125	121	122	115	125	115	118	121
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



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

Performance

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

Service Improvement Actions – Immediate (0 to 3 months)

Daily monitoring of platelet stock position and assessment of likely demand in the upcoming days.
Controlled adjustments in production of pooled platelets to better align overall stock holding to daily demand.

Lead: Georgia Stephens
Timescale: Ongoing – Business As Usual

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve
A workstream for the review of the WBS Platelet Strategy has been initiated under the WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q1 2024/25

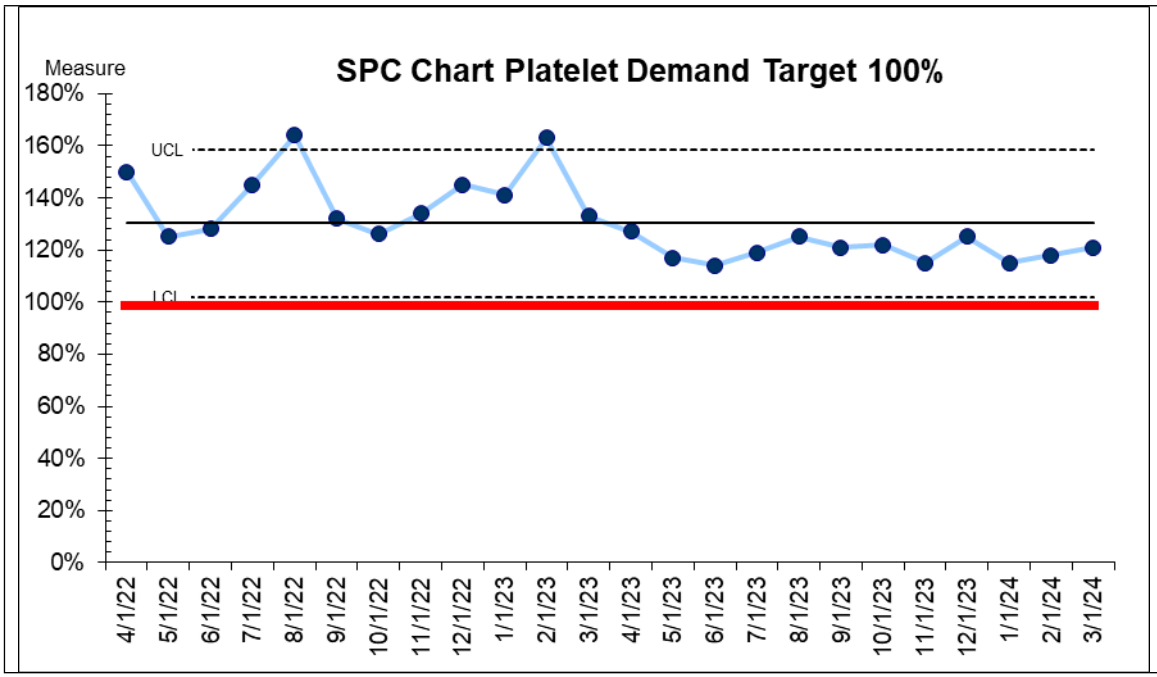
Timescale: Q1 2024/25

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 130% consistently exceeding the 100% target.

KPI Indicator KPI.25

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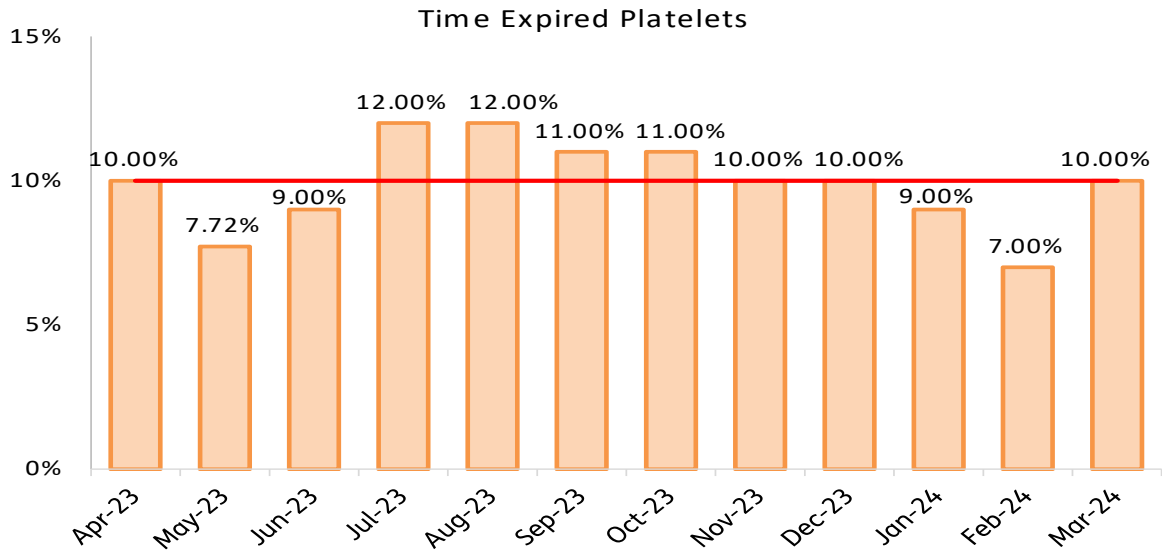
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	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	Feb 24	Mar 24
Actual %	23	25	20	10	8	9	12	12	11	11	10	10	9	7	10
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 10% performance deteriorated but met target for March for this metric. This is expected variance in this metric.

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

Service Improvement Actions – Immediate (0 to 3 months)

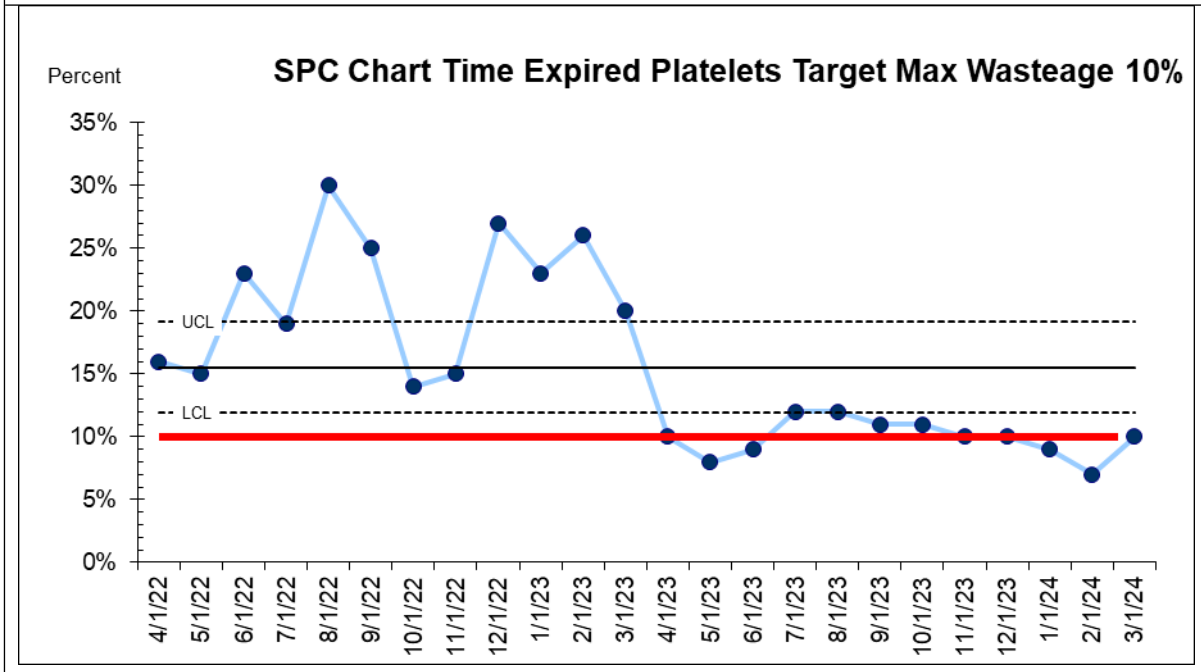
Actions: what we are doing to improve	Lead: / Timescale:
a. Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings. b. A Platelet Strategy is being developed. This will sit under WBS Futures under the Lab Services Modernisation Programme. c. Develop a forecasting tool to inform decisions around pooled platelet manufacture. This action has been delayed due to insufficient capacity within the Business Intelligence Team.	**Lead:** 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 workstream for the review of the WBS Platelet Strategy has been initiated under the WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation	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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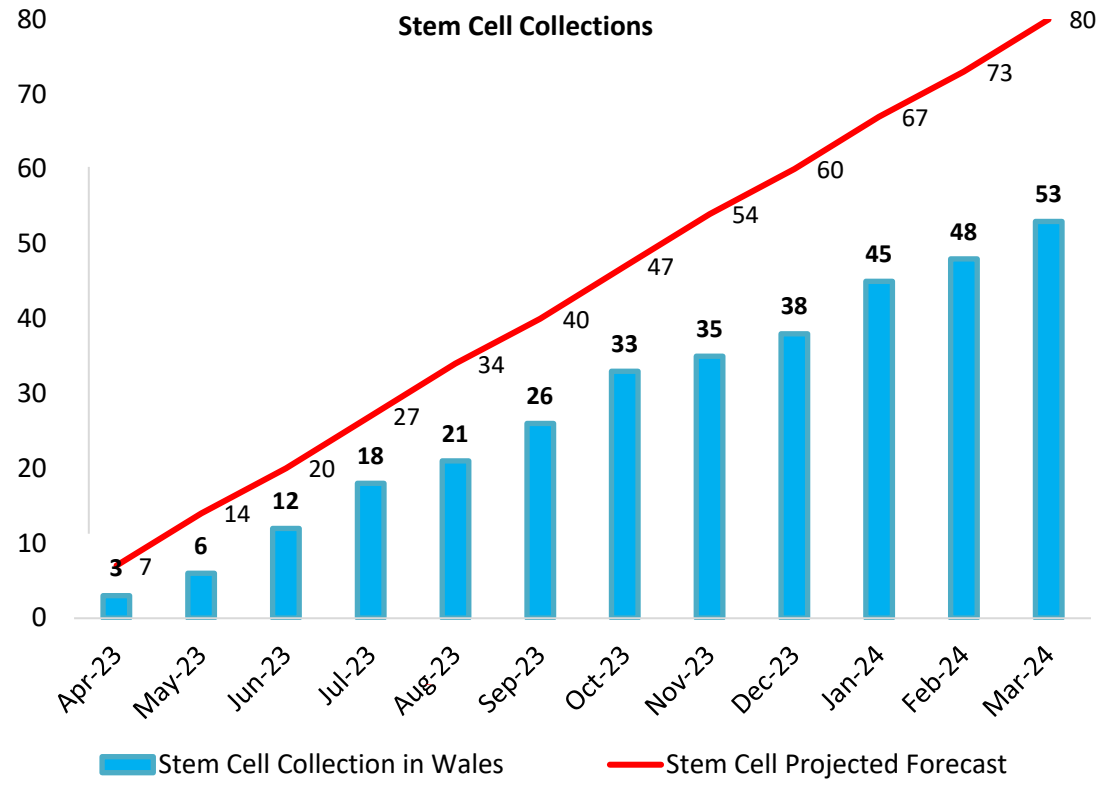
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Deborah Pritchard

Current Performance against Target or Standard

	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	Feb 24	Mar 24
Cumulative Actual	23	26	32	3	6	12	18	21	26	33	35	38	45	48	53
Cumulative Target p/a	70	77	80	7	14	21	28	35	42	49	56	63	70	77	80



Performance

4 Peripheral Blood Stem Cell (PBSC) collections and 1 import for a Welsh patient totalling 5 cell provisions for March is below Service target.

The financial year end total collections is 54 (against a target of 80) made up of 49 PBSC and 5 Donor Lymphocyte Infusion (DLI) collections.

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.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
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	Q1 **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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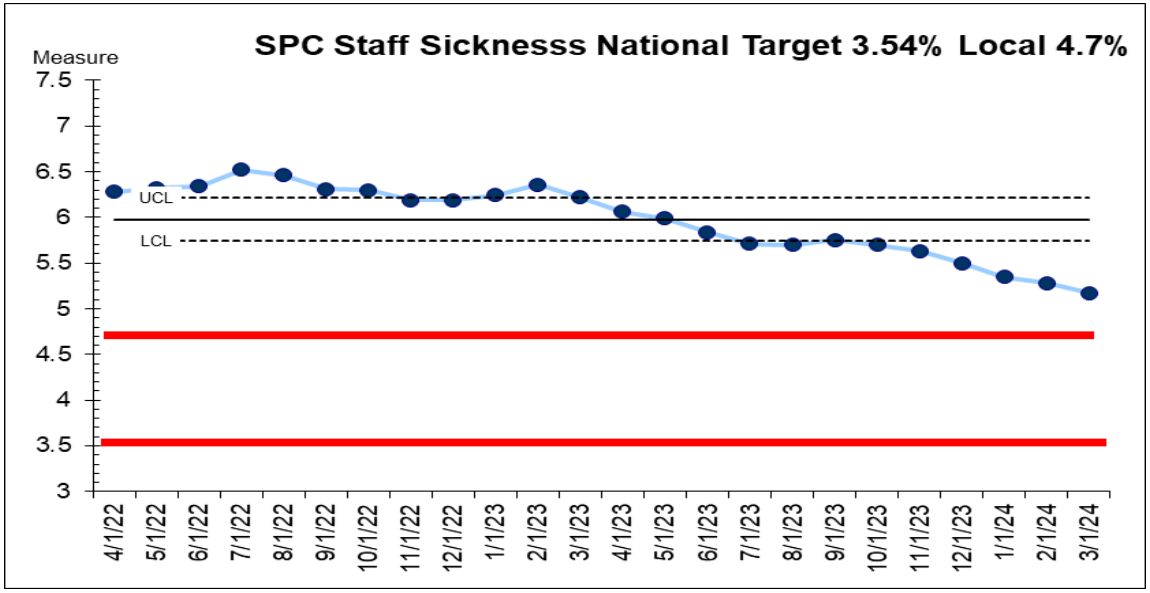
Staff Sickness levels against Target

Target: National 3.54% Local Stretch Target 4.70%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	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	Feb 24	Mar 24
Actual %	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	5.28	5.17
Local target 4.70%	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70
National Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

The SPC chart shows an improving trend over the last 7 months. However, the overall average 6.2% sickness level remains higher than the 3.54% target

Performance

Assessment of current performance, set out key points:

There is a 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

	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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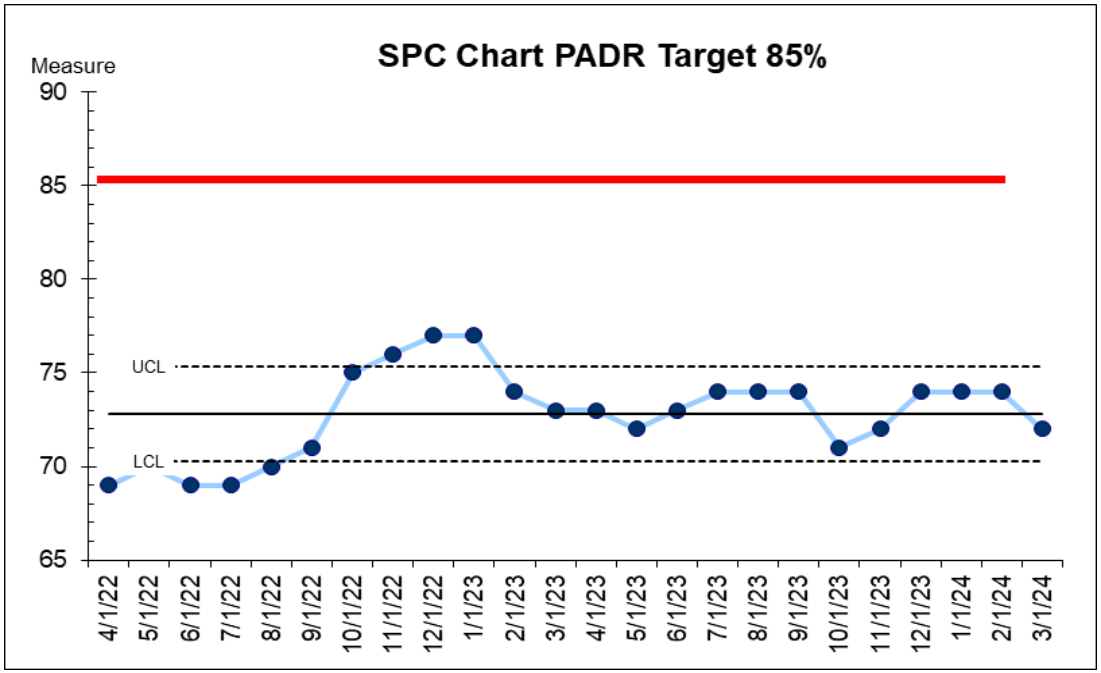
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	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	Feb 24	Mar 24
Actual %	77	74	73	73	72	73	74	74	74	71	72	74	74	74	72
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	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	Feb 24	Mar 24
Would you recommend us? %	93	96	95	95	98	96	97	97	95	95	94	95	89	97	96
Your Velindre Experience? %	84	86	82	82	68	71	91	94	63	83	87	95	98	94	94
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 92.45% = Good 3.77% = 96.22%

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

Excellent (10/10) 74.47 + Very good (9/10) 14.89% + Good (8/10) 4.26 = 93.62%

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	49	92.45%
Good	2	3.77%
Neither good nor poor	0	0.00%
Poor	1	1.89%
Very poor	1	1.89%
Don't know	0	0.00%
Total	53	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 (Excellent)	35	74.47%
9	7	14.89%
8	2	4.26%
7	0	0.00%
6	0	0.00%
5 (Neutral)	2	4.26%
4	0	0.00%
3	0	0.00%
2	0	0.00%
1	0	0.00%
0 (Very Bad)	1	2.13%
Total	47	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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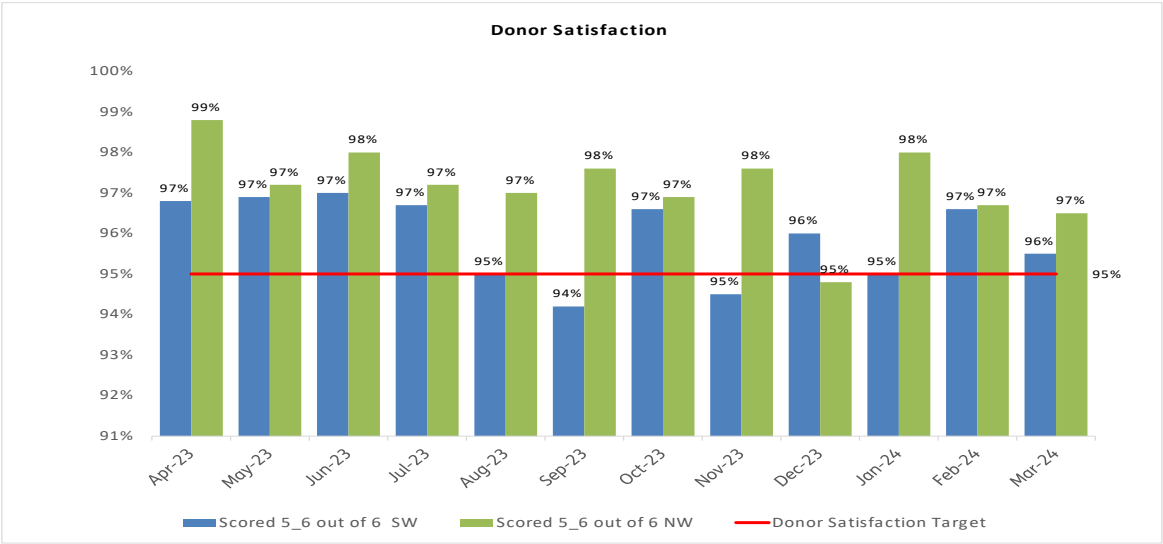
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	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	Feb 24	Mar 24
Actual %	97	97	95	97	97	97	97	96	94.9	96.7	95.1	95.6	96.3	96.7	96.5
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 96.5%, donor satisfaction is above target for March. In total there were 1,071 respondents to the donor survey, 183 from North Wales (scoring satisfaction at 97.6%), and 877 from South or West Wales (scoring satisfaction at 95.5%).

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	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	Feb 24	Mar 24
Actual %	100	100	100	100	100	100	100	100	100	100	100	100	100	0	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:

- 100% of concerns for March responded to within the 30 day PTR time frame

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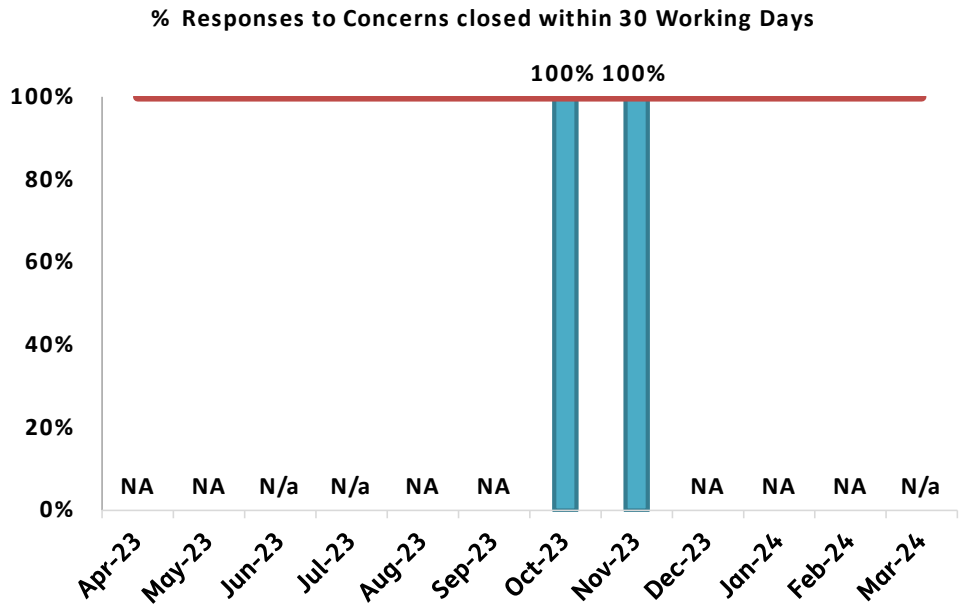
% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 100%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	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	Feb 24	Mar 24
Actual %	100	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A	N/a	N/A	N/A
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



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

Performance

Assessment of current performance, set out key points:
The 1 formal concern received in February was closed in March ahead of the 30-day deadline (02/04/24).

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

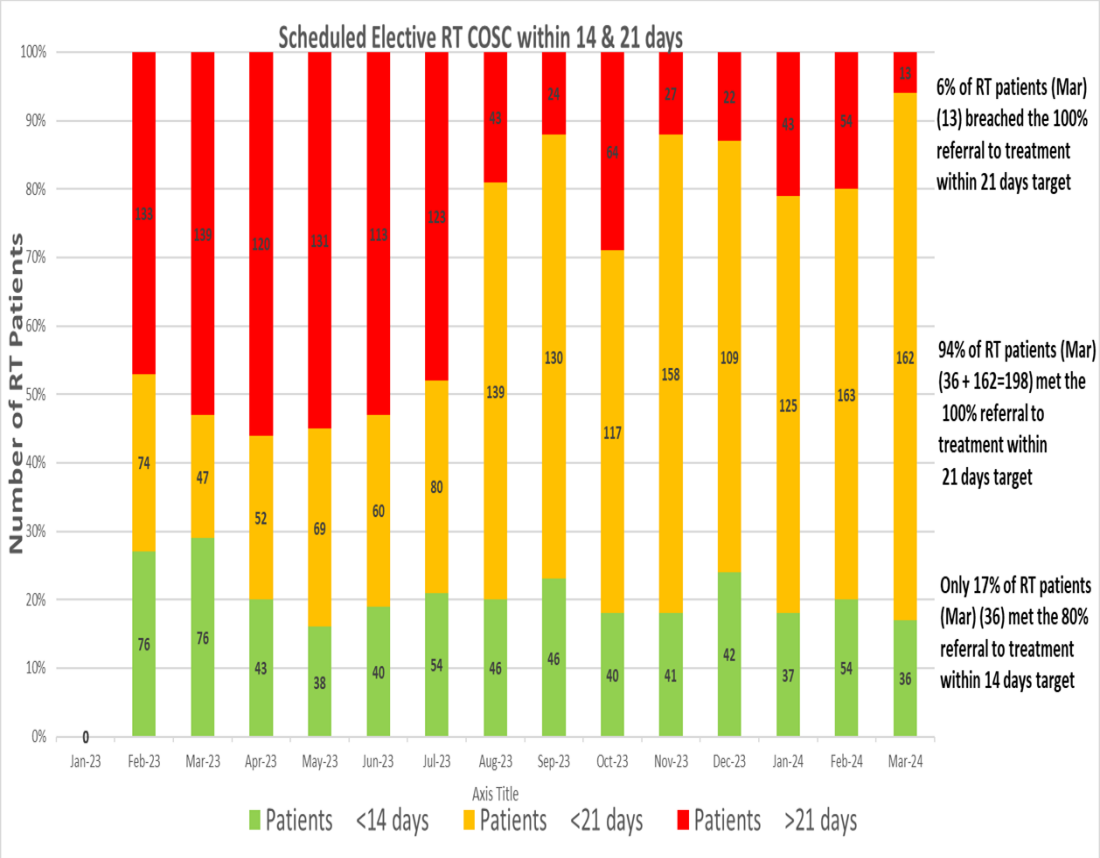
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Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days

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	210	
treated within 14 days of referral (80% target)	37	17%
treated within 21 days of referral (100% target)	198	94%

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

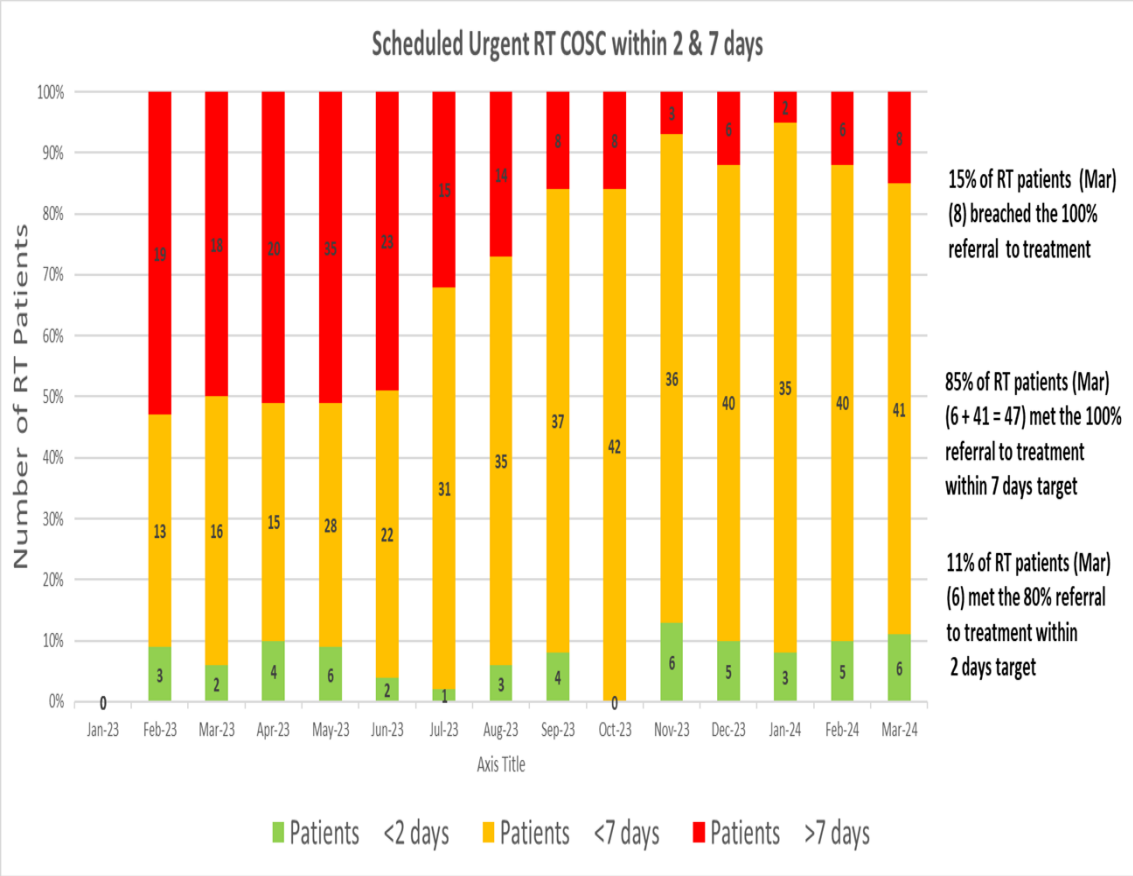
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Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days

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	55	
treated within 2 days of referral (80% target)	6	11%
treated within 7 days of referral (100% target)	41	85%

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

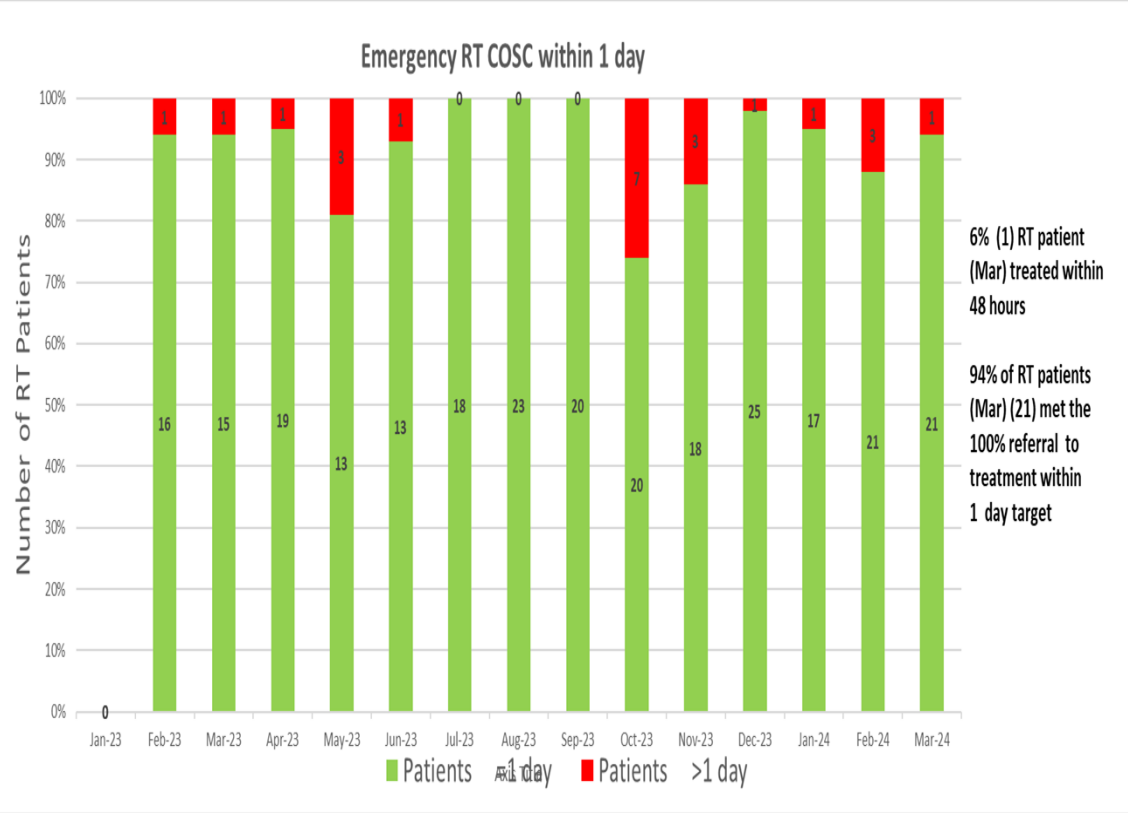
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Emergency Radiotherapy Patients Treated Within 1 Day

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	22	
80% treated within 1 day of referral	21	94%
100% treated within 2 days of referral	22	100 %

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

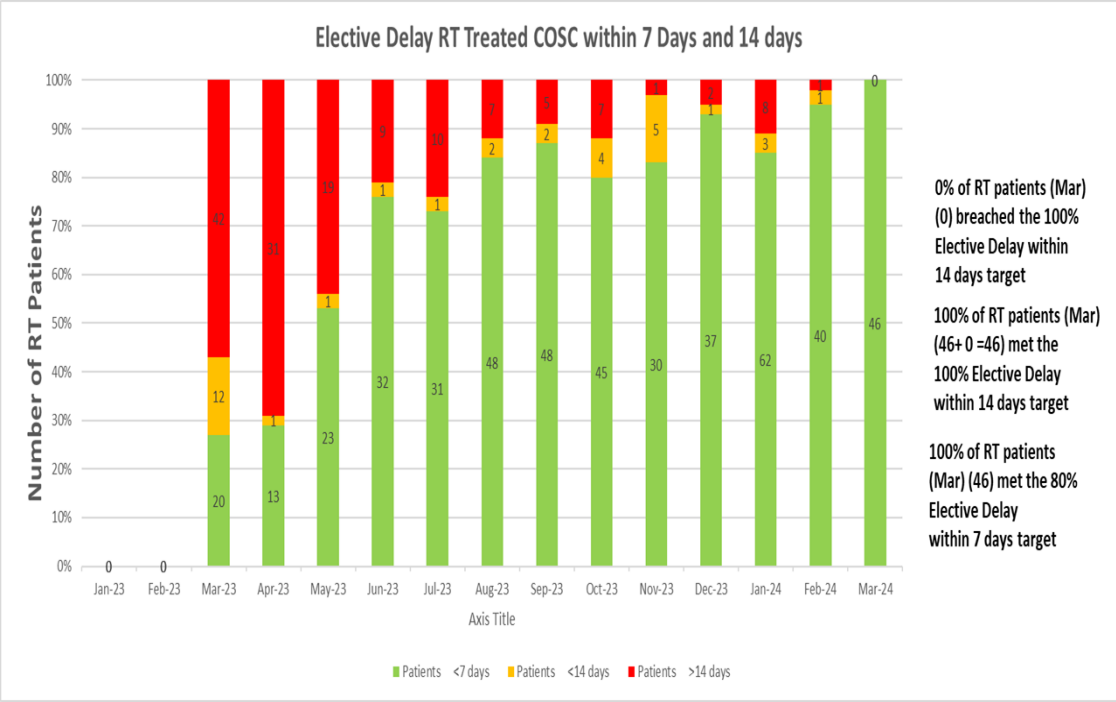
KPI Indicator KPV.17

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

Current Performance against Target or Standard

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	46	
treated within 7 days of referral (80% target)	46	100 %
treated within 14 days of referral (100% target)	46	100 %

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve •		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.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

	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	Feb 24	Mar 24
Actual %	97	98	98	93	90	90	94	92	90	98	85	90	64	79	N/A
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days	9	9	8	26	40	40	25	32	35	10	57	29	160	95	
Within 21 days	336	388	409	343	354	378	370	380	323	414	329	251	283	362	

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

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

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

Performance

February position:

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	70	15	3	7

The longest wait was 55 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.

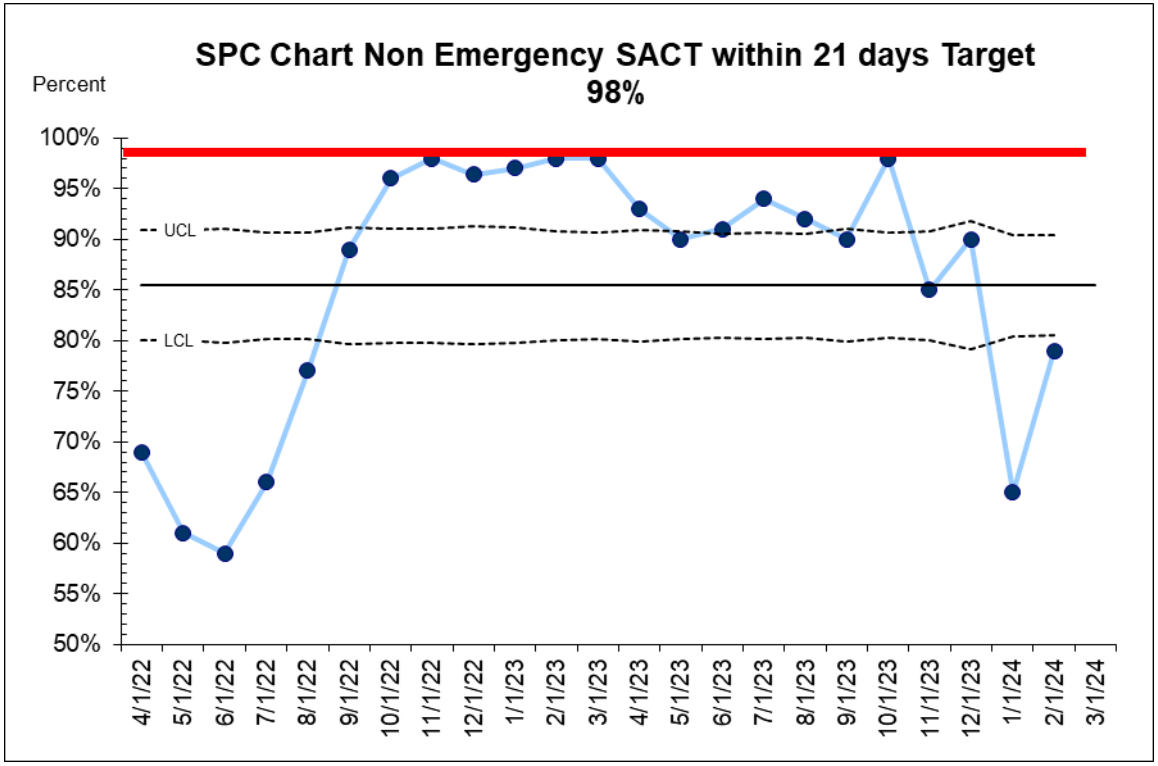
Service Improvement Actions – Immediate (0 to 3 months)

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 July 2024.	31/07/2024	BT
2) Agreed increase on mobile unit from 14 to 20 patients daily x 2 days weekly.	31/05/2024	BT
3) provide cleaning provision from operations to allow for potential release pharmacy staff on weekends to produce additional regimens	31/07/2024	MD/MRM

Expected Performance gain – immediate

Not until July 2024

Service Improvement Actions – tactical (12 months +)



SPC Chart Analysis

The SPC chart shows a reduced performance in January with an upturn in February 2024.

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.	31/05/24	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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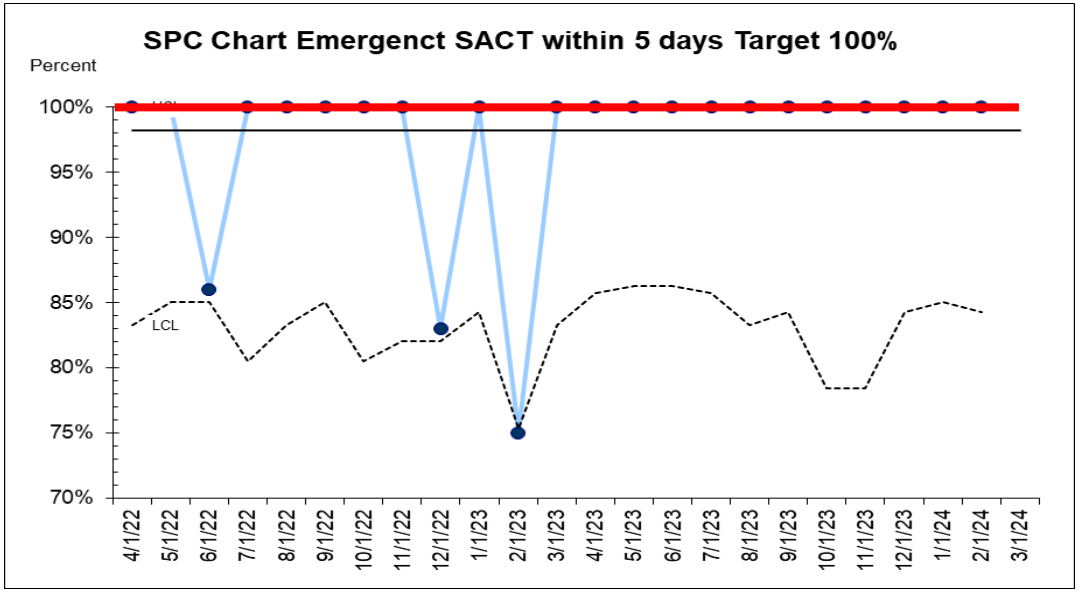
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	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	Feb 24	Mar 24
Actual %	100	75	100	100	100	100	100	100	100	100	100	100	100	100	
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
More than 5 days	0	1	0	0	0	0	0	2	0	0		1	0	0	
Within 5 days	8	3		5	0	12	10	5	8	4		7	9	8	



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

February position

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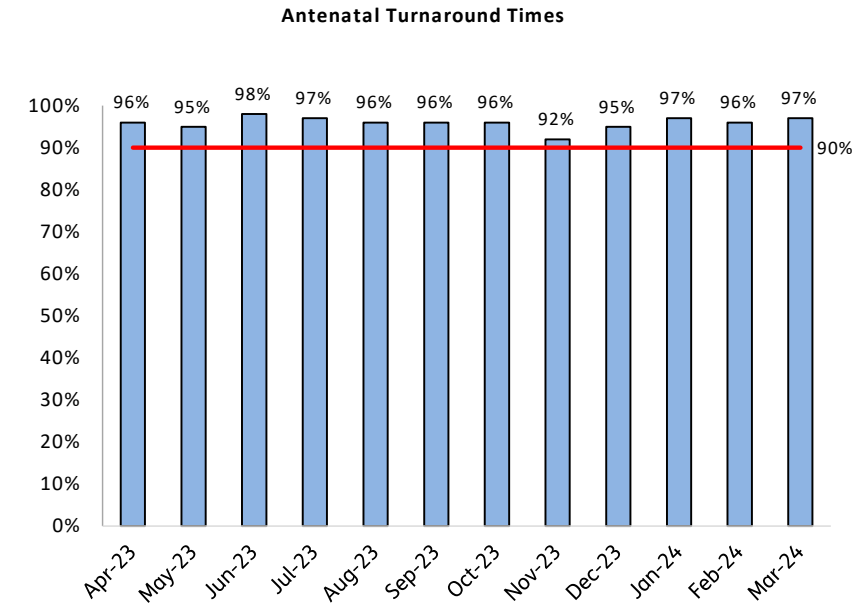
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	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	Feb 24	Mar 24
Actual %	97	96	96	96	95	98	97	96	96	96	92	95	97	96	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 March 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.

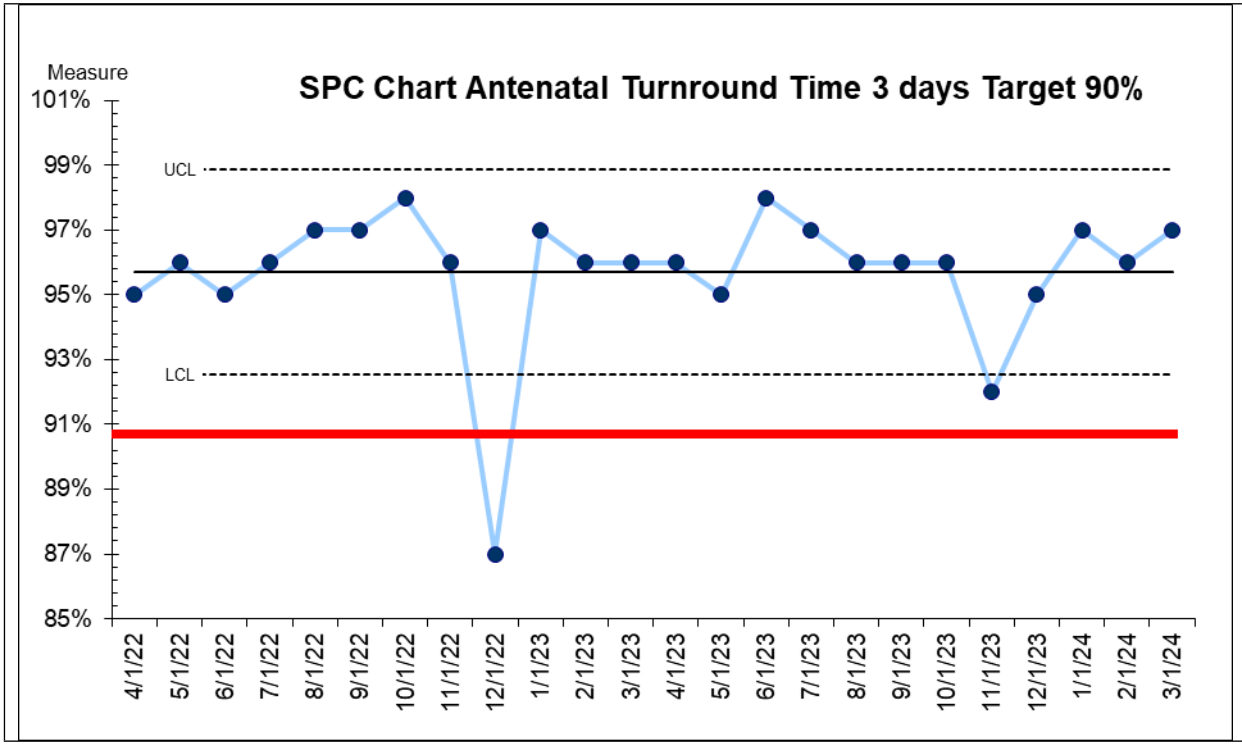
Service Improvement Actions – tactical (12 months +)

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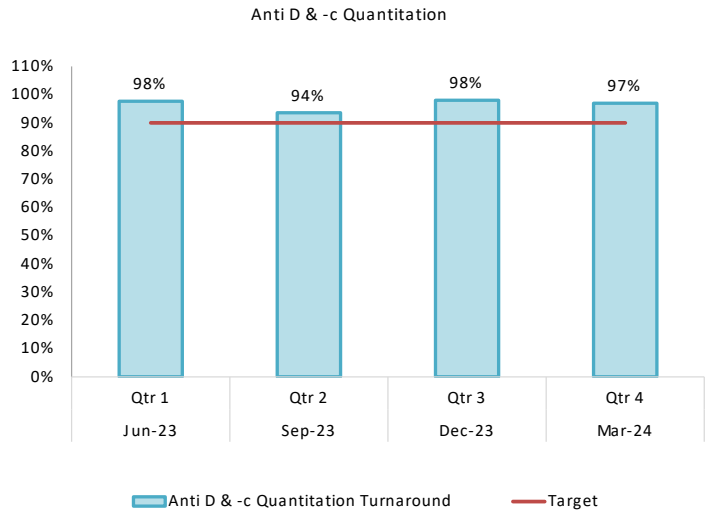
% Antenatal -D & -c quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	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	Feb 24	Mar 24
Actual %	96	60	92	97	98	97	98	99	100	99	100	98	100	92	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, 92% in February and 100% in March 2024, performance averaged 97% in quarter 3, meeting target and showing consistent high performance.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:
N/A		

Expected Performance gain - immediate.

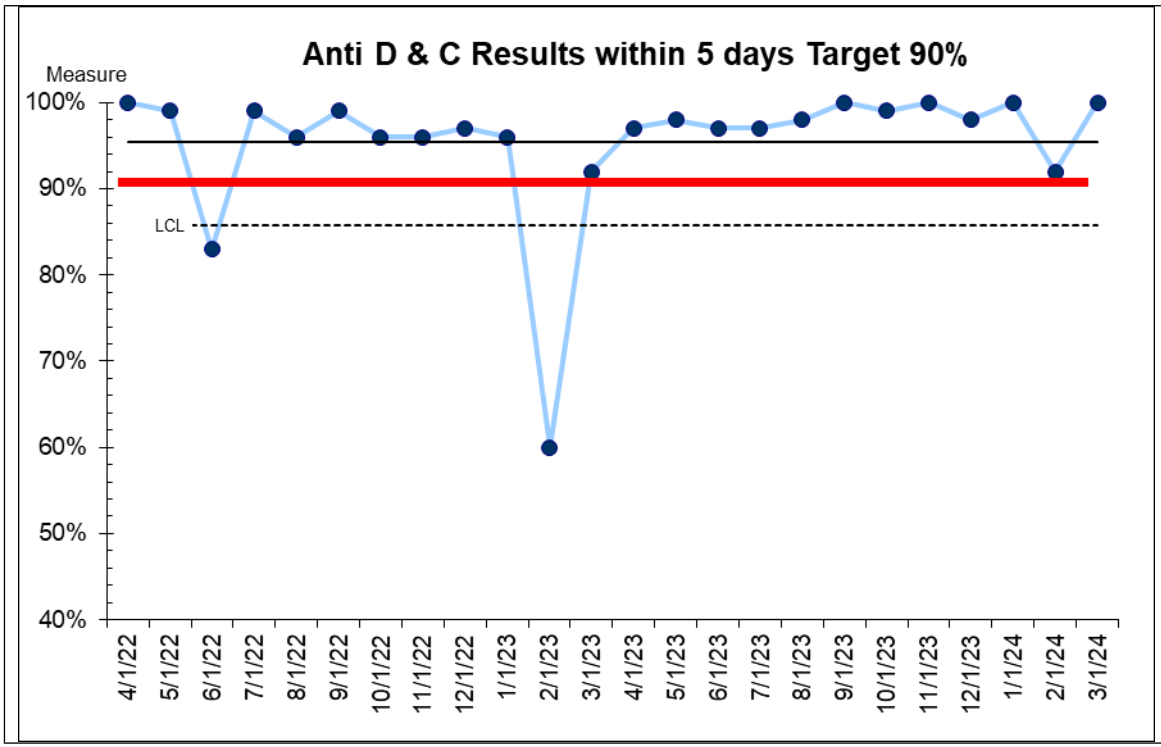
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.



SPC Chart Analysis

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

EFFICIENT

KPI Indicator FIN.71

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Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Director of Finance

Current Performance against Target or Standard

Trust Position (core)	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	25	30
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at March 24

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
VCC	(43.594)	(43.590)	0.004
RD&I	(0.114)	(0.000)	0.114
WBS	(21.734)	(21.514)	0.220
Sub-Total Divisions	(65.442)	(65.104)	0.338
Corporate Services Directorates	(14.027)	(14.517)	(0.491)
Delegated Budget Position	(79.469)	(79.622)	(0.152)
TCS	(0.744)	(0.613)	0.131
Health Technology Wales	(0.117)	(0.115)	0.001
Trust Income / Reserves	80.330	80.381	0.050
Trust Position	0.000	0.030	0.030

Performance

The core Trust has reported a £0.005m underspend on the in-month position for March '24, which gives a cumulative final unaudited underspend position of £0.030m for 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 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£2.5m cost reduction to the overall NHS position and were submitted to WG on the 11th August in line with Trust Board agreement.

The core Trusts final contribution to support the NHS financial position was £2.537m for 2023-24.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead: 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 worked 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 reduced 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 during 2023-24.
Energy	0.537	Energy costs reduced in year by £0.537m from the forecast presented at the IMTP planning stage, which was released to support the NHS deficit on a non-recurrent basis.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	0.500	The emergency reserve was not required to support service during the period and so was offered up to support the NHS deficit on a non-recurrent basis
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	2.537	

Actions addressed through Divisional Action Plans		
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	24.6 m	31.0 m
Target £31.005m CEL		1.389m	1.637m	5.646m	10.333m	8.683m	11.326m	14.277m	19.331m	20.672m	22.987m	24.6 m	31.0 m

Capital Position as at March 2024

	Approved CEL 2023/24 £m	Actual Spend 2023/24 £m	Year End Variance 2023/24 £m
All Wales Capital Programme			
nVCC - Enabling Works	10.896	10.881	0.015
nVCC - Project costs	3.257	3.257	0.000
nVCC - Advanced Design Works	3.882	3.882	0.000
nVCC - Advanced Works	0.898	0.898	0.000
nVCC - Advanced Design Works	1.229	1.229	0.000
nVCC - Whitchurch Hospital Site	0.000	0.014	(0.014)
Integrated Radiotherapy Solutions (IRS)	7.826	7.613	0.213
IRS Satellite Centre (RSC)	0.147	0.145	0.002
Digital Priorities Investment Fund	0.164	0.164	0.000
Digital DPIF -RISP	0.168	0.168	0.000
Digital Cyber Security	0.051	0.051	0.000
Digital Cyber Security (2)	0.085	0.095	(0.010)
Digital DPIF - EPMA	0.100	0.100	0.000
Digital WHAIS	0.250	0.246	0.004
Capital Year End Spend	0.257	0.252	0.005
Establish Microfludic Technology (WBS)	0.112	0.104	0.008
Total All Wales Capital Programme	29.322	29.099	0.223
Discretionary Capital	1.683	1.903	(0.220)
Total	31.005	31.002	0.003

The final approved Capital Expenditure Limit (CEL) as at March 2024 was **£31.005m**. This represents all Wales Capital funding of **£29.322m**, 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 £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 Trust was provided with £3.257m for the nVCC related project costs and £0.112m towards Establishing Microfluidic Technology in WBS during February.
Finally in March the Trust was provided a further £1.229m towards advanced design works associated with the nVCC.
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 for 2023-24 and represented 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 was 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 was also released and redistributed against prioritised schemes within the Trust which could be delivered before the 31st March.

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 completed a prioritisation form for all schemes included within the IMTP which were presented to EMB shape on the 18th March, and submitted to WG alongside the IMTP on the 28th March.

Year-end Performance

The actual total expenditure for 2023-24 on the All-Wales Capital Programme schemes was £29.099m against an agreed CEL of £29.322m. With WG agreement £0.213m was released from the IRS scheme back to discretionary, which is following the Trusts discretionary providing £0.248m to support the IRS implementation phase in prior years. .

Spend on Discretionary Capital to March was £1.903m.

The Trust reported actual total Capital spend of £31.002m ensuring that the Trust CEL target of £31.005m was achieved for 2023-24.

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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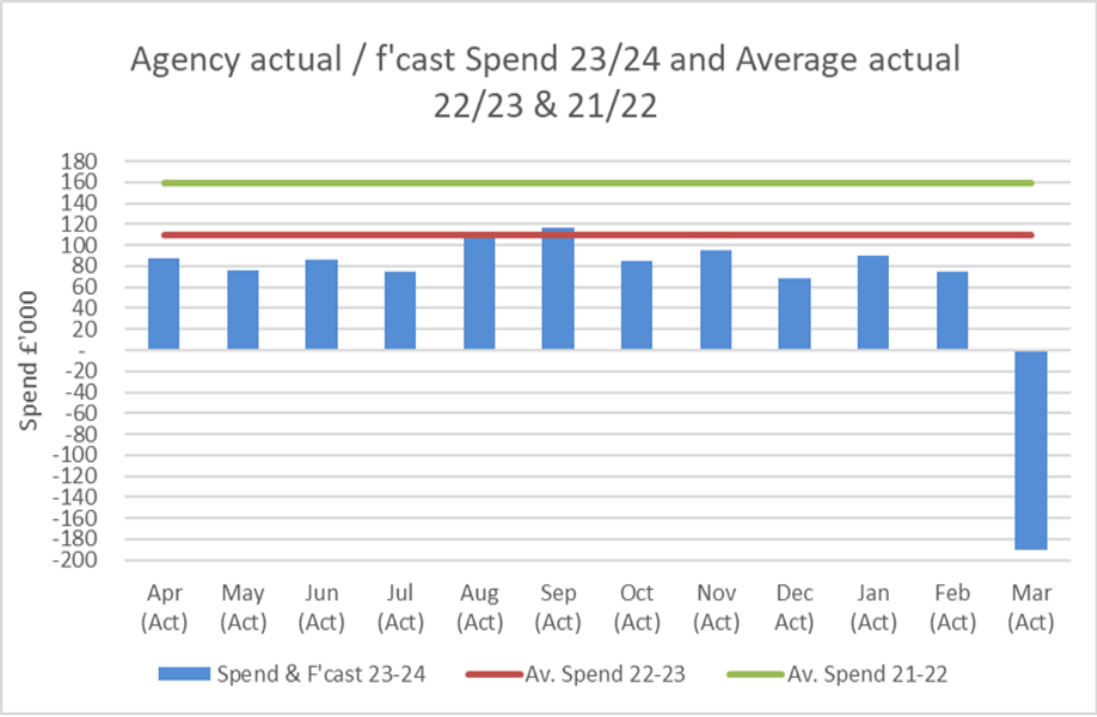
Usage of Overtime Bank and Agency Staff within Budget

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	75	(120)
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 March'24 was £(0.120)m (Feb £0.075m), which gives a cumulative full year spend of £0.775m (£1.323m 2022/23).

During March a review of agency committed orders was undertaken which resulted in several receipted orders being identified as no longer being required. This generally occurs when agency staff leave before their agreed term and the orders need to be closed, consequently a credit is released back into the revenue position.

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

Return to Top

Cost Improvement Programme delivery against plan

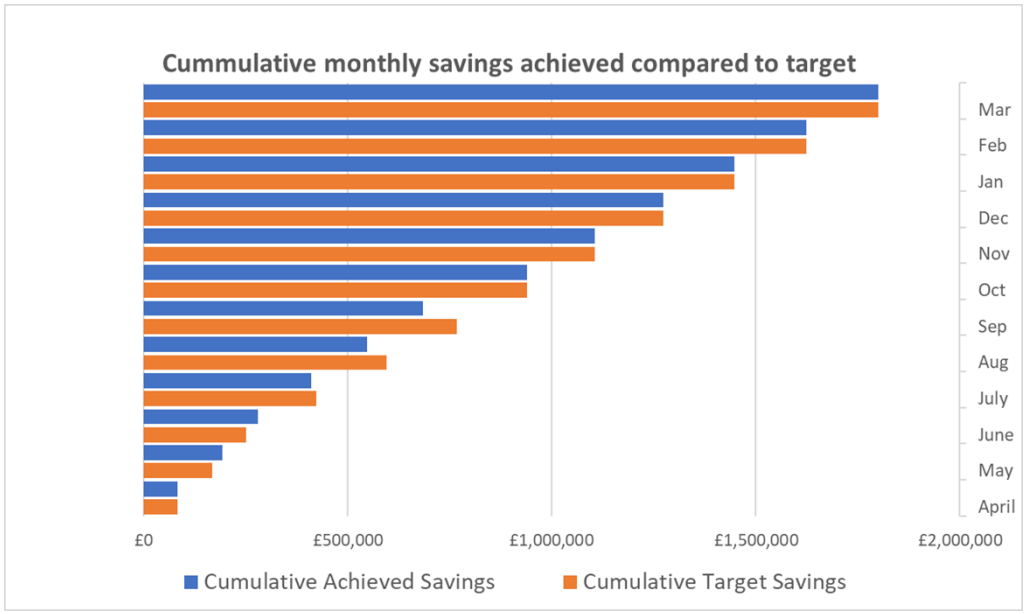
Target: Savings in line with Forecast CIP

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	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	0.172m	1.8m
Target £1.8M Forecast		0.084M	0.08 4m	0.08 4m	0.17 2m	0.17 2m	0.17 2m	0.172m	0.17 27m	0.17 2m	0.17 2m	0.172m	1.8m

Overall VUNHST Cost Improvement Programme £1.8M



Performance

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. Work will continue with procurement colleagues next year 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	98	98
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

During March '24 the Trust (core) achieved a compliance level of **98%** of Non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **97.7%** for 2023-24, and a Trust position (including hosted) also 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 into 2024-25 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	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	Feb 24	Mar 24
Actual %	-	-	11.63	-	-	10.30	-	-	9.81	-		9.41			7.50
Target %	-	-	0%	-	-	0%	-	-	0%	-					

Trust

Welsh Language (Listening/Speaking)

31-Mar-24

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1149	1746	65.81%
1 - Entry/ Mynediad	243	1746	13.92%
2 - Foundation / Sylfaen	69	1746	3.95%
3 - Intermediate / Canolradd	41	1746	2.35%
4 - Higher / Uwch	52	1746	2.98%
5 - Proficiency / Hyfedredd	61	1746	3.49%
Not Stated	131	1746	7.50%
Grand Total	**1746**	**1746**	**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

Return to Top

Mean Gender Pay Gap – Annual

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	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	Feb 24	Mar 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

Return to Top

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	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	Feb 24	Mar 24
Actual %	-	-	5.18	-	-	4.56	-	-	5.45	-		5.62			5.96
Target TBA%		-	TBA	-	-	TBA	-	-	TBA	-					

Trust
Ethnic Origin
31-Mar-24

Ethnic Origin	Headcount	%	BAME %
Asian	55	3.15%	**5.96%**
Black	21	1.20%	
Chinese	12	0.69%	
Mixed	16	0.92%	
Other	10	0.57%	
White	1531	87.69%	
Unspecified	71	4.07%	
Not Stated	30	1.72%	
Grand Total	**1746**	**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	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	Feb 24	Mar 24
Actual %	-	-	4.63	-	-	4.9	-	-	4.9	-		5.33			5.74
Target TBA%	-	-	TBA	-	-	TBA	-	-	TBA	-					

Trust
Disability
31-Mar-24

Disability	Headcount	%
No	1442	85.38%
Not Declared	46	2.72%
Prefer Not To Answer	13	0.77%
Unspecified	148	8.76%
Yes	97	5.74%
Grand Total	**1746**	**103%**

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 MARCH (M12)

DATE OF MEETING	23/05/2024
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 March 2024. The three main issues are highlighted below: **1. Key Financial targets / KPIs** • The core Trust reported a small underspend in its final revenue position for 2023/24.

	• The Trust achieved the PSPP target of paying 95% of Non-NHS invoices within 30 days for 2023-24. • The Trust achieved the Capital CEL target for 2023-24 by spending £31.002m of the £31.005m Capital budget allocated. **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. As expected, the final LTA income position based on activity delivered for 2023/24 confirmed that the income did cover the cost of the additional capacity made to date. **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 £2.537m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit. *Please note that due to the financial year the month 12 WG monitoring return letter which normally accompanies the report was not available in time for this meeting.*

RECOMMENDATION / ACTIONS	**Trust Board** is asked to: **NOTE** the contents of the March 2024 financial report, (noting that the figures provided are unaudited at this stage)

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board (EMB)	29/04/2024
Quality, Safety and Performance Committee	09/05/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

- The finance report was received and noted at EMB on the 29th April 24 and QSP on 9th May 24.

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 – March 2024
Appendix 2	TCS Finance Report – March 2024

1. SITUATION/ BACKGROUND

1.1 The attached report outlines the financial position and performance for 2023-24.

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 £m	Total Actual 2023-24
Revenue	Variance	0.005	£0.030m
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	6.392	£31.002m
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98%	97%

2.2 Revenue Budget

The overall position against the profiled revenue budget for 2023-24 was an underspend of **£0.030m**.

Long Term Agreement (LTA) Contract Performance

Velindre Cancer Service (VCS) Contract income had recovered during the period to a level that sufficiently funds the capacity investments made to date.

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£2.5m 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 worked 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 reduced 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 during 2023-24.
Energy	0.537	Energy costs reduced in year by £0.537m from the forecast presented at the IMTP planning stage, which was released to support the NHS deficit on a non-recurrent basis.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	0.500	The emergency reserve was not required to support service during the period and so was offered up to support the NHS deficit on a non-recurrent basis
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	2.537	

As detailed in the table above the core Trusts final contribution to support the NHS financial position was £2.537m for 2023-24.

2.3 Savings

The Trust fully achieved the revised savings target of £1.8m during 2023-24. Following a review of the savings plan, £0.305m additional non-recurrent savings schemes were identified to replace several recurrent 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

The Final PSPP performance for the whole Trust for was 97.7% against a target of 95%, with the performance against the Core Trust excluding NWSSP also achieving a target of 97.7% for 2023-24.

2.5 Covid Expenditure

Covid Programme Costs

In line with the WG approval letter the Trust only drew £0.053m of funding from WG towards PPE costs for 2023-24.

Covid Recovery and Planned Care Capacity

The final position for 2023/24 confirms that the contract performance had recovered to a level that sufficiently funds the capacity investments made to date.

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 £0.305mof 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 to the above reserves, each year the Trust holds an emergency reserve of £0.522m which was not utilised in the period and per previous agreement by the Board this was provided to WG on a non-recurrent basis to support the NHS was financial position during 2023-24.

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 all risks were either been managed or mitigated for 2023/24.

A recurrent risk had emerged in terms of the Trust receiving full funding for the 2023-24 pay award. WG provided the funding requirement during 2023-24 but are yet to confirm whether it was provided as a recurrent allocation. 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.

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 was provided funding award letters to support all Capital project requirements for 2023-24.

Other Major Schemes in development that are detailed in the main finance report were included within the IMTP submission to WG.

Discretionary Programme

The discretionary allocation of £1.683m represented 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.

Yearend Performance

The core Trust reported actual total Capital spend of £31.002m ensuring that the Trust CEL target of £31.005m was achieved for 2023-24.

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 eventually received all funding to support the pay awards that were processed during 2023-24.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	08 - Trust Financial Investment Risk
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒

	Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	N/A. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	N/A
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of **£0.030m** ensuring that the target was met for 2023-24. The Trust also achieved the Capital (CEL) target for the period.
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 MARCH 2024

TRUST BOARD
23/05/2024

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.

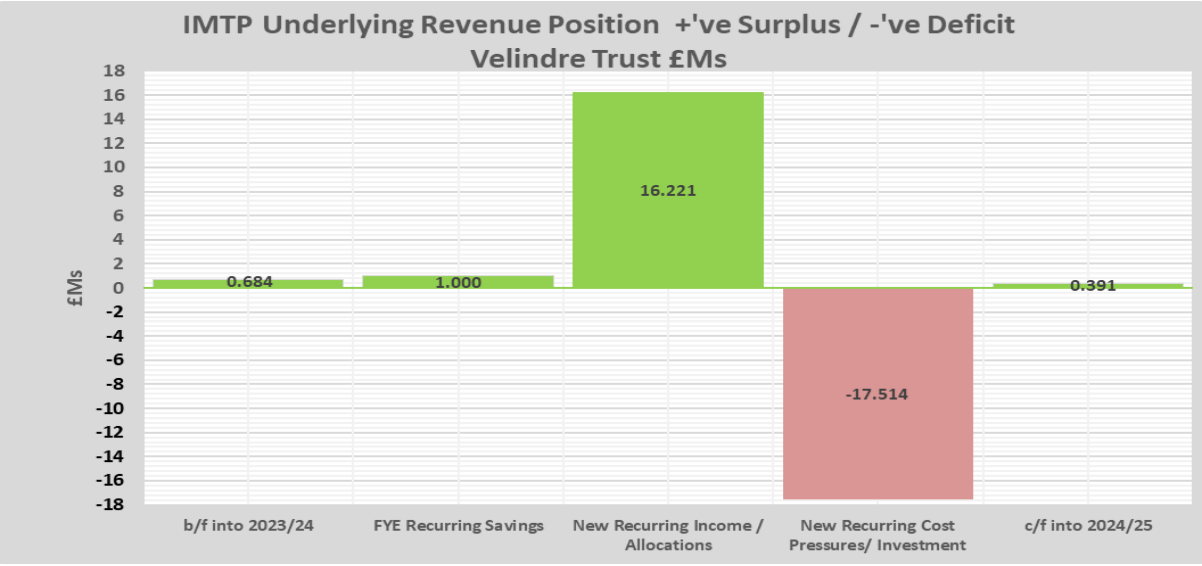
- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

- 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 £m	Total Actual 2023-24
Revenue	Variance	0.005	£0.030m
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	6.392	£31.002m
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98%	97%

Performance against Planned Savings Target

	Unit	Current Month £m	Total Actual 2023-24
Efficiency / Savings	Variance	0.000	0.000

Revenue

The core Trust has reported a **£0.005m** underspend on the in-month position for March '24, which gives a cumulative final unaudited underspend position of **£0.030m** on revenue for 2023-24.

Capital

The final approved Capital Expenditure Limit (CEL) for 2023-24 was **£31.005m**. This represents all Wales Capital funding of **£29.322m**, and Discretionary funding of **£1.683m.** The Trust reported actual total Capital spend of **£31.002m** ensuring that the Trust CEL target was achieved for 2023-24.

The Trust's final CEL position 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
nVCC Project Costs		3.257	3.257
Microfluidic Technology (WBS)		0.112	0.112
nVCC Advanced Design Works		1.229	1.229
Total All Wales Capital	**22.733**	**6.589**	**29.322**
Total CEL	**24.416**		**31.005**

PSPP

During March '24 the Trust (core) achieved a compliance level of **98%** of Non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **97%** for 2023-24, and a Trust position (including hosted) also of **97%** compared to the target of 95%.

Efficiency / Savings

The Trust fully achieved the savings target of £1.8m during 2023-24, however, during July additional £0.305m non-recurrent savings schemes were identified to replace several recurrent schemes that had been assessed as non-deliverable i.e. Red Status.

Revenue Position

2023/24 Financial Position			
£0.030m Underspent			
Type	**Full Year Budget (£m)**	**Full Year Actual (£m)**	**Full Year Variance (£m)**
Income	(207.558)	(208.716)	1.158
Pay	90.518	89.587	0.931
Non Pay	117.040	119.099	(2.059)
Total	**0.000**	**(0.030)**	**0.030**

The overall final revenue position against the profiled revenue budget for 2023-2024 was an underspend of **£0.030m.**

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 ensured 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 worked 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 reduced 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 during 2023-24.
Energy	0.537	Energy costs reduced in year by £0.537m from the forecast presented at the IMTP planning stage, which was released to support the NHS deficit on a non-recurrent basis.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	0.500	The emergency reserve was not required to support service during the period and so was offered up to support the NHS deficit on a non-recurrent basis
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	2.537	

As detailed in the table above the core Trusts final contribution to support the NHS financial position was £2.537m for 2023-24.

Suspension of expenditure recharges to Charity 2023-24

Like in 2022-23 the Trust has accumulated £1.5m of non-recurrent income during 2023-24 from several sources including significantly higher levels of bank interest, and over performance of plasma and private patient income.

The Trust receives funding from the Charity which supports the supplementation of cancer services, the administration of the funds and investment in research and development. Given the c£1.5m of extraordinary non-recurrent income generated the level of Trust expenditure funded by the Charity in 2023-24 was reduced by £1.5m.

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 final position for 2023/24 confirms that the contract performance had recovered to a level that sufficiently funds the capacity investments made to date.

The tables below set out the year-end LTA Income performance:

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Outturn Variance £m	Outturn £m	Variance (%)
Hywel Dda (7A2)	0.283	-0.011	0.272	-4%
Swansea Bay (7A3)	0.294	0.011	0.305	4%
Cardiff & Vale (7A4)	15.036	1.240	16.276	8%
Cwm Taf Morgannwg (7A5)	13.221	0.809	14.030	6%
Aneurin Bevan (7A6)	17.344	1.222	18.566	7%
Powys (7A7)	0.758	0.162	0.920	21%
WHSSC	2.633	0.310	2.943	12%
Total	**49.569**	**3.742**	**53.311**	**8%**

Financial Performance Per Contract Currency	Base Contract Value £m	Outturn Variance £m	Outturn £m	Variance (%)
Radiotherapy	17.929	-0.321	17.608	-2%
Nuclear Medicine	0.923	-0.036	0.887	-4%
Radiology Imaging	2.840	0.592	3.432	21%
Preparation for Systemic Anti-Cancer Therapy	2.594	0.207	2.801	8%
Delivery of Systemic Anti-Cancer Therapy	5.935	1.073	7.008	18%
Ambulatory Care Services	1.235	0.259	1.494	21%
Outpatient Services		2.161	11.390	23%
Inpatient Admitted Care	9.229	-0.193	8.691	-2%
Total	**49.569**	**3.742**	**53.311**	**8%**

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

Pay Highlights / Key Issue

The Trust received full funding from WG during 2023-24 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 paid in October (c£0.7m). However, whilst the Trust received full funding to support the pay award during 2023-24 WG are yet to confirm whether the allocation was provided on a recurrent basis, which if not confirmed during 2024-25 could lead to an underlying shortfall being carried into next financial year.

During the period the Trust 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 will continue into 2024/25 to update the likely cancer activity demand forecasts and associated income to help mitigate the financial risk exposure.

On top of the savings plans VCS (£0.450m), WBS (£0.450m) and Corporate (£0.150m) hold a recurrent vacancy factor target, which was achieved during the period ensuring that the overall Trust financial position was achieved for 2023-24.

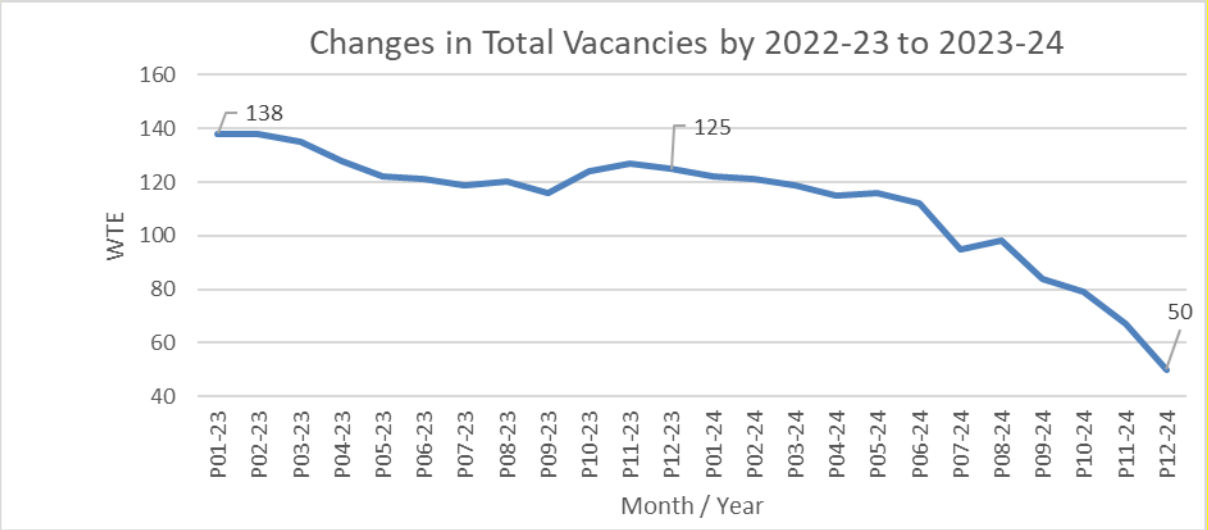
Non-Pay Key Issues

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.

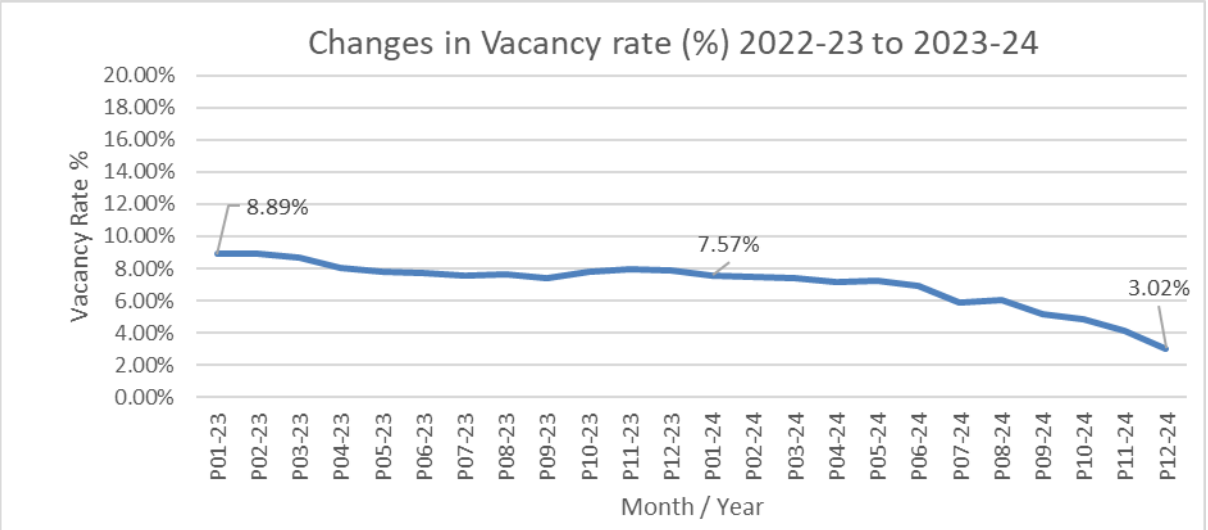
4.2 Pay Spend Trends (Run Rate)

As of March 2024, the current staff in post is 1,603 WTE, (119 WTE increase from the 1484 WTE as at April 2023). The current number of vacancies is 50 WTE, which represents a vacancy rate of 3.2% (4.1% February) against the budget of 1653 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, particularly due to the recruitment of 17wte Nurses during February via the international recruitment scheme. The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to March 2024:

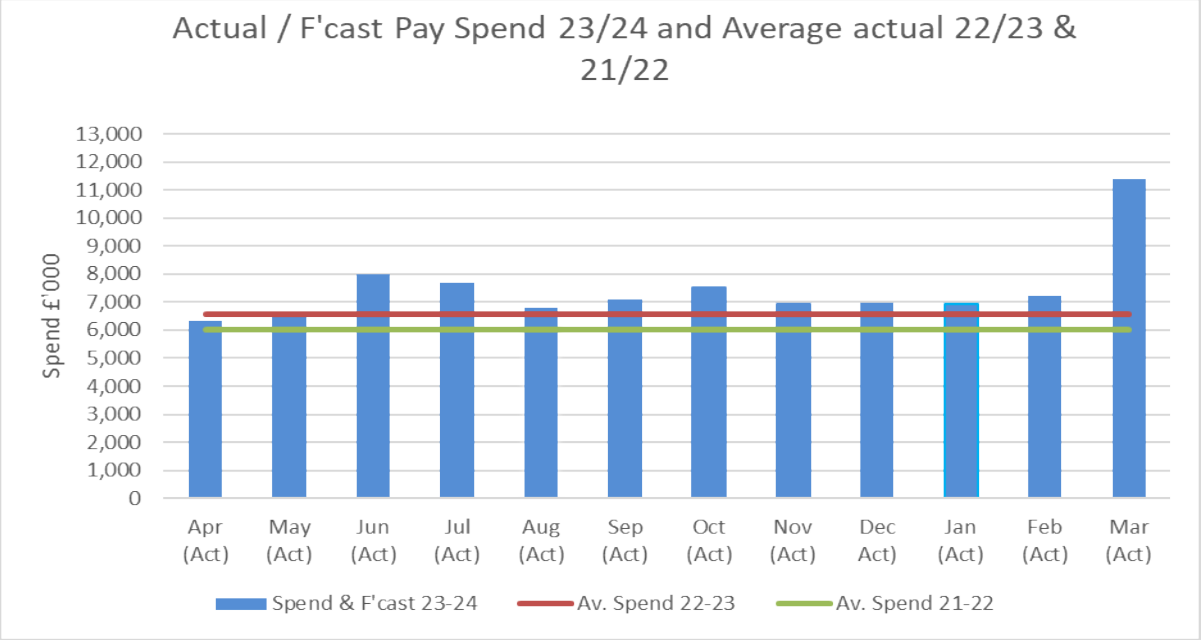


The total Trust vacancies as of March 2024 is 50wte (February 67wte), VCC (25wte), WBS (8wte), Corporate (7wte), R&D (6wte), TCS (2wte) and HTW (2wte).

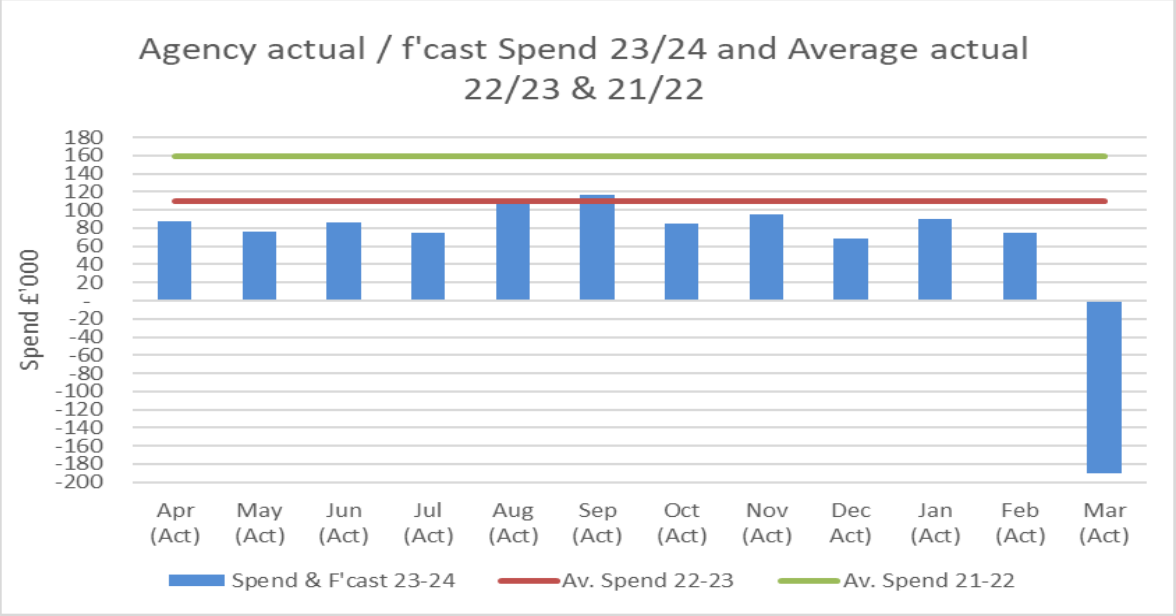


Per the IMTP the Trust has been reducing the reliance on agency throughout 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions 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 and sickness levels may continue to prove challenging.

Per the IMTP The Trust is aiming to remove the reliance on agency by the second quarter of next financial year.

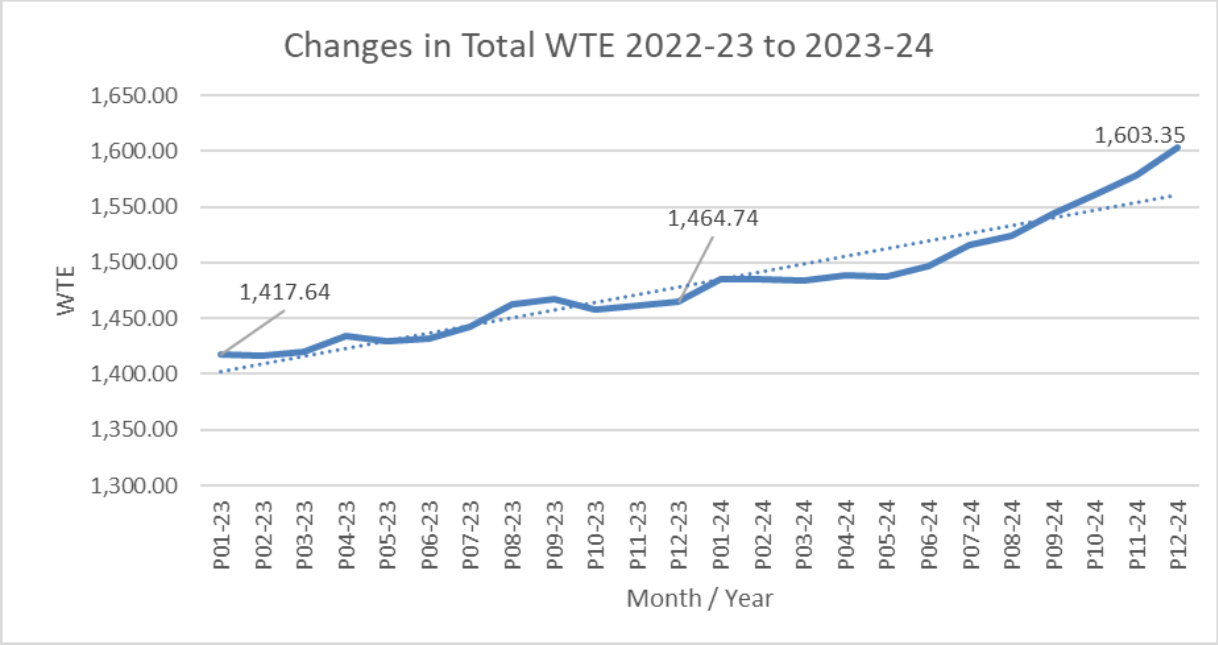


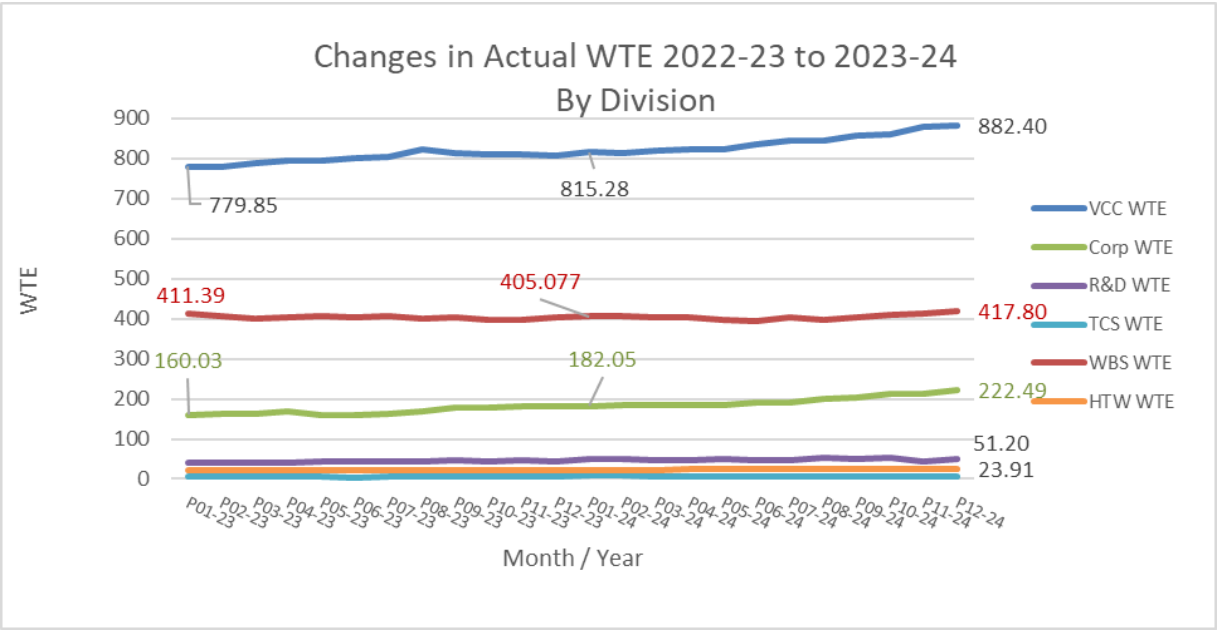
*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% AFC consolidated pay award backdated to April 2023.
*The Spike in pay during October relates to the 5% Medical consolidated pay award backdated to April 2023.
* The additional 6.3% pension contribution funded via WG of c£4m explains the surge in pay during March.



The spend on agency for March'24 was **£(0.120)m** (Feb £0.075m), which gives a cumulative full year spend of £0.775m (£1.323m 2022/23).

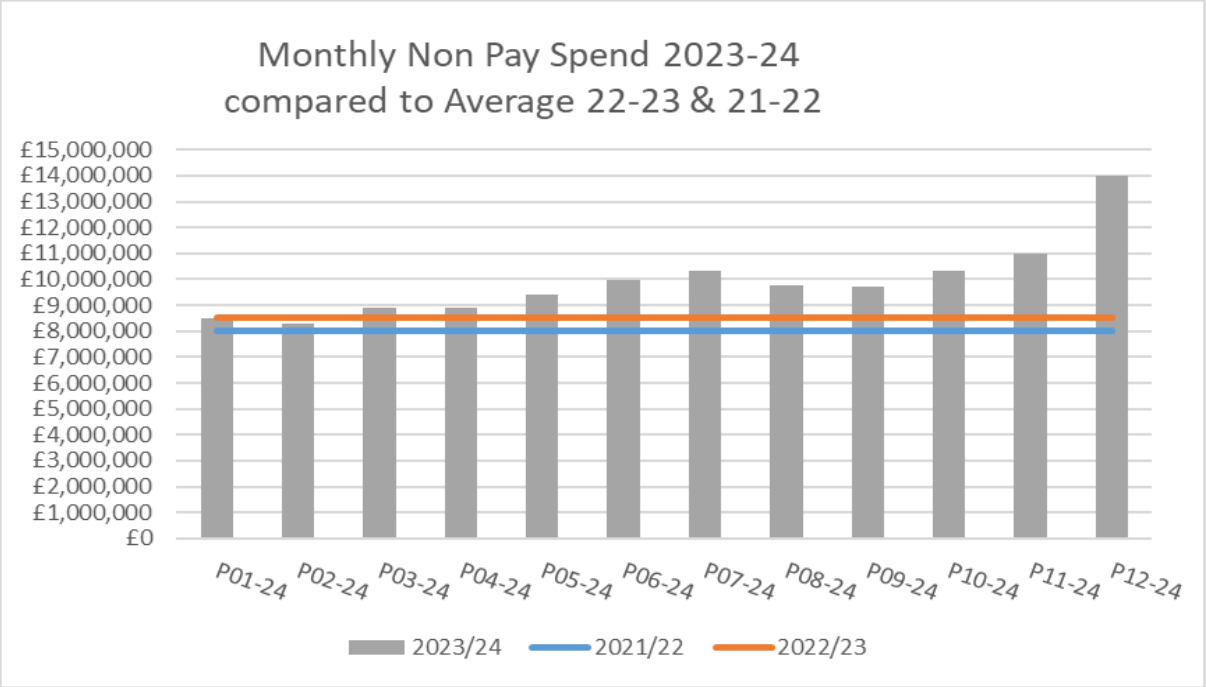
During March a review of agency committed orders was undertaken which resulted in several receipted orders being identified as no longer being required. This generally occurs when agency staff leave before their agreed term and the orders need to be closed, consequently a credit is released back into the revenue position.





4.3 Non-Pay

The Average non-pay spend for 2023/24 was £9.9m per month which is a £1.4m increase from the previous whole year average. Largest movement is in drug spend which has increased by £10m in total or £0.9m average per month when compared with the previous year's spend for the same period. Other notable increases year on year include WBS Wholesaling £3.3m or £0.3m average per month and depreciation charges of £1.2m or £0.100m per month. Non-Pay expenditure has significantly increased over the past 2 years (c20%) which has been largely drive by drug spend, commercial blood products (wholesaling), along with an increase in energy prices and genera inflation.



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.

The Trust only drew funding from WG towards PPE costs of £0.053m for 2023-24. However, if at any point in the future the Trust is required to support the LHBs with any further vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

Covid Recovery and Planned Care Capacity

Committed investment in Velindre Cancer Services capacity was a recurrent sum of £3.5m made in 2021-22 and 2022-23 using WG Covid funding which ceased from 1st April 2023. The income to fund this additional capacity flows from Commissioners via performance related LTA contracting income which is dependent on activity levels being delivered above the 2019-20 baseline contract. 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 decided in August to relinquish the income protection arrangements to contribute to the reduction of the NHS Wales planned deficit. This was formally communicated with Commissioners and transacted following updated LTAs in September.

The Trust's Integrated Medium-Term Financial Plan assumed that activity levels may not be sufficient to recover all the £3.5m investment made to support the planned care backlog capacity. The final position for 2023-24, however confirmed that the contract activity performance recovered sufficiently to cover the £3.5m investment.

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

4. Savings

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

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

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

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

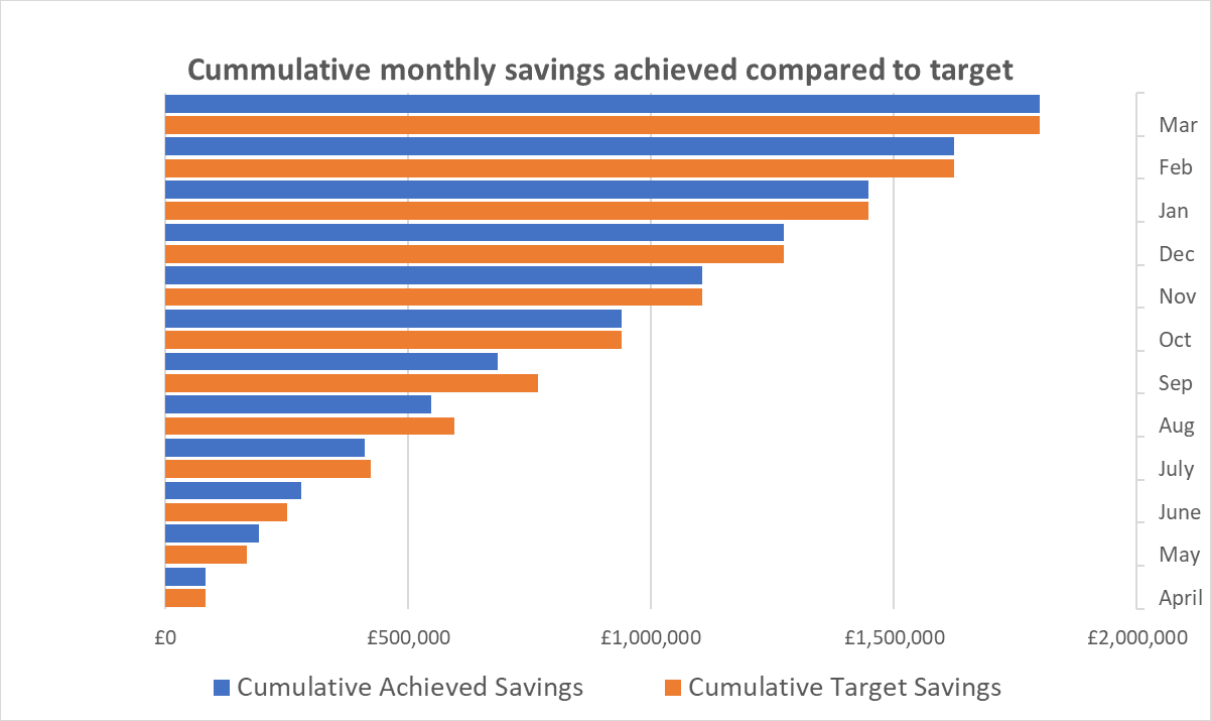
Service redesign and support service structures continue to be a key area for the Trust where it is focusing on to find efficiencies in the ways we are working, ensuring the appropriate staff are undertaking each activity. Whilst this remains a high priority the ability to enact change has been challenging 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 delivery was not achieved this year work will continue with procurement colleagues to identify further opportunities to deliver savings through the supply chain as we move into 2024-25.

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	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**950**	**950**	**0**
		100%	
WBS TOTAL SAVINGS	**700**	**700**	**0**
		100%	
CORPORATE TOTAL SAVINGS	**150**	**150**	**0**
		100%	
TRUST TOTAL SAVINGS IDENTIFIED	**1,800**	**1,800**	**0**
		100%	

Scheme Type	TOTAL £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes			
Establishment Control (N/R) (Corporate)	75	75	0
Procurement Supply Chain (R) (WBS)	100	0	(100)
Collection Team Costs Reduction (R) (WBS)	10	10	0
Collection Team Costs Reduction (NR) (WBS)	8	8	0
Establishment Control (R) (WBS)	60	60	0
Reduced use of Nitrogen (R) (WBS)	55	0	(55)
Reduced Research Investment (R) (WBS)	25	25	0
Stock Management (NR) (WBS)	125	125	0
Reduced Transport Maintenance (NR) (WBS)	30	30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	137	137	0
Service Workforce Re-design (R) (VCS)	50	0	(50)
Establishment Control (NR) (VCS)	175	175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	150	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	125	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	50	50	0
Procurement Supply Chain (R) (VCS)	100	0	(100)
Total Saving Schemes	**1,275**	970	(305)
Income Generation			
Bank Interest (R) (Corporate)	75	75	0
Sale of Plasma (R) (WBS)	150	150	0
Expand SACT Delivery (R) (VCS)	200	200	0
Private Patient Income (R) (VCS)	50	50	0
Private Patient Income (N/R) (VCS)	50	50	0
NEW Medicines at Home (N/R) (VCS)		150	150
NEW Sale of Plasma (NR) (WBS)		155	155
Total Income Generation	**525**	830	305
TRUST TOTAL SAVINGS	**1,800**	**1,800**	**0**
		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 £0.305m 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 had arisen during the year as financial pressures built into the IMTP financial plan 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, each year the Trust holds an emergency reserve of £0.522m which was not utilised in the period and per previous agreement by the Board this was provided to WG on a non-recurrent basis to support the NHS Wales financial position during 2023-24.

6. 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 all risks were either been managed or mitigated for 2023/24.

The remaining key financial risks & opportunities relating to 2024-25 as highlighted to Welsh Government are provided below:

Risks

2023/24 Pay Award – c£0.300m

The Trust received full funding from WG during 2023-24 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 paid in October (c£0.7m). However, whilst the Trust received full funding to support the pay award during 2023-24, WG are yet to confirm whether the allocation was on a recurrent basis, which if not forthcoming could lead to an underlying shortfall being carried into next financial year.

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

Whilst there are several cost pressures within the service Divisions these have been manged from within normal budgetary control procedures or through utilisation of the Trust non-recurrent reserve during 2023/24. The recurrent impact of these cost pressures for future years has removed any underlying surplus and has been considered as part of the 2024-25 to 2026-27 IMTP process with an increase savings target required to offset the cost pressures.

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

There are a number of annual revenue costs that the Trust will inherit on the transfer of the Whitchurch land and hospital building as well as future costs of disposal / development. The annual costs include site security, utilities and maintenance/upkeep of the Whitchurch hospital and site based on information provided by C&VUHB. These are forecast to be £0.640m (Exc VAT).The Trust 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 fund these costs.

The site surveys, transaction and disposal costs are estimated at £0.300m (Exc VAT) and the make safe cost for the Whitchurch Hospital is estimated at between £1.65m - £2.73m (Exc VAT).

The Trust submitted a paper to the WG Health Strategy Board (HSB) held on 8th March setting out all the costs implications of the land & hospital transfer and future disposal / development. WG HSB approved in principle the proposed approach and funding of the costs. The annual revenue costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre UNHST from C&VUHB. The official transfer will be dependent on completion of the WG formal process for transfer which is currently anticipated to take place before the 31st March 2024. Once the land is transferred to the Trust, the annual revenue cost pressure would remain on a recurrent basis, until the residual Whitchurch estate can be disposed of or developed. This £0.640m 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.

Opportunities Pipeline

The Trust has identified some initial opportunities that could be explored but these require further development including identification of Senior Responsible Officers to take accountability at Exec level to oversee the development and delivery.

Title	Scope	Total value Opportunity £'m	2024/25 ambition £'m	2025/26 ambition £'m	V&S Board Category	Programme Complexity
Pre-Operative Anaemia Pathway Project	Value Based Healthcare project led by WBS where all patients undergoing elective major surgery in Wales will be screened pre-operatively, and offered treatment with intravenous Iron as required prior to surgery. Savings to be established and delivered via Health Boards and represents WBS / VUNHST contribution to system wide financial performance.	tbc	tbc	Tbc	Pathway	3
Medicine Unit Supply	Identify opportunities to increase use of NWSSP Medicines unit to identify further potential cost savings for high cost drugs. Note that any cost savings are passed through to LHB Commissioners	Tbc	0.500	0.500	Medicines Management	3
Workforce Re-design	Review of workforce models and pathways to identify opportunities to deliver services more efficiently in addition to the schemes outlined in the savings tracker.	Tbc	0.000	0.250	Workforce	4
Procurement	Continue to work with procurement and divisions on a regular basis to review non pay	0.400	0.200	0.200	Procurement & Non-pay	2

	spend and cost improvement opportunities above savings target					

7. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL 2023/24 £m	Actual Spend 2023/24 £m	Year End Variance 2023/24 £m
All Wales Capital Programme			
nVCC - Enabling Works	10.896	10.881	0.015
nVCC - Project costs	3.257	3.257	0.000
nVCC - Advanced Design Works	3.882	3.882	0.000
nVCC - Advanced Works	0.898	0.898	0.000
nVCC - Advanced Design Works	1.229	1.229	0.000
nVCC - Whitchurch Hospital Site	0.000	0.014	(0.014)
Integrated Radiotherapy Solutions (IRS)	7.826	7.613	0.213
IRS Satellite Centre (RSC)	0.147	0.145	0.002
Digital Priorities Investment Fund	0.164	0.164	0.000
Digital DPIF -RISP	0.168	0.168	0.000
Digital Cyber Security	0.051	0.051	0.000
Digital Cyber Security (2)	0.085	0.095	(0.010)
Digital DPIF - EPMA	0.100	0.100	0.000
Digital WHAIS	0.250	0.246	0.004
Capital Year End Spend	0.257	0.252	0.005
Establish Microfludic Technology (WBS)	0.112	0.104	0.008
Total All Wales Capital Programme	29.322	29.099	0.223
Discretionary Capital	1.683	1.903	(0.220)
Total	31.005	31.002	0.003

The final approved Capital Expenditure Limit (CEL) as at March 2024 was **£31.005m**. This represents all Wales Capital funding of **£29.322m**, 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 £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**

The Trust was provided with £3.257m for the nVCC related project costs and £0.112m towards Establishing Microfluidic Technology in WBS during February.

In March the Trust was provided a further £1.229m towards advanced design works associated with the nVCC.

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 for 2023-24 and represented 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 was 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 was also released and redistributed against prioritised schemes within the Trust which could be delivered before the 31st March.

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

completed a prioritisation form for all schemes included within the IMTP which were presented to EMB shape on the 18th March and submitted to WG alongside the IMTP on the 28th March.

Yearend Performance

The actual total expenditure for 2023-24 on the All-Wales Capital Programme schemes was £29.099m against an agreed CEL of £29.322m. With WG agreement £0.213m was released from the IRS scheme back to discretionary, which is following the Trusts discretionary providing £0.248m to support the IRS implementation phase in prior years. .

Spend on Discretionary Capital to March was £1.903m.

The core Trust reported actual total Capital spend of £31.002m ensuring that the Trust CEL target of £31.005m was achieved for 2023-24.

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	15.791	11.000	36.962	1.741		65.494
TCS nVCC Enabling works	2.900		0.600			3.500
Digital - IT Infrastructure	1.086	0.688	0.680	0.400		2.854
WHAIS	0.494	0.092				0.586
WBS Electrical Resilience	0.320					0.320
Liquid Nitrogen Vessel	0.500					0.500
Welsh Plasma - Medicine	0.970	0.064	0.064	0.203		1.301
Talbot Green - Infrastructure	0.303	1.346	10.633	10.640	19.707	42.629
WBS Fleet Replacement		0.373	1.112	1.285		2.770
WBS Asset Replacement	0.100	0.494	0.121		1.560	2.275
First Floor Ward Ventilation	0.370					0.370
Condition Survey Recommendations	0.250	0.200	0.150			0.600
BECS Blood Mangagement System	0.100	0.200	0.200	1.000		1.500
Total Unapproved Capital Schemes	**23.184**	**14.457**	**50.522**	**15.269**	**21.267**	**124.699**
Total All Wales Capital Plans	**39.613**	**18.044**	**66.322**	**16.108**	**21.267**	**161.354**

8. BALANCE SHEET / 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.

Due to the financial year end the balance sheet is currently will not be ready for presentation until the accounts are completed at the end of April 24.

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 was waiting to receive confirmation of the 2023-24 Pay award allocation, WG provided an interim payment of c£10m during February which equates to 90% of the pay award for the whole Trust with the final 10% being provided during March 24.

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

Due to the financial year end the Cash Flow is currently will not be ready for presentation until the accounts are completed at the end of April 24.

DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
VCC	**(43.594)**	**(43.590)**	**0.004**
RD&I	**(0.114)**	**(0.000)**	**0.114**
WBS	**(21.734)**	**(21.514)**	**0.220**
Sub-Total Divisions	**(65.442)**	**(65.104)**	**0.338**
Corporate Services Directorates	**(14.027)**	**(14.517)**	**(0.491)**
Delegated Budget Position	**(79.469)**	**(79.622)**	**(0.152)**
TCS	**(0.744)**	**(0.613)**	**0.131**
Health Technology Wales	(0.117)	(0.115)	0.001
Trust Income / Reserves	**80.330**	**80.381**	**0.050**
Trust Position	0.000	0.030	0.030

VCS

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**76.919**	**77.749**	**0.830**
Expenditure			
Staff	**50.197**	**50.113**	**0.084**
Non Staff	**70.316**	**71.226**	**(0.909)**
Sub Total	**120.513**	**121.338**	**(0.825)**
Total	**(43.594)**	**(43.590)**	**0.004**

VCS Key Highlights/ Issues:

The final reported financial position for Velindre Cancer Services as at the end of March 2024 was an underspend of **£0.004m.**

Income surplus of **£0.830m**. 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 reported a year end underspend of **£0.084m** 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 this year had been particularly high especially within in Nursing budgets, this along with recruitment challenges, has offset 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 having been recruited during February and March.

Non-Staff Expenditure reported an overspend of **£(0.909)m** 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

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**29.588**	**30.193**	**0.605**
Expenditure			
Staff	**18.127**	**18.145**	**(0.018)**
Non Staff	**33.195**	**33.562**	**(0.367)**
Sub Total	**51.322**	**51.707**	**(0.385)**
Total	**(21.734)**	**(21.514)**	0.220

Key Highlights/ Issues:

The final reported financial position for the Welsh Blood Service at the end of March 2024 was an underspend of **£0.220m**.

Income overachievement of **£0.605m**. 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 annual target underachieves by c40%.

Staff reported a **£(0.018)m** overspend. Vacancies are offsetting the divisional Vacancy target of £0.450m and helping to supported posts recruited 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 **£(0.367)m** . 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 contributed to the overspend.

Corporate

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**7.125**	**6.781**	**(0.344)**
Expenditure			
Staff	**16.739**	**16.340**	**0.399**
Non Staff	**4.412**	**4.958**	**(0.546)**
Sub Total	**21.151**	**21.298**	**(0.147)**
Total	**(14.027)**	**(14.517)**	(0.491)

Corporate Key Highlights / Issues:

The final reported financial position for the Corporate Services division at the end of March 2024 was an overspend of **£(0.491)m**.

The £1.5m agreed suspension of recharges to the Charity was reflected within the Corporate Position at the financial year end resulting in an underachievement on income, which offset the significant over achievement on bank interest during 2023-24.

Staff reported a £0.399m underspend. Several vacancies have been carried throughout the year across the division particularly within finance. This offset the Divisional cost of agency and the divisional savings target set against non-pay.

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

RD&I

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**3.757**	**3.925**	**0.168**
Expenditure			
Staff	**3.217**	**3.037**	**0.180**
Non Staff	**0.654**	**0.889**	**(0.234)**
Sub Total	**3.871**	**3.925**	**(0.054)**
Total	**(0.114)**	**(0.000)**	0.114

RD&I Key Highlights / Issues

The final reported financial position for the RD&I Division at the end of March 2024 was an underspend of **£0.114m**.

Trials activity crystallising in March resulted in significant income and expenditure be recognised at the financial year end.

Overall underspend is a result of the pay award funding not being factored into the position until the financial year end.

TCS – (Revenue)

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**0.000**	**0.144**	**0.144**
Expenditure			
Staff	**0.693**	**0.676**	**0.017**
Non Staff	**0.051**	**0.080**	**(0.029)**
Sub Total	**0.744**	**0.757**	**(0.012)**
Total	**(0.744)**	**(0.613)**	0.131

TCS Key Highlights / Issues

The final reported financial position for the TCS Programme at the end of March 2024 was an underspend of **£0.131m.**

The underspend was a result of accrued interest on the Escrow bank account.

HTW (Hosted Other)

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**1.677**	**1.626**	**(0.051)**
Expenditure			
Staff	**1.545**	**1.528**	**0.018**
Non Staff	**0.248**	**0.214**	**0.035**
Sub Total	**1.794**	**1.741**	**0.052**
Total	**(0.117)**	**(0.115)**	0.001

HTW Key Highlights / Issues

The final reported financial position for Health Technology Wales at the end of March 2024 was **a** small underspend of **£0.001m.**

HTW programme costs are funded directly by WG.

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TCS PROGRAMME
FINANCE REPORT 2023-24

Period Ending 31st March 2024

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1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2023-24, outlining spend against budget for the financial year 2023-24.

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

2. EXECUTIVE SUMMARY

2.1 The final financial position for the TCS Programme for the year 2023-24 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	2023-24 Full Year		
	Budget	Forecast	Variance
Capital	£20.163m	£20.162m	£0.001m
Revenue	£0.785m	£0.756m	£0.030m
Total	**£20.948m**	**£20.918m**	**£0.030m**

2.2 The overall outturn for the Programme is an underspend of £0.030m for the financial year 2023-24 against a budget of £20.948m.

2.3 Additional capital funding of £1.229m was allocated by WG to the ADDA Project for this financial year in March 2024.

2.4 The current financial risks associated with the TCS Programme are:

- There are four new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum.

- There is a risk of a lack of funding for the Whitchurch Hospital Site, which is being mitigated by securing additional funding from WG.

3. BACKGROUND

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

3.2 By 31st March 2023, the Welsh Government (WG) had provided a total of £42.377m funding (£40.084m capital, £2.293m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.380m non-recurrent revenue funding.

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

3.4 The current funding provided to support the TCS Programme in 2023-24 is £18.934m capital and £0.785m revenue, as outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding

Initial Allocation (as at 1st April 2023)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£0	£0
ADDA	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£10.896m**	**£10.896m**

Overall Change to Allocation

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£3.257m	£3.257m
ADDA	£6.009m	£6.009m
Whitchurch Hospital Site	£0	£0
Total	**£9.266m**	**£9.266m**

Current Allocation (as at 31st March 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£3.257m	£3.257m
ADDA	£6.009m	£6.009m
Whitchurch Hospital Site	£0	£0
Total	**£20.163m**	**£20.163m**

Sources of Revenue Funding

Initial Allocation (as at 1st April 2023)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Escrow Interest	Total Funding
PMO	£0.240m	£0.060m	£0	£0	£0.300m
nVCC	£0	£0	£0	£0	£0
SDT	£0.180m	£0.131m	£0	£0	£0.311m
Total	**£0.420m**	**£0.191m**	**£0**	**£0**	**£0.611m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Escrow Interest	Total Funding
PMO	£0	£0	£0.028m	£0	£0.028m
nVCC	£0	£0	£0.096m	£0.041m	£0.137m
SDT	£0	£0	£0.009m	£0	£0.009m
Total	**£0**	**£0**	**£0.133m**	**£0.041m**	**£0.174m**

Current Allocation (as at 31st March 2024)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Escrow Interest	Total Funding
PMO	£0.240m	£0.060m	£0.028m	£0	£0.328m
nVCC	£0	£0	£0.096m	£0.041m	£0.137m
SDT	£0.180m	£0.131m	£0.009m	£0	£0.320m
Total	**£0.420m**	**£0.191m**	**£0.133m**	**£0.041m**	**£0.785m**

4. CAPITAL POSITION

4.1 The current capital funding for 2023-24 is outlined below:

- Enabling Works Project £10.896m
- nVCC Project £3.257m
- ADDA £6.009m
- Whitchurch Hospital Site £0

Total £20.163m

4.2 The capital position as at 31st March 2024 is outlined below, with a total spend of £20.162m for 2023-24 against a budget of £20.163m.

Capital Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Enabling Works Project	£10.896m	£10.251m	£0.645m
nVCC Project	£3.257m	£3.874m	-£0.618m
ADDA	£6.009m	£6.009m	£0
Whitchurch Hospital Site	£0	£0.027m	-£0.027m
Total	**£20.163m**	**£20.162m**	**£0.001m**

4.3 Further capital funding of £1.229m was allocated to the ADDA Project by WG for 2023-24 in March 2024.

4.4 There are four new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.900m. This additional capital funding will require Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum.

5. REVENUE POSITION

5.1 The revenue funding for 2023-24 is outlined below:

- PMO £0.328m
- nVCC Project £0.137m
- SDT Project £0.320m

Total £0.785m

5.2 The revenue position as at 31st March 2024 is outlined below, with a total spend of £0.756m for 2023-24 against a budget of £0.785m.

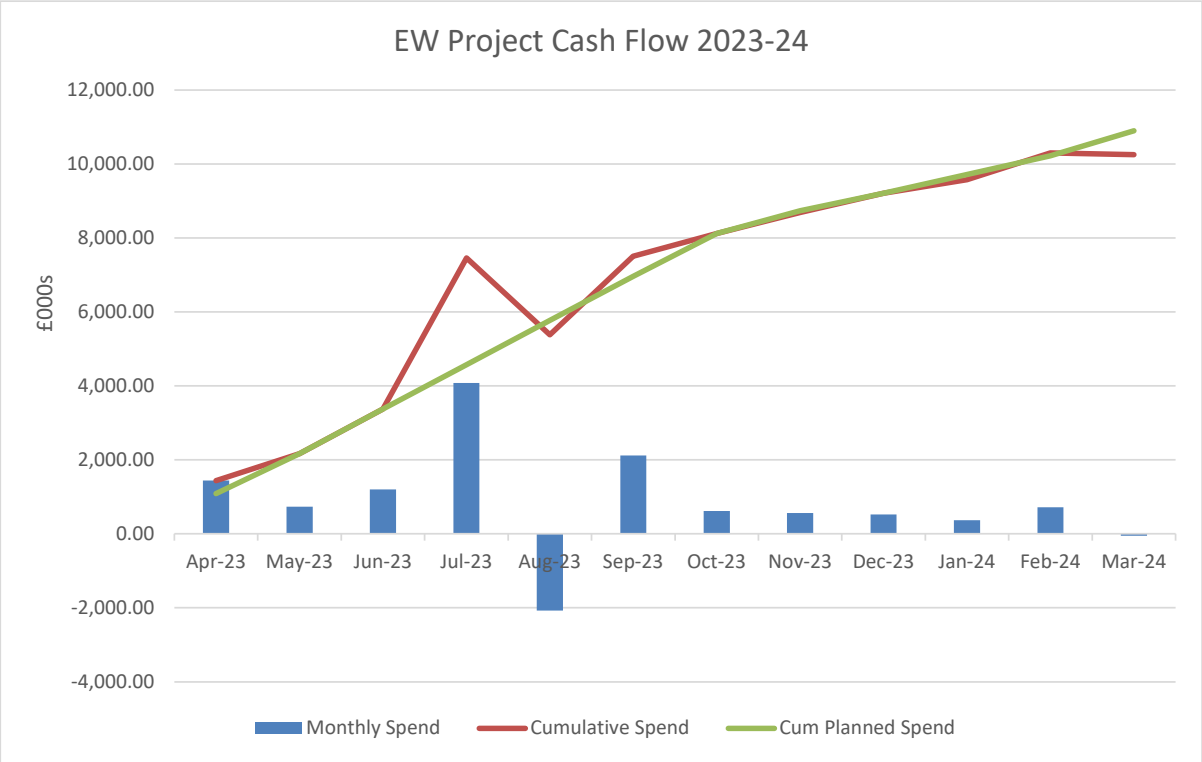
Revenue Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
PMO	£0.328m	£0.320m	£0.008m
nVCC Project	£0.137m	£0.136m	£0.002m
SDT Project	£0.320m	£0.300m	£0.019m
Total	**£0.785m**	**£0.756m**	**£0.030m**

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

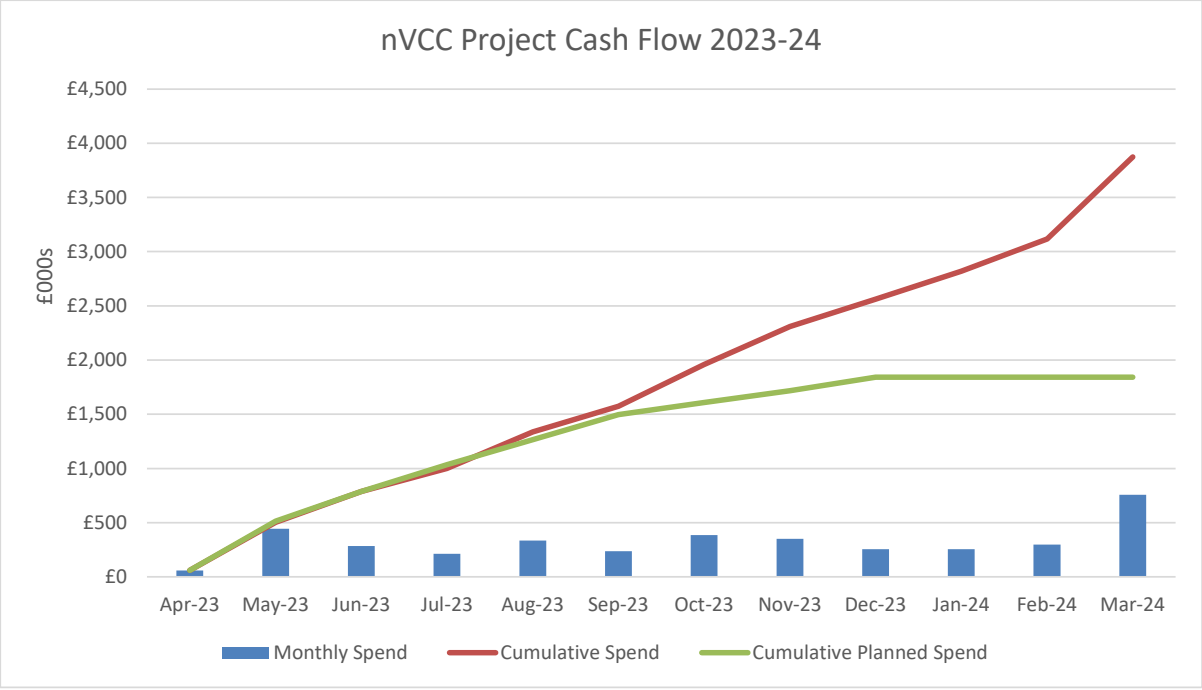
5.4 The 2022-23 one-off pay recovery payment was paid out in June 2023, with funding provided by WG in June 2023 via the Trust. Funding has also been provided by WG to cover the recurrent pay award for 2023-24 paid out in August 2023.

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The run rate indicates that the majority of costs were incurred within the first half of the financial year.



6.2 The capital cash flow for the **nVCC Project** is outlined below. Actual spend is higher than planned spend due to the increased costs associated with the delay in financial close.



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

7. PROJECT FINANCE UPDATES

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

Programme Management Office

7.2 The revenue funding for the PMO for 2023-24 is £0.328m. £0.240m of this has been provide from NHS Commissioners' funding, £0.060m from the Trust Reserves, and £0.028m from WG 2022-23 for pay awards.

7.3 There has been no capital funding requirement for the PMO in 2023-24.

7.4 The revenue position for the PMO as at 31st March 2024 is shown below, showing a total spend of £0.320m for the year against a budget of £0.328m.

PMO Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Pay	£0.316m	£0.307m	£0.009m
Non Pay	£0.013m	£0.013m	£0
Total	**£0.328m**	**£0.320m**	**£0.008m**

7.5 The underspend of £0.008m has been returned to Trust Reserves.

Enabling Works Project

7.6 In February 2022, the Minister for Health and Social Services approved the Enabling Works FBC. This has provided capital funding of £28.089m in total, with £10.896m provided in 2023-24.

7.7 The Project's financial position for 31st March 2024 is shown below. This reflects an underspend of £0.645m against a budget of £10.896m for this financial year. The underspend will offset capital overspend elsewhere within the TCS Programme.

Enabling Works Capital Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Pay	£0.230m	£0.286m	-£0.056m
Non-Pay	£10.667m	£9.965m	£0.702m
Total	**£10.896m**	**£10.251m**	**£0.645m**

7.8 There are four new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.900m. This additional capital funding will require Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum. The elements are:

- Water Main Diversion £0.850m inc VAT
- S278 Works – Longwood Drive £1.200m inc VAT

- Off Site Habitat Creation £0.400m inc VAT
- HV Intake Room £0.450m inc VAT

Total **£2.900m inc VAT**

7.9 The Project spend relates to the following activities:

Enabling Works FBC Project Capital Budget & Spend Summary 2023-24

Description		Financial Year Annual Budget £	Annual Forecast £	Annual Variance £
PAY				
Project 1b - Enabling Works FBC		229,841	286,327	-56,486
Pay Capital Total		**229,841**	**286,327**	**-56,486**
NON-PAY				
EF02	Utility Costs	2,873,927	2,118,971	754,955
EF03	Supply Chain Fees	375,000	558,016	-183,016
EF04	Non Works Costs	312,505	409,519	-97,013
EF05	ASDA Works	3,813,893	2,284,906	1,528,987
EF06	Walters D&B	3,033,982	4,659,110	-1,625,128
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0
EF08	Section 278	0	0	0
EFQR	Quantified Risk	257,245	512	256,733
EFQS	QRA - SCP	0	-65,439	65,439
EFRS	Enabling Works FBC Reserves	0	-763	763
Enabling Works FBC Project Capital Total		**10,666,552**	**9,964,833**	**701,719**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**10,896,393**	**10,251,160**	**645,233**

7.10 There is currently one financial risk associated with the Enabling Works Project:

- The four new elements to the Enabling Works Project require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum.

New Velindre Cancer Centre Project

Capital

7.11 The nVCC Project has been allocated capital funding of £3.257m for 2023-24 by WG in January 2024.

7.12 The capital financial position for the nVCC Project for 31st March 2024 is shown below, with an overspend of £0.618m. This overspend is offset by an underspend in the Enabling Works Project.

nVCC Capital Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Pay	£1.164m	£1.153m	£0.011m
Non-Pay	£2.093m	£2.721m	-£0.629m
Total	**£3.257m**	**£3.874m**	**-£0.618m**

7.13 The spend relates to the following activities:

nVCC OBC Project Capital Budget & Spend Summary 2023-24

Description		Financial Year Annual Budget £	Annual Forecast £	Annual Variance £
PAY				
Project Leadership nVCC OBC		213,691	226,260	-12,569
Project 2a - New Velindre Cancer Centre OBC		950,370	926,859	23,511
Pay Capital Total		**1,164,061**	**1,153,119**	**10,942**
NON-PAY				
nVCC OBC Project Delivery		**63,963**	**60,864**	**3,099**
Work Packages				
VC08	Competitive Dialogue - Dialogue & SP to FC	1,828,788	2,404,090	-575,302
VC10	Legal Advice	32,398	13,314	19,084
VC11	S73 Planning	14,437	14,437	0
VC12	nVCC FBC	153,216	207,667	-54,451
VCRS	nVCC OBC Reserves	0	20,945	-20,945
nVCC Project Capital Total		**2,028,839**	**2,660,453**	**-631,614**
TOTAL nVCC OBC CAPITAL EXPENDITURE		**3,256,863**	**3,874,435**	**-617,572**

7.14 There are currently no capital financial risks to the Project.

Revenue

7.15 The revenue funding for the nVCC Project for 2023-24 is £0.137m, provided from WG for pay awards and interest incurred from the Escrow account. The latter supersedes the proposed request for revenue funding of £0.030m for nVCC Project Delivery and £0.011m for the Judicial Review.

7.16 The revenue financial position for the nVCC Project for 31st March 2024 is shown below, reflecting an underspend of £0.002m for the year against a budget of £0.137m.

nVCC Revenue Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Pay	£0.096m	£0.096m	£0
Project Delivery	£0.030m	£0.028m	£0.002m
Judicial Review	£0.011m	£0.011m	£0
Total	**£0.137m**	**£0.136m**	**£0.002m**

7.17 The Judicial Review matter is now closed, with the final costs being submitted in July 2023. The final cost in 2023-24 is £0.011m, with a total cost for this matter of £0.138m.

7.18 There are no revenue financial risk associated with the nVCC Project at present.

Advanced Design Delivery Agreement (ADDA)

7.19 The ADDA Project reflects the commercial agreement between the Trust and SACYR for advance design services that covers RIBA stage 4 design / design not falling under the nVCC MIM Project bid deliverables and including masterplan amendments. In addition, it covers design costs associated with the Value Engineering exercise. The RIBA Stage 4 direct costs have been incurred (including management team) in the sum of £5.111m, for which funding has been provided by WG.

7.20 The Project includes the Advanced Works Agreement, which received funding of £0.898m from WG in early January 2024.

7.21 The capital financial position for this Project for 31st March 2024 is shown below, with a total spend of £6.009m against a budget of the same for the year.

ADDA Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Non-Pay	£6.009m	£6.009m	£0
Total	**£6.009m**	**£6.009m**	£0

7.22 The spend relates to the following activities:

ADDA Capital Budget & Spend Summary 2023-24

Description	Financial Year Annual Budget £	Annual Forecast £	Annual Variance £
PAY			
Project 2b - Advanced Design Development Agreement	0	0	0
Pay Capital Total	**0**	**0**	**0**
NON-PAY			
Work Packages			
AD01 Advanced Design Development Agreement	5,110,995	5,110,995	0
AD02 Advanced Works Agreement	898,457	898,458	-1
nVCC Project Capital Total	**6,009,452**	**6,009,453**	**-1**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**6,009,452**	**6,009,453**	**-1**

7.23 There are currently no financial risks for this project.

Whitchurch Hospital Site

7.24 The achievement of the EPSL from NRW required the granting of a habitat Licence on elements of the residual Whitchurch Hospital estate by Cardiff and Vale University Health Board. In order for the Trust to receive the habitat Licence from Cardiff and Vale University Health Board (C&VUHB), it agreed in principle to accept the formal transfer of the residual estate. The Trust is currently undertaking the required legal and technical diligence. With regards technical diligence, asbestos and condition surveys are being commissioned by the Trust to meet its obligations. The cost of the surveys is funded by securing additional funding from WG as part of the Enabling Works FBC Addendum.

7.25 The capital financial position for the Whitchurch Hospital Site Project for 31st March 2024 is shown below, with an overspend of £0.027m. This is offset by an underspend in the Enabling Works Project.

Whitchurch Hospital Site Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Non-Pay	£0	£0.027m	-£0.027m
Total	**£0**	**£0.027m**	**-£0.027m**

7.26 The spend relates to the following activities:

Whitchurch Hospital Site Capital Budget & Spend Summary 2023-24

Description	Financial Year Annual Budget £	Annual Forecast £	Annual Variance £
PAY			
Project 2c - Whitchurch Hospital Site	0	0	0
Pay Capital Total	**0**	**0**	**0**
NON-PAY			
Work Packages			
WS01 Advisory Services	0	20,300	-20,300
WS02 Prelimiary Works	0	6,495	-6,495
WSRS Whitchurch Hospital Site Reserves	0	0	0
nVCC Project Capital Total	**0**	**26,795**	**-26,795**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**26,795**	**-26,795**

Service Delivery and Transformation Project

7.27 The revenue funding for the Project for 2023-24 is £0.180m from NHS Commissioners' funding, £0.131 from Trust reserves, and £0.009m from the WG 2022-23 one-off recovery payment funding. The resulting budget is £0.320m for this financial year.

7.28 There is no capital funding requirement for the Project in 2023-24.

7.29 The SDT Project revenue position for 31st March 2024 is shown below, showing a total spend of £0.300m for the year against a budget of £0.320m.

SDT Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Pay	£0.281m	£0.273m	£0.009m
Non-Pay	£0.038m	£0.028m	£0.011m
Total	**£0.320m**	**£0.300m**	**£0.019m**

7.30 The underspend for year of £0.019m has been returned to Trust Reserves.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 The current two financial risks associated with the TCS Programme are outlined below:

- There are four new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum.

- There is a risk of a lack of funding for the Whitchurch Hospital Site, which is being mitigated by securing additional funding from WG.

9. TCS SPEND REPORT SUMMARY

9.1 At the end of 2019, a financial model was developed by the TCS Finance Team to provide a spend profile for the TCS Programme. The model allocates reported spend by year to defined deliverables and outputs within each project within the Programme. It also allocates spend to the various resources need to deliver the Programme, such

as pay, advisors, suppliers, etc. The output for the model itself is an in-year report providing spend details on a quarterly basis. A cumulative report is also produced for the Programme for its inception to the end of the latest quarter.

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

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

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

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

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

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

APPENDIX 1: TCS Programme Budget and Spend as at 31st March 2024

TCS Programme Budget & Spend 2023-24

CAPITAL	Year to Date Budget Jan-24	Year to Date Spend Jan-24	Year to Date Variance Jan-24	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership nVCC OBC	178,076	183,970	-5,895	213,691	225,596	-11,905
Project 1b - Enabling Works FBC	200,534	256,251	-55,717	229,841	293,393	-63,552
Project 2a - New Velindre Cancer Centre OBC	791,975	772,925	19,050	950,370	942,152	8,218
Capital Pay Total	**1,170,585**	**1,213,146**	**-42,561**	**1,393,902**	**1,461,142**	**-67,240**
NON-PAY						
nVCC OBC Project Delivery	42,209	42,209	0	63,963	62,963	1,000
Project 1b - Enabling Works FBC	9,516,402	9,323,789	192,613	10,666,552	10,611,674	54,877
Project 2a - New Velindre Cancer Centre OBC	0	1,818,868	-1,818,868	2,028,839	2,011,868	16,971
Project 2b - Advanced Design Development Agreement	4,780,452	4,761,986	18,466	4,780,452	4,780,452	0
Project 2c - Whitchurch Hospital Site	0	13,535	-13,535	0	13,535	-13,535
Capital Non-Pay Total	**14,339,062**	**15,960,386**	**-1,621,324**	**17,539,805**	**17,480,492**	**59,313**
CAPITAL TOTAL	**15,509,647**	**17,173,533**	**-1,663,886**	**18,933,707**	**18,941,634**	**-7,927**

REVENUE	Year to Date Budget Jan-24	Year to Date Spend Jan-24	Year to Date Variance Jan-24	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
PAY						
nVCC Pay Award	83,413	83,413	0	96,408	96,408	0
Programme Management Office	259,366	259,354	12	315,656	315,644	12
Project 6 - Service Change Team	230,927	230,927	1	281,219	281,219	1
Revenue Pay Total	**573,707**	**573,694**	**13**	**693,283**	**693,271**	**13**
NON-PAY						
nVCC OBC Project Delivery	25,390	23,987	1,403	30,000	30,000	0
nVCC OBC Judicial Review	11,000	11,000	0	11,000	11,000	0
Programme Management Office	6,324	3,174	3,150	12,644	12,656	-12
Project 6 - Service Change Team	24,542	17,542	7,000	38,411	38,412	-1
Revenue Non-Pay Total	**67,257**	**55,703**	**11,553**	**92,055**	**92,068**	**-13**
REVENUE TOTAL	**640,963**	**629,397**	**11,566**	**785,339**	**785,339**	**0**

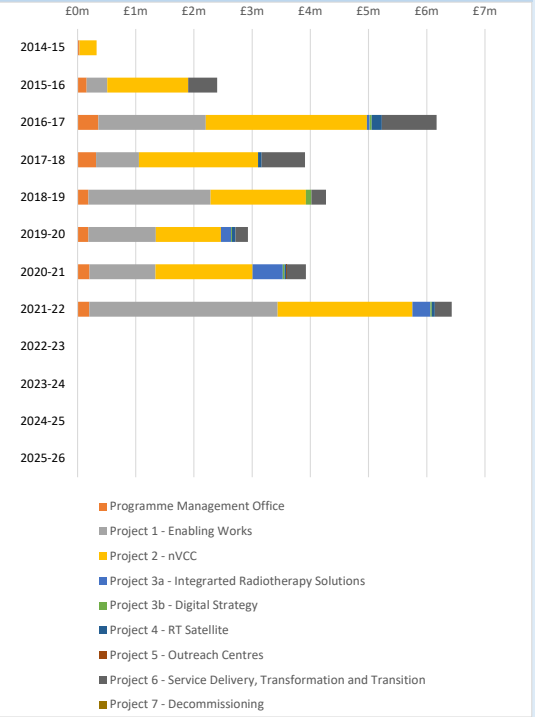
APPENDIX 2: TCS Programme Funding for 2023-24

Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0**	**£0.328m**
Commissioner's Funding		£0.240m
Trust Revenue Funding		£0.060m
WG One Off Pay Award 2022/23 Funding		£0.006m
WG Recurrent Pay Award Funding		£0.022m
Enabling Works FBC	**£10.896m**	**£0**
2023-24 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£10.896m	
New Velindre Cancer Centre OBC	**£3.257m**	**£0.137m**
WG One Off Pay Award 2022/23 Funding		£0.019m
WG Recurrent Pay Award Funding		£0.077m
Escrow Interest		£0.041m
2023-24 CEL from Welsh Government funding for nVCC Project approved in January 2024	£3.257m	
Advanced Design Development Agreement	**£6.009m**	**£0**
2023-24 CEL from Welsh Government funding for ADDA approved October 2023	£3.882m	
2023-24 CEL from Welsh Government funding for AWA approved January 2024	£0.898m	
2023-24 CEL from Welsh Government funding for ADDA approved March 2024	£1.229m	
Whitchurch Hospital Site	**£0**	**£0**
Funding for Whitchurch Hospital Site to be provided by WG	£0	
Radiotherapy Satellite Centre	**£0**	**£0**
No funding requested or provided for this project to date		
SACT and Outreach	**£0**	**£0**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0**	**£0.320m**
Commissioner's Funding		£0.180m
Trust Revenue Funding		£0.131m
WG One Off Pay Award 2022/23 Funding		£0.002m
WG Recurrent Pay Award Funding		£0.007m
VCC Decommissioning	**£0**	**£0**
No funding requested or provided for this project to date		
Total	**£20.163m**	**£0.785m**

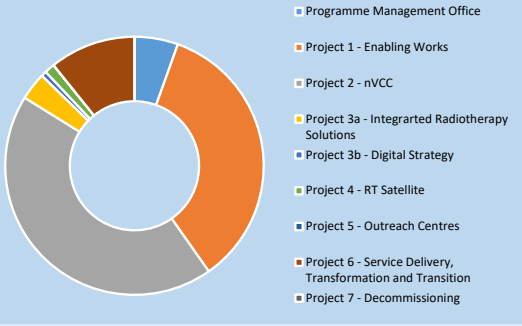
APPENDIX 3: TCS Cumulative Spend Report to 31st March 2022

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

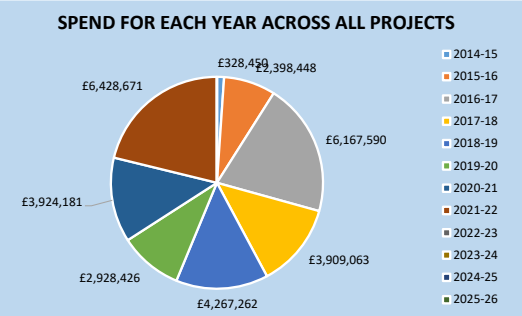
SPEND PER PROJECT PER YEAR



SPEND FOR EACH PROJECT ACROSS ALL YEARS



SPEND FOR EACH YEAR ACROSS ALL PROJECTS

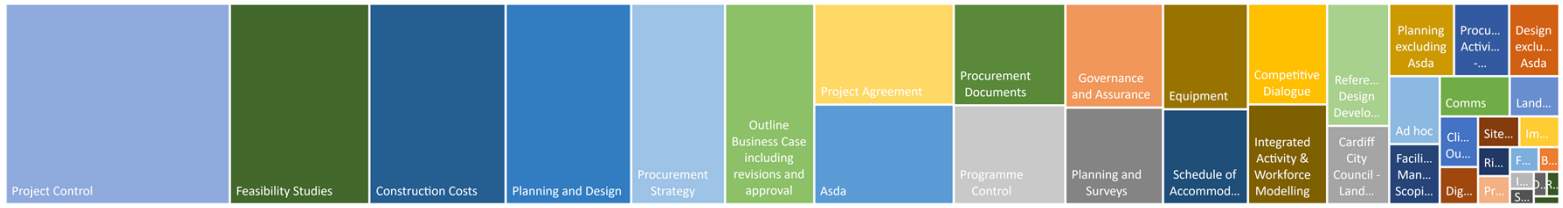


TOTAL SPEND BY PROJECT TO DATE	£30,352,092
Programme Management Office	£1,655,897
Project 1 - Enabling Works	£10,559,242
Project 2 - nVCC	£13,234,264
Project 3a - Integrarted Radiotherapy Solutions	£1,049,380
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£385,490
Project 5 - Outreach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

SUPPLIERS WITH HIGHEST EXPENDTITURE TO DATE

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

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS



Trust Board

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY ACTIONS FOR 2023 / 2024 (Q4 YEAREND)

Date of meeting	23/05/24
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 31st March 2024) of progress against the actions (January – March 2024) which were included within the IMTP for 2023/24 as at Quarter 4. 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 4.

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 4 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**
VCS SLT / Performance Review	**20 April 2024**
Executive Management Board	**29 April 2024**
Quality Safety and Performance Committee	**9 May 2024**
Summary and outcome of previous governance discussions: **The report has been considered and endorsed at the VCS Performance Review and Executive Management Board and is presented to the QSP 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 4 at 31/3/24.**
2	**Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 4 at 31/3/24.**
3	**Trust-wide Initiatives - IMTP Quarterly Progress Report 2023/24 for Quarter 4 at 31/3/24.**

ACRONYMS and INITIALISM	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

2. SITUATION/BACKGROUND

2.1 The Integrated Medium Term Plan (IMTP) 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 4 (January to March 2024), has given only a short time for a detailed assessment of progress against IMTP actions during early April for EMB consideration.

3.2 The table below gives a high-level overview of progress made in the delivery of actions at Q4 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		**3 Q Actions**	
GREEN	Satisfactory progress being made against action in line with agreed timescale	**11 Q actions**	**9 Q actions**	**26 Q actions (Finance, Digital Estates & Sustainability)**
YELLOW	Issues with delivery identified and being resolved with remedial actions in place	**4 Q actions**	**9 Q actions**	**6 Q actions (Workforce)**
AMBER	Delays in implementation / action paused due to external issues beyond our control		**1 Q actions (TrAMs)**	
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, categorized as '*green or yellow*', against all 15 of their actions as at Q4, **see Appendix 1.**

3.4 VCS are making satisfactory progress, categorised as 'blue, *green or yellow*', against 21 of their 22 actions, **see Appendix 2.**

3.5 However, one action remains 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.23)

3.6 There are 32 Trust-wide actions or 'themes' (Digital 6; workforce 6; Estates 4; Sustainability 10 and finance 6). Good progress is again being made against these actions, **see Appendix 3.**

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	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

APPENDIX 1

Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 4 as at 31/3/2024.

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 Q4**	**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.	The donor data recovery plan is complete. The appointment system portal launch is planned for Summer 2024. Scoping completed for the 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 • Improved clinical	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. Stem cell donor recruitment has been	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q4**	**Progress Rating**
		outcomes in Wales/globally • Increased income levels					incorporated within the new donor strategy.	
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 improved insights and	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 in Qtr. 1 2024/25 prior to initiating a review of systems and processes	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q4**	**Progress Rating**
		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. • Improved efficiency • Cost efficiencies.	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).	Revised All-Wales Pre-Operative Anaemia Pathway out for consultation. Gap analysis of Local Health Boards against the pathway complete. Patient Blood Management (PBM) education delivered to all F1/F2 doctors across Wales. Anaemia presentations delivered at BHNOG Conference. £20k cost saving identified at one Local Health Board (LHB) using test set developed for programme. Scoping further roll-out across LHBs.	

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 Q4**	**Progress Rating**
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.	Business case for North Wales 'Tours' drafted, with staff engagement commencing in April 2024. Fixed site for plasma collection in north Wales scoped and included as part of 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 Q4**	**Progress Rating**
	Introduce clinically led collection team model by 2023/24.	• Improved leadership capability. • Standardisation of terms and	Continue phased implementation of OCP (2019) outcomes.	Continue phased implementation of OCP (2019) outcomes.	Complete implementation of OCP (2019) outcomes.	Prepare OCP 2 process in relation to clinically led service model.	The Organisational Change Process (OCP) implementation completed.	

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 Q4**	**Progress Rating**
		conditions across collection teams. • Improved quality • Improved safety • Reduction in staff turnover. • Improved collection efficiency.	Complete new job descriptions.	Complete review of existing service model.	Develop workforce plan. Provide and promote leadership learning opportunities.	Complete OCP2 consultation. Implement new clinically led collection team model.	Impact review upon collection teams continues. OCP2 will form part of the WBS Futures portfolio. Timelines are being reappraised.	
	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 transferred to WBS Futures portfolio and work is underway. Phase 1 (Demand Planning Tool) to be completed by Qtr. 1 2024/25 and Phase 2 (Human Leukocyte (HLA) Selected Platelets) to be completed by Qtr. 4 2024/25. .	

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 Q4**	**Progress Rating**
	Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.	• Improved availability of information • Increased efficiency /productivity through Improved patient experience • Reduced turnaround times. • Reduction in avoidable waste	Secure funding from Welsh Government.	Commence procurement process.	Complete procurement process.	Develop implementation plan.	Contract awarded in March 2024. System licences issued in March 2024 enabling implementation in April 2024. Implementation plan included in 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 undergoing final review. Outline Business Case to be presented to Trust Board in May 2024. Funding position remains unconfirmed but both commissioners and Welsh Government	

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 Q4**	**Progress Rating**
							have been alerted to this system requirement.	
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25.	• Reduction in risk of HepB virus transmission to recipients of blood components in Wales • Compliance with SaBTO recommendations.	Implemented testing strategy in 2022/23. Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	The project has run to plan, in compliance with SaBTO recommendations. Data has been submitted for a planned SaBTO review. The review report date to be confirmed.	
	Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of	• Maintain compliance with regulatory standards • Improved quality • Improved safety • Improved donor experience.	Complete reconfiguration of the Regulatory Assurance and Governance Group to create the Divisional Quality Hub.	Validation and deployment of eQMS. Review document hierarchy structure. Adapt change management process to	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	The digital signature system procurement is complete. Updated system due by the end of Q1 2024-25. High level project plan for eQMS agreed with supplier and change project underway. System configuration to commence by mid-April	

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 Q4**	**Progress Rating**
	regulatory compliance and maximises digital technology by 2023/24.		Launch the pilot of electronic signatures. Commence formal procurement of an electronic quality Management system (eQMS). Review feedback from Change Management workshops and update processes.	support Continuous Improvement culture.		functionality.	with support from the supplier.	
	Implementation of Foetal DNA typing by 2023/24.	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women • Improved safety	Procure commercial kit	Undertake digital developments to support new test. Validate test.	Complete validation and implementation of new test.	Implement all-Wales service for cell free Foetal DNA testing.	Validation of test and development of software in progress. National integration requirements have been moved to phase 2. 'Go live' planned for May 2024.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q4**	**Progress Rating**
		• Improved patient experience • Reduction in avoidable waste/costs						
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales.	• Secure the supply chain for Immunoglobulins in Wales • Reduces need for importation. • Cost avoidance/reduction • Avoids patient rationing.	Develop project plan for supply of recovered plasma for fractionation (estimated start date April 2025). Develop high level business case for investment to support the plasma programme.	Renegotiate / renew supply contracts for diagnostic plasma to align with fractionation plan and maximise income. Develop detailed business case for plasma programme (subject to WG policy decision).	Commence validation of leucocyte filtration (NQT) blood packs. Commence validation of Hepatitis A and Parvo B19 testing.	Scope Source Plasma collection programme once WG pathway and governance arrangements are clear. Consider options for BC preparation for Welsh Government for source and recovered plasma.	Financial modeling review completed & updated business case submitted to Welsh Government (WG) and WHSCC in March 2024. The Business Case is awaiting Ministerial approval. WG advice on program governance at Wales level to be agreed, subject to approval of the business case.	
SP6 Sustainable services that deliver the greatest value	Develop and implement an energy efficient, sustainable, SMART estate	• Improved donor satisfaction • Improved staff well-being	Refresh of Programme Business Case (PBC).	Further development of Outline Business Case (OBC) to	Internal scrutiny of Outline Business Case (OBC).	Submission to Welsh Government.	Following a proposal from Specialist Estate Services (SES), Welsh Government have been	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q4**	**Progress Rating**
to our communities **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2 and 5)**	at Talbot Green site that will facilitate a future service delivery model	• 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.	Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation.	incorporate Laboratory Services Modernisation (following outcome of Feasibility Study).			approached to consider combined OBC/FBC. Initial support received from Welsh Government with a request to share preferred option with SES and submit a bid for funding.	
SP7 Develop great people and a great place to work **(Link to Trust Destination 2032 – 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	Consult on new Senior Leadership Team (SLT) workforce model and recruit to roles where there are substantive job holders.	Permanently recruit to remaining SLT roles where there are currently only seconded post holders. Scope out new WBS workforce model for	Permanently recruit to remaining SLT roles where there are currently only seconded post holders. Plan and deliver training / team development	Review of newly implemented SLT workforce model. Phased implementation of new Clinical Services workforce model.	Senior Leadership Team (SLT) recruitment complete. The Clinical Services delivery model scoping has concluded, and a new model recommended. Existing roles are being reviewed/introduced via a phased approach.	

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 Q4**	**Progress Rating**
		• Improved staff well-being • Improved service quality, safety and donor satisfaction.		Clinical Services. Laboratory Services Modernisation Programme determine requirements for future workforce in Laboratory Services.	sessions with new SLT. Phased implementation of new (Clinical Services workforce model. Scope out new WBS workforce model for Laboratory Services.	Phased implementation of new Laboratory Services workforce model.	The Laboratory Services Modernisation Programme is on schedule, and will 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 4 as at 31/3/2023

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 Q4**	**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 .	• Build programme on track. • Workforce recruitment progressing well with several appointments offered. • Working on service specification and SLA progressing. Joint workshops held in January, February and March.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Integrated Radiotherapy Solution**	• Improved patient outcomes	Clinical commissioning of first replacement	Realise initial pathway improvements. Initiate digital	Decommissioning and removal of second linear accelerator.	Installation and commissioning of second	• All aspects of phase 1 (year 1) delivered on-	

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 Q4**	**Progress Rating**
	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	linear accelerator at the existing VCS First patient treatment (June 2023)	implementation and develop benefits realisation plan.	Bunker refurbishment commenced in advance of installation of second replacement linear accelerator.	replacement linear accelerator at VCS	time and on-budget. • Linear accelerator 3 bunker refurbishment on track for completion in quarter 1 2024-25. • Planning for phase 1 (year 2) in development.	
Trust Strategic Goals 1 and 2	**Implementation of findings of Clatterbridge peer review within brachytherapy**	• Improved patient outcomes • Improved quality of care	Establish Brachy therapy service improvement group. Identify actions	Optional appraisal to be completed to identify and agree service model required to address	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	

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 Q4**	**Progress Rating**
	services by Q1 2024/25	• Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction	requiring divisional/Trust support. 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	capacity gap. Continue to implement local actions. In conjunction with CAV review processes and flows aligned to Brachy theatre utilisation	Continue to implement local actions		MPE. Now single handed MPE focused 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**	• Improved diagnostics information • Better information sharing and enhanced	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	Velindre Cancer Services 'go-live' scheduled for quarter 2 2024-25 by national implementation programme.	

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 Q4**	**Progress Rating**
	System Procurement.	clinical decision-making • Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction						
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		Complete phase 2 of SDEC programme Develop business case to secure ongoing funding			• Year 3 work plan complete. • All year 2 objectives complete.	

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 Q4**	**Progress Rating**
		• Improved productivity and efficiency levels • 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 fully implemented.	
Trust Strategic Goals 1 and 2	**Implementation of Cancer Nurse Specialist**	• Improved patient outcomes • Improved quality of care	Identify possible funding requirements and develop business case to support	Align work to wider scope/review of CNS as part of charity funding expectations	Engage with commissioners on matter of funding of CNS posts	Review and evaluate impact of implementation	• CNS competency framework formally approved.	

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 Q4**	**Progress Rating**
	Review by Q3 2023/24	• Improved patient safety • Improved patient • Satisfaction • Reduction in avoidable admissions	change of service model / finance		Completion of review		• Capacity and demand review 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.	

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 Q4**	**Progress Rating**
Trust Strategic Goals 1, 2 and 5	**Expansion of VAP services by Q4 2023/24**	• Provision of care at home/close to home • Reduced patient needs to travel • Increased patient experience / satisfaction		Develop service model for expansion of service (to include opportunities for service transformation).	Develop workforce plan. Develop financial plan and supporting business case.	Realise service expansion subject to any resource requirement being secured. Evaluation of service change.	• Business case to support VAP expansion completed and 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	Recruit VCS system implementation team	Recruit to VCS System Implementation Team (if staff additional to Pre-implementation Team required)	• National business case in development. Anticipated that case will be submitted to Welsh Government in early quarter 2 2024-25. Velindre Cancer Services Senior Leadership Team have confirmed a preferred implementation timetable.	

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 Q4**	**Progress Rating**
				plan for implementation				
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 – all recommendations complete. • Bookings – 4 of 6 recommendations complete. • Pharmacy – all recommendations complete.	
Trust Strategic Goals 1 and 2	**Enhance the Velindre Cancer Services SACT telephone helpline to provide 24hr advice, triage service and**	• Improved quality • Improved patient safety • Improved access • Improved clinical outcomes	Establish working group as part of the Safe Care Collaborative Technical capability to record all telephone calls	Develop guidelines for audit. Conduct audit process	SACT treatment helpline fully implemented	Respond to audit findings Ensure the SACT triage line is achieving agreed VCS standards in accordance	• Improvements to processes implemented supported by the Safe Care Collaborative. • Further digital telephony	

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 Q4**	**Progress Rating**
	achieve required standards by Q3 2023/24	• Reduced waiting times • Improved patient experience	is in place Digitalise UKONS tool and upload to clinical system Revise guidelines for escalation of calls.			with the VCS Generic Patient Enquiry implementation action plan	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 Cancer Pathway compliance. Improving compliance	Establish work streams to support the delivery of the pathway programme to include RRTT Develop action plan in response to support work with Improvement Cymru and Toyota to address area for improvement Establish project teams to take forward Safe	Develop supporting business case(s) where required to support new delivery models, identifying funding stream. Implementation of pathway improvements where possible Review ways of working and identify opportunities for workforce reconfiguration	Develop and implement revised processes / pathways. Implementation of service delivery model for Attend Anywhere Continued engagement in Safe Care Collaborative Programme Identify new ways of working and	• Scoping work on development of interim process to rationalize referral processes ahead of introduction of Hospital 2 Hospital referral solution undertaken. New referral proforma developed and trial initiated with Cardiff 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 Q4**	**Progress Rating**
			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 improvements / opportunities for change aligned to best practice / national	care Collaborative project and ensure clear scope of work Develop and Implement new service and delivery model for Attend Anywhere.	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	opportunities for workforce reconfiguration	Vale UHB lung team. • 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 Q4**	**Progress Rating**
			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 Collaborative within MSSC pathway and SACT telephone helpline					

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 Q4**	**Progress Rating**
			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 / decision-making) • Improved levels of efficiency/productivity	Establish Project group	Identify service improvements / opportunities for change	Identify additional resource requirements Undertake options appraisal Explore off-site storage options as part of a	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 Q4**	**Progress Rating**
		• Reduced carbon emissions			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 facilitate prehabilitation service development.	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	• Local working group fully operational. • Continued engagement with national prehabilitation meetings. • Staff engagement and awareness survey in development. • First project communication newsletter developed.	

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 Q4**	**Progress Rating**
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 submitted to Welsh Government for approval.	
Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Outreach Programme by 2025/26**	• Increase care close to home • Improved access • Improved equity	Project board re-established in conjunction with HBs	Service model developed and agreed in partnership with ABUHB Development of service model in	Identify and agree additional workforce requirements and funding streams	Service model developed and agreed with both CTMUHB and C&VUHB	• Strategic planning assumptions and baseline data reviewed.	

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 Q4**	**Progress Rating**
		• Improved patient experience • Reduction in carbon emissions		partnership with CTMUHB	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.		• Engagement with Aneurin Bevan UHB, in the first instance, on delivery model undertaken. Further joint workshops scheduled for quarter 1 2024-25.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Phase 1 of the regional Acute Oncology Service by 2023/24**	• Improved quality • Improved patient safety • Improved clinical outcomes • Reduction in avoidable admissions • Improved patient experience	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. • Velindre specific acute oncology project progressing	

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 Q4**	**Progress Rating**
		• Reduction in carbon footprint					with particular focus on pathways, processes and patient transport issues. • Regional workshop scheduled for May 2024.	
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	• Initial meetings focusing on the development of an agreed, sustainable model for palliative radiotherapy 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 Q4**	**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 Q4**	**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). • Continued engagement with WHSSC on local commissioning of PRRT. Agreement likely to be secured in quarter 1 2024-25 and implementation plan to be delivered thereafter.	

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 Q4**	**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 Q4**	**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 Q4**	**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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

APPENDIX 3

Trust-wide Initiatives - IMTP Progress Report 2023/24 for Quarter 4 as at 31/3/2024.

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 Q4**	**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 now established. Digital Design Authority to be established in April 2024 – delayed from Q4 2023/24. 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 relationships with Academia – e.g. Digital Degree Apprenticeships Roadshow planned for Q4 2023/24.	

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 Q4**	**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	Digital Infrastructure Strategy and Supplier Management Framework approved – actions built into 2024/25 digital / IMTP plans. New Assistant Director of Data & Insight commenced in post January 2024. Piloting of 'Agile' delivery model for digital transformation activities due to commence in Q4 2024/25.	
Workforce and Organizational Development	**Theme 1: Wellbeing and Engagement** **Theme 2: Supply and Shape** **Theme 3: Skilled and Developed People**	• 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	• 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 2022-23 and 2023-24 overseen by the Healthy and Engaged Steering Group. A highlight report is sent to EMB quarterly. A Trust training plan was developed in 2022/23 and is now a	

	Theme 4: Leadership and Succession Planning **Theme 5: Digital Ready People** **Theme 6: Attracting and Retaining the Best Talent**	• 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 • Growing the Trust Inspire Leadership and Management Programme		standard agenda item for the Education and Training Steering Group. A highlight report is sent to EMB quarterly. The Strategic Equality Plan 2020-24 has been reviewed as the basis for developing the Strategic Equality Plan for 2024-28. Actions for this are agreed and monitored by the Healthy and Engaged Steering Group. An Agile Working Programme has been delivered to support hybrid working across the Trust and a comprehensive Toolkit is available to staff and managers to guide them through the process. During 2023-24, guidance was re-issued on determining Welsh Essential/Desirable in job roles leading to an increase in Welsh skills being sought at appointment. The All Wales Welsh Awareness elearning	

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 Q4**	**Progress Rating**
				has been rolled out across the Trust. Language training at all levels is made available in line with service needs and staff requests. The Trust ran a successful Employee Excellence Awards event in 2023 and has a programme of Long Service Awards in place. The Trust Inspire Management and Leadership programme is in its 7th Cohort. An intermediate evaluation was undertaken in 2023 which shaped the taught programme and influenced the wider leadership and management development offer.	

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 Q4**	**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:	○ Engagement with departments through divisional groups to ensure stakeholders requests are being met. ○ Recently completed a condition survey of both divisions VCC & WBS to address category C & D. ○ Refurbishment of Linac 3 with a new Varian Halcyon machine that has 40% less operational energy consumption. ○ Progression of the First Floor Ward inpatient Ventilation system to provide staff and patients safe and high quality environment. ○ Progress has been made on the	

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 Q4**	**Progress Rating**
			○ 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	construction of the Radio Therapy Satellite unit at Neville Hall hospital. ○ Development of the nVCC design through various safety groups to ensure a safe and high quality estate. Expected benefits are on target for the reduction of carbon.	
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**	• 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	• The Trust has developed a sustainability implementation plan. • The Trust has developed a decarbonisation action plan. • Walking aids recycling centers have been completed at VCC completed by local	

	Theme 6: Sustainable Use of Resources
	
	Theme 7: Connecting with Nature
	
	Theme 8: Greening our Travel and Transport
	
	Theme 9: Adapting to Climate Change
	
	Theme 10: Our people as Agents for Change
			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);
				business Men's Sheds and is now being fully utilized by Patients at VCC.
				• Continue to support agile working across the trust to reduce carbon and support wellbeing.
				
				• Work has been undertaken in Q4 to plan a active travel day in both divisions VCC & WBS.
				
				• Trust has recently employed a Arts in Health coordinator to develop a arts in health program.
				
				The Trust has recently refreshed the Wellbeing Objectives.	

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 Q4**	**Progress Rating**
			becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Governments Foundational economy		
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	The Trust is forecast to report a breakeven position for 2023/24 financial year and meet its statutory duties.	

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

INTEGRATED MEDIUM TERM PLAN – ACCOUNTABILTY CONDITIONS

DATE OF MEETING	23th May 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). This is the current Q4 progress report.

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	**29/02/24**
Quality Safety and Performance Committee	**9/05/24**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The approach for reporting against the accountability conditions was approved by the Executive Management Board.	

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) as at the end of Quarter 4 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.

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

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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	**Savings** Trust is currently planning to fully achieve the savings target of £1.8m during 2023-24 **Opportunities pipeline** The Trust has identified some initial opportunities that could be explored but these require further development including identification of Senior Responsible Officers to take accountability at Exec level to oversee the development and delivery.

			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	Further to the update provided for Q3, the Trust has reviewed the non-recurrent reserve for 2023/24 and has been able to release a further £0.5m back to the system. This brings the total contribution by the Trust to £2.5m in 2023/24 which will contribute towards the reduction of the NHS Wales deficit.

			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	**Covid Programme Costs** Update as per Q3.

			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.	**Covid Recovery and Planned Care Capacity** Update as per Q3. The latest LTA income trajectory based on activity delivered from April to February 2024 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:	**Value Based Healthcare Programme** Further to updates provided in Q3, the following updates apply for Q4. **Pre-op anaemia pathway (Welsh Blood Service)** The project team is working with DHCW to incorporate data feeds relating to transfusion from health boards into a central repository. This will have a wider benefit than for the pre-operative anaemia project alone. A proposal has been submitted to increase the funding to this

			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).	programme to enable the team to widen the remit to incorporate the diagnosis and management of anaemia within Primary care, Paediatrics and Obstetrics. **Value Intelligence Centre** The Site-Specific Team wide dashboard was launched at the beginning of March. This now enables Clinical and Operational teams to generate insights from linked data sets, e.g. comparing treatment types by clinical outcome (toxicity and survival) and cost. This theme will now focus on embedding this new tool into existing review meetings within VCS.

			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	**Food Mission** Food Mission was approved by the Trust Board in March 2024 and an action plan is now being developed to take forward.

			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

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 26 March 2024 to 16 May 2024

DATE OF MEETING	23 May 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** Nicola Phillips, NWSSP Director of Primary Care Services and Medical Examiners Service
EXECUTIVE SUMMARY	This report details the Trust Board decisions required for Commitment of Expenditure exceeding the Chief Executive's Limit (£100k), for the period **26/03/2024 – 16/05/2024.** There is one (1) item of expenditure are required for the Trust Board Approval during this period: • **Appendix 1** – NHS Resolution Service Level Agreement provided by the NHS Litigation Authority

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** Divisional Senior Management Team NHS Wales Shared Services Partnership Committee	 25/04/2024 16/05/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS • **Appendix 1 –** The NWSSP/NHS Wales Shared Services Partnership Committee **APPROVED** the NHS Resolution Service Level Agreement provided by the NHS Litigation Authority	

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
Appendix 1	NHS Resolution Service Level Agreement provided by the NHS Litigation Authority

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 **26/03/2024 – 16/05/2024** 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	NHS Resolution Service Level Agreement provided by The NHS Litigation Authority	Start: 01/04/2024 End: 31/03/2027 Option to Extend: All Wales Contract	£1,432,000 (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	**NHS RESOLUTION SERVICE LEVEL AGREEMENT PROVIDED BY THE NHS LITIGATION AUTHORITY**
DIVISION / HOST ORGANISATION	**NHS Wales Shared Service Partnership**
DATE PREPARED	16th May 2024
PREPARED BY	Nicola Phillips, Director of Primary Care Services and Medical Examiners Service
SCHEME SPONSOR	Nicola Phillips, Director of Primary Care Services and Medical Examiners Service

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

NHS Resolution provide a wide range of services to Health Boards and Trusts across NHS Wales, in support of primary care contractors and secondary care consultants concerning the management of issues arising from complaints. Services provided to NHS Wales under the Service level agreement range from the provision of a case management service; support for case advice; assessments and interventions, including Professional Support and Remediation (PSR) services; conduct advisor case review meetings; education and training direct to NHS Wales Bodies and the provision of activity reports.

Advisory services provided into both Primary and Secondary care is deemed essential and has been hosted by NHS Wales Shared Services Partnership (NWSSP) since April 2017, at the request of the Chief Medical Officer.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/04/2024
Expected End Date of Contract	31/03/2027
Contract Extension Options **(E.g. maximum term in months)**	None

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. Included in annual revenue allocation from Welsh Government to NWSSP as a service hosted by NWSSP. No actual expenditure has taken place under this agreement to date.		

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

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED Please mark with a (x) in the box the relevant principles for this scheme. Click **here** for more information									
Prevention	☐	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

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

3.1 Please state alternative options considered and reasons for declining
Alternative Options not considered. This is renewal of a Live service. NHS Resolution's purpose is to provide expertise to the NHS to resolve concerns fairly, share learning for improvement and preserve resources for patient care. NHS Resolution is a special health authority, sponsored by the Department of Health and Social Care.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Continuous Partnership working. NHS Resolution established relationships with NHS Wales Health Boards, as a trusted partner. Supporting Practitioners with concerns Supporting Health Boards with performance issues/concerns Provides expertise to NHS Wales on resolving disputes and concerns fairly Shared learning to improve patient experiences and care,

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
No provision/lack of expertise to NHS Wales to resolve concerns fairly, share learning for improvement and preserve resources for patient care.	No mitigation – the service would cease to be provided.

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 requirement concerns the formation of a SLA between NHS Bodies. The hosting arrangement for this service transferred from Welsh Government in April 2017 **SLA has been agreed at formal Senior Leadership Group, NHS Wales Shared Services Partnership – 25th April 2024 and Shared Services Partnership Committee – 16Th May 2024.**
6.3 What is the approximate time line for procurement?
This is a live service extension request to support service delivery until 2027. SLA renewal as at 1st April 2024.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	N/A - This is an intra NHS agreement and as such not subject to commercial procurement
Signature:	
Date:	

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £1,194k	**Including VAT (£k)** £1,432k
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: Included in annual revenue allocation from Welsh Government to NWSSP	

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
NHS Resolution in support of primary care contractors and secondary care consultants re: management of issues arising from complaints	398	398	398		1,194	1,432
Overall Total	398	398	398		1,194	1,432

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*N/A*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Nicola Phillips
Signature:	
Service Area:	Primary Care Services, NWSSP
Date:	16th May 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	25th April 2024
Executive Management Board	

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	16th May 2024
HTW – Senior Management Team	

THIS AGREEMENT is made on the 1st day of April 2024.

PARTIES
(1) **NHS LITIGATION AUTHORITY** of 8th Floor 10 South Colonnade, Canary Wharf, London, E14 4PU **("NHS RESOLUTION")**; and (2) **NHS Wales Shared Services Partnership** (**NWSSP**), 4/5 Charnwood Court, Heol Billingsley, Parc Nantgarw CF15 7QZ.
BACKGROUND
The NHS Wales Shared Services Partnership and NHS Resolution wish to enter into an arrangement regarding maintaining high professional standards policy for handling concerns regarding Practitioners employed and/or commissioned by NHS Wales Health Boards and Trusts. Practitioner Performance Advice, an operating division of NHS Resolution, will provide support to the Shared Services Partnership and their nominated NHS Wales Health Boards. Details of the Health Boards shall be provided in writing by the Shared Services Partnership to NHS Resolution during the Term. Subject to and in accordance with the terms of this agreement: The members and staff of NHS Resolution will perform the functions set out in Schedule 2 as services to the Shared Services Partnership to deal with practitioners whose performance gives cause for concern.

NOW IT IS HEREBY AGREED as follows:

1. DEFINITIONS AND INTERPRETATIONS

1.1 In this Agreement (including the Background), the following terms shall, unless the context otherwise requires, have the following meanings:

"Practitioner Performance Advice" an NHS Resolution function that provides impartial advice, assessment and intervention services to health organisations to help the effective management and resolution of performance concerns about the performance of doctors, dentists, pharmacists and optometrists;

"the Shared Services Partnership" means the NHS Wales Shared Services Partnership or their nominated Health Boards/Trust;

"In writing" means documented, signed and sent by post or by electronic mail;

"Practitioners" means Doctors, Dentists, Pharmacists and Optometrists:

"Maximum limit of the contract price" means one year SLA charge.

1.2 References in this Agreement to numbered clauses are references to the clauses in the Agreement in which the reference bearing that number appears.

2. TERM

2.1 This Agreement shall come into force on the 1 April 2024 and remain in force for a period of 36 months unless terminated in accordance with clause 14 below.

2.2 This agreement will be reviewed at the end of each 12-month period during the term of this agreement for the period set out above at paragraph 2.1. or on an ad-hoc basis where deemed necessary by both parties.

2.3 This includes reviewing the agreement cost, in line with the Consumer Price Index (CPI). With the actual level of increase to be agreed by both parties in January each year ahead of the 1 April renewal date.

3. FUNCTIONS OF PRACTITIONER PERFORMANCE ADVICE

3.1 NHS Wales Shared Services Partnership, with a view to accessing the advice and support system for Practitioners whose performance gives rise to concern, agrees that NHS Resolution will exercise the following Practitioner Performance Advice functions as more specifically set out in Schedule 2 to this Agreement including but not limited to:

3.1.1 to provide an advisory service to NHS Wales Shared Services Partnership for advice cases arising and an assessment service on a case-by-case basis as agreed between the parties;

3.1.2 to provide an assessment and remediation service, including Professional Support and Remediation (PSR) services when required;

3.1.3 to provide support to local efforts to improve good practice in relation to the resolution of difficulties and concerns between the Practitioners and their employers and contractors, through policy support and website resources;

3.1.4 to provide support for reporting at a local level.

3.2 In addition to the services described above at 3.1, Practitioner Performance Advice may provide to NHS Wales Shared Services Partnership on agreement and at an agreed cost, the additional services as listed in Schedule 1 (these prices of ad hoc services are subject to review on an annual basis).

3.3 Practitioner Performance Advice shall also provide under this Agreement all ancillary administrative, professional or technical services necessary to enable Practitioner Performance Advice to carry out the functions in clauses 3.1 to 3.2 inclusive. Schedule 2 to this Service Level Agreement sets out the services to be provided.

4. STANDARD OF PERFORMANCE

4.1 NHS Resolution shall exercise all Practitioner Performance Advice functions and provide all services in accordance with NHS Resolution's standard policies or guidance and reflecting the resources and information provided by NHS Wales Shared Services Partnership.

5. ACTIVITY REPORTS

5.1 Practitioner Performance Advice shall provide an activity report at the end of quarter two and an annual activity report at the end of each financial year.

6. CONDUCT OF BUSINESS

6.1 NHS Resolution shall carry out its functions under this Agreement having regard to the matters specified in Schedule 2 Service Specification) to this Agreement.

7. INDEMNITY AND INSURANCE

7.1 Each Party accepts unlimited liability to the other for:

- death or personal injury caused by the negligence of that Party; and
- fraud or fraudulent misrepresentation committed by or on behalf of that Party.

7.2 Save as in Clause 7.1, NHS Resolution shall not be liable to NHS Wales Shared Services Partnership for (a) any indirect or consequential loss or (b) any loss of use or loss of profits, business, contracts, revenues or anticipated savings whether arising from tort (including, without limitation, negligence or breach of statutory duty), breach of contract or otherwise.

7.3 Except as otherwise provided in this Agreement, NHS Resolution limits its liability to NHS Wales Shared Services Partnership in contract, tort (including, without limitation, negligence or breach of statutory duty) or howsoever arising to a maximum limit of the contract price only.

7.4 (a) Save as set out in Clause 7.1 and subject to the limitation provision in 7.4(b) NHS Wales Shared Services Partnership will indemnify NHS Resolution with any reasonable costs and compensation awarded as a result of civil action in connection with the exercise of its functions described in the Service Level Agreement, provided NHS Resolution and its employees have acted in good faith and with due care and diligence.

(b). Except as otherwise provided in this Agreement NHS Wales Shared Services Partnership limits its liability to NHS Resolution in contract, tort (including, without limitation negligence or breach of statutory duty) or howsoever arising to a maximum limit of the contract price together with five (5) per cent interest on such contract price only.

7.6 Each Party hereby acknowledges and agrees that the provisions of this Clause 7 are fair and reasonable having regard to the circumstances as at the date hereof. The provisions of this clause 7 shall survive the termination of this agreement, however arising.

8. FREEDOM OF INFORMATION ACT and DATA PROTECTION ACT

8.1 NHS Resolution and the NHS Wales Shared Services Partnership are subject to the Freedom of Information Act 2000. Both parties may be required to disclose information to ensure compliance with Freedom of Information legislation. Both parties note and acknowledge this legislation and the relevant Codes of Practice. The parties will act in accordance with their respective Freedom of Information legislation and Codes of Practice (and any other applicable codes of practice or guidance).

8.2 Any decision regarding the application of any exemption to the request for disclosure of recorded information is a decision solely for the body receiving and processing the request. Where a party is managing a request as referred to in this clause, the other party shall co-operate with them if they so request and shall respond within five (5) working days of any request by it for assistance in determining how to respond to a request for disclosure.

8.3 The parties must protect personal data in accordance with the provisions and principles of the UK Data Protection Act 2018. Both parties shall be registered under their respective legislation and both parties shall comply at all times with the Data Protection Legislation and shall not perform their obligations under the Agreement in such a way as to cause either party to breach any of their applicable obligations under the Data Protection Legislation. Both parties must promptly notify the other if they breach this clause.

9. INTELLECTUAL PROPERTY

9.1 In this clause 9, "Intellectual Property Rights" means all patents, rights to inventions, utility models, copyright and related rights, trademarks, service marks, trade, business and domain names, rights in trade dress or get-up, rights in goodwill or to sue for passing off, unfair competition rights, rights in designs, rights in computer software, database rights, topography rights, moral rights, rights in confidential information (including know-how and trade secrets) and any other intellectual property rights, in each case whether registered or unregistered and including all applications for and renewals or extensions of such rights, and all similar or equivalent rights or forms of protection in any part of the world.

9.2 All Intellectual Property Rights arising from or relating to the services, including without limitation any material prepared by or supplied by NHS Resolution in connection with Practitioner Performance Advice services shall remain the property of NHS Resolution.

9.3 To the extent that NHS Wales Shared Services Partnership or any individual employed or engaged by NHS Wales Shared Services Partnership, have been involved in the development of or provision of the services ("contribution"), NHS Wales Shared Services Partnership hereby assigns to NHS Resolution all Intellectual Property Rights in such Contribution by way of present and future assignment with full title guarantee.

9.4 NHS Wales Shared Services Partnership shall have no right or licence to use any Intellectual Property of NHS Resolution except that it shall be entitled to use any material, information or other documents provided by NHS Resolution as part of the delivery of the services and for NHS Wales Shared Services Partnerships internal business processes pursuant to the services provided under this agreement only.

10. FINANCIAL ARRANGEMENTS

10.1 NHS Resolution shall charge NHS Wales Shared Services Partnership for the services described in this agreement, in the following manner:

10.1.1 A fixed cost for each 12-month period as set out in Schedule 1 and 2 to this agreement to cover;

a) Provision of a case management service to NHS Wales Shared Services Partnership (with access to sufficient case advice staff as required);
b) Provision of support for case advice for up to **60** cases;
c) Two Clinical Performance Assessments (for any specialty but excluding a surgery simulation, for which an additional charge will be made)*

d) Five Behavioural Assessments*
e) Two Team Reviews (up to a maximum team size of 20 delegates)*
f) Two PSR cases
g) One Assisted Mediation*

*** *To note:*** The Intervention Consideration Group decides whether the cases referred to it are suitable for Practitioner Performance Advice to provide an assessment or intervention and then recommends whether or not an assessment or intervention is carried out.

h) up to 15 days of education training, including:
- Case Manager workshops
- Case Investigator workshops
- 'Understanding and using UPSW effectively' workshops
- Resolving performance concerns
- Compassionate Conversations train the trainer workshops (once they are rolled-out in Wales)
- Other refresher and customised workshops according to Health Board requirements.

i) Two activity reports (one mid-year and one annual report)
j) One annual review meeting with the Practitioner Performance Advice Director and Link Adviser to Wales

10.2 NHS Wales Shared Services Partnership may also request Practitioner Performance Advice provide additional services, at an additional cost as specified in Schedule 1.

10.3 Travel, accommodation and further expenses incurred providing services specified in clause 10.1.1. above will be claimed in accordance with the NHS Resolution expenses policy.

10.4 NHS Resolution shall invoice for the fixed cost at the commencement of this agreement and at the commencement of any subsequent term. Any additional charges for services specified in clauses 10.1.2 above shall be invoiced on agreement to the provision of the service.

11. AUDIT

11.1 In the exercise of its functions and provision of services under this agreement. NHS Resolution shall keep all case related documents for all referrals made by NHS Wales Shared Services Partnership.

12. DESIGNATED REPRESENTATIVES

12.1 NHS Resolution and NHS Wales Shared Services Partnership shall both nominate designated representatives for the day-to-day operation of the Agreement and senior officers with responsibility for resolving function and service issues of a more serious nature. These contacts shall be set out at Schedule 4 to this agreement.

13. DISPUTE RESOLUTION

13.1 In the first instance any dispute arising under the Agreement shall be discussed by the designated representatives of the parties, as described in clause 12.

13.2 In the event that the dispute is not resolved under clause 13.1, either party shall notify the other within 21 days of the dispute setting out reasonable details of the

dispute. The dispute shall then be referred to the Senior Officer of the Department and the Director of Practitioner Performance Advice, who shall meet reasonably promptly to seek to resolve the matter.

13.3 If the dispute is not resolved in accordance with clause 13.2 above, then the Parties will attempt to settle it by mediation in accordance with the Centre for Effective Dispute Resolution ("CEDR") Model Mediation Procedure or any other model mediation procedure as agreed by the Parties. To initiate mediation the Parties may give notice in writing (a "Mediation Notice") to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Parties asking them to nominate a mediator.

14. TERMINATION

14.1 Either party may terminate this agreement forthwith by notice in writing if the other party is in breach of this agreement and fails to remedy the breach (if capable of remedy) within 30 days of written notice of the breach being given and has not or will not comply with the Dispute resolution procedure as set out above at Clause 13.

14.2 Termination or expiry of this Agreement for any reason shall be without prejudice to any right or remedy of either Party which may have accrued prior to such termination.

14.3 NHS Wales Shared Services Partnership shall return any NHS Resolution equipment or materials in its possession or control at its own cost to NHS Resolution no later than 30 days after the termination or expiry of this Agreement.

14.4 Upon expiry or earlier termination of this Agreement, NHS Resolution shall continue to be entitled to receive and NHS Wales Shared Services Partnership shall pay NHS Resolution the contract price for any services provided by NHS Resolution up to and including the date of termination or expiry.

14.5 The provisions of Clauses 7, 8, 9, 13 and 14 shall survive termination of this Agreement with three months' notice in writing to the other party, unless a shorter timescale is agreed by both parties.

15. MISCELLANEOUS

15.1 No variation of this Agreement shall be effective unless it is in writing signed by each of the parties.

15.2 No waiver of any term, provision or condition of this Agreement shall be effective unless it is in writing and signed by the waiving party.

16. ASSIGNMENT AND NOVATION

16.1 Either party may assign, novate or otherwise dispose of its rights and obligations under the Contract or any part thereof to:

(a) any other body established by the Crown or under statute in order substantially to perform any of the functions that had previously been performed by the transferring body;

provided that any such assignment, novation or other disposal shall not increase the burden of the other party's obligations under the Contract.

17. ENTIRE AGREEMENT CLAUSE

17.1 This SLA, together with the documents referred to in it/attached to it, constitutes the entire agreement and understanding between the parties in respect of the matters dealt with in it and supersedes, cancels and nullifies any previous agreement between the parties in relation to such matters notwithstanding the terms of any previous agreement or arrangement expressed to survive termination.

17.2 Each of the parties acknowledges and agrees that in entering into this SLA and the documents referred to in it/attached to it, it does not rely on, and shall have no remedy in respect of, any statement, representation, warranty or undertaking (whether negligently or innocently made) other than as expressly set out in this SLA. The only remedy available to either party in respect of any such statements, representation, warranty or understanding shall be for breach of contract under the terms of this Agreement.

17.3 Nothing in this clause shall operate to exclude any liability for fraud.

Signed for and on behalf of **NHS Wales Shared Services Partnership**

By:

Name: Nicola Philips, Director of Primary Care and Medical Examiner Services for Wales

Date:

Signed for and on behalf of **NHS Resolution**

By:

Name: Vicky Voller, Director of Practitioner Performance Advice

Date:

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Schedule 1: Agreement Costs

Fee Structure

Fixed annual fee
The fixed annual fee will provide the mechanism for Practitioner Performance Advice to plan and maintain the capacity to provide and deliver the following:

Annual cost element	
This will include: a) Provision of a case management service to NWSSP (with access to sufficient case advice staff as required) b) Support for up to 60 new advice cases per year c) Advice case review meetings with contracting/employing organisations as required **Assessment and Remediation services**, including up to: d) Two Clinical Performance Assessments (for any specialty but excluding a surgery simulation, for which an additional charge will be made)* e) Five Behavioural Assessments* f) Two Team Reviews (up to a maximum team size of 20 delegates)* g) Two PSR cases h) One Assisted Mediation* *** *To note:*** The Intervention Consideration Group decides whether the cases referred to it are suitable for Practitioner Performance Advice to provide an assessment or intervention and then recommends whether or not an assessment or intervention is carried out. **Education services:** up to 15 days of training, including: • Case Manager workshop • Case Investigator workshop • 'Understanding and using UPSW effectively' workshop • Resolving performance concerns • Compassionate Conversations train the trainer workshops (once they are rolled-out in Wales) • Other refresher and customised workshops according to Health Board requirements. **Reporting and learning** • Two activity reports (one mid-year and one annual report) i) Annual review meeting with the Practitioner Performance Advice Director and Link Adviser to Wales j) All direct and indirect costs, including travel, accommodation and further expenses incurred in providing the services listed above as part of the fixed cost.	
Total per annum (FY24/25)	£398,000 (plus VAT)

Pricing is subject to an annual review, in line with the Consumer price index (CPI). With the final figure to be agreed in January of each year of the agreement.

If more of the outlined services are needed to meet demand, they are available and would be charged on a case-by-case basis. NWSSP should confirm whether it wants to agree and pay for these services, or whether they should be applied to individual health boards as and when they request them.

NWSSP can request additional professional services advice under this agreement, such as input and advice to inform policy development, for which an additional fee may be charged. NHS Wales Shared Services Partnership and NHS Resolution shall agree the scope and costs of any additional services request before any additional work is undertaken.

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Schedule 2: Service Specification

1. Practitioners Covered

This Agreement covers all doctors, dentists, pharmacists and Opticians for which NHS Wales Shared Services Partnership has responsibility, including those GPs on NHS Wales Shared Services Partnership's GP Performers List.

2. Areas of Clinical Care Covered

- Primary care services
- Secondary care services
- Public Health
- Mental Health and Psychiatric Services

3. Contact/Request for advice

Contact/Request for advice and support to Practitioner Performance Advice for any activity/service covered by this Agreement will be made by NHS Wales Shared Services Partnership's Group Medical Director or by the named designated representative at Schedule 4.

Telephone requests for advice and support directly from Practitioners concerned about their own performance are acceptable but Practitioner Performance Advice will make theses callers aware that the relevant employing/contracting body will be informed of the conversation and that no more than telephone advice will be given without the formal involvement of their employing/contracting body.

4. Assessors

Practitioner Performance Advice clinical performance assessments are carried out by assessors who are clinicians in the same specialty as the practitioner. Practitioner Performance Advice behavioural assessments are carried out by specialist assessors who are chartered occupational psychologists.

All assessors work within the Practitioner Performance Advice assessment framework and guidelines for assessors devised by Practitioner Performance Advice.

5. Quality and performance indicators

Practitioner Performance Advice will aim to work to the highest standards of quality in all its activities; in particular; all work undertaken by Practitioner Performance Advice under the terms of this agreement will be subject to Practitioner Performance Advice's programme of evaluation and quality assurance.

6. Timescales

Practitioner Performance Advice will undertake to respond to requests from the employing/contracting body in accordance with standard operating procedures. Practitioner Performance Advice will complete all case assessments within a reasonable timeframe, taking account of the complexity of each individual case and the requirements outlined within this agreement and the associated service level agreement.

7. Summary of services from Practitioner Performance Advice

Case advice service
Our advice is provided by an established team of trained Advisers, comprising senior staff who are aligned regionally to specific healthcare organisations. In responding to requests for advice from healthcare organisations with concerns about the practice of individual practitioners, the advice we offer focuses on:

- the fair and effective application of the healthcare organisation's own local performance management and associated procedures
- good practice in relation to local case management and investigation
- helping to identify and consider options available to the healthcare organisation to address and resolve concerns raised about an individual's practice
- signposting available avenues of professional support and other resources

Our Advisers will provide telephone advice which will be followed up in writing and conduct regular case review meetings as required. Support for each case will continue until it is agreed with the employing/contracting organisation that the case can be closed.

Further details about our case advice service can be found on the NHS Resolution Website: https://resolution.nhs.uk/services/practitioner-performance-advice/advice/

Assessment and Remediation services
Our assessments help to clarify and understand the performance of individual practitioners and provide the healthcare organisation and practitioner with a sound basis upon which to bring the case towards a resolution.

Detailed information about Practitioner Performance Advice's Assessment and Remediation services is available via the NHS Resolution Website: https://resolution.nhs.uk/services/practitioner-performance-advice/assessment-and-remediation/

Clinical Performance Assessment
The purpose of this assessment is to:

- provide an independent view on the clinical performance of the practitioner, identifying both satisfactory practice and any areas of poor practice.
- provide information to assist the referring organisation in decisions about the next steps in their management of the case.

The result is a comprehensive report with fair, robust and evidence-based findings and conclusions in respect of the individual's practice, which provide the basis for a clear way forward to bring the case towards a resolution.

Further details about our Clinical Performance Assessments can be found on the NHS Resolution website: https://resolution.nhs.uk/services/practitioner-performance-advice/assessment-and-remediation/clinical-performance-assessment/

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Behavioural assessment
The purpose of this assessment is to:

- provide an independent view on the behavioural characteristics of the practitioner, including any areas which require consideration.
- provide information to assist the referring organisation in decisions about the next steps in their management of the case.

Where the concerns about an individual practitioner primarily focus on their behaviours and relationships with colleagues, and where there is not misconduct requiring the use of disciplinary procedures, we may offer to undertake an assessment of the practitioner's behaviours.

Further details about our behavioural assessments can be found on the NHS Resolution website: https://resolution.nhs.uk/services/practitioner-performance-advice/assessment-and-remediation/behavioural-assessment/

Professional support and remediation action plan

We prepare draft action plans for doctors, dentists, pharmacists and opticians who have been identified as needing support in order to return to safe and effective clinical practice. The reasons for practitioners needing support are wide ranging, and usually involve:

- remediation - following the identification of deficiencies in aspects of their clinical practice
- return to work/re-integration - following a period of absence from clinical practice.

Further details about our professional support and remediation action plans can be found on the NHS Resolution website: https://resolution.nhs.uk/services/practitioner-performance-advice/assessment-and-remediation/professional-support-and-remediation/

Assisted mediation
Assisted mediation is an independent, voluntary and confidential process in which two accredited mediators work with the parties concerned to create a mutual understanding of the issues and to find a way forward that enables a more effective professional working relationship, which leads to a positive impact on the immediate team and ultimately better patient care.

Further details about assisted mediations can be found on the NHS Resolution website: https://resolution.nhs.uk/services/practitioner-performance-advice/assessment-and-remediation/assisted-mediation/

Team review
The purpose of a team review is to:

- identify and better understand key issues that are perceived to be contributing to relationship difficulties within a team.
- identify any barriers to resolving the issues which have been highlighted
- to assist the employing/contracting organisation in formulating a plan for improving professional relationships within the team.

The benefit is likely to have a positive impact on the immediate team and patient or public safety.

Further details about team reviews can be found on the NHS Resolution website: https://resolution.nhs.uk/services/practitioner-performance-advice/assessment-and-remediation/team-reviews/

Education and training services
Our training courses aim to provide NHS organisations the knowledge and skills to identify and manage performance concerns locally. They also provide staff and teams the opportunity to share good practice and network with colleagues.

Our courses can be run in-house in individual organisations or in most cases can be delivered virtually. Courses can be tailored to meet individual requirements.

Further details of education and training services can be found on the NHS Resolution website: https://resolution.nhs.uk/ppa-training/

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Schedule 3: Significant Concerns

Significant Concerns
At NHS Resolution we have a duty to act upon a significant concern if we identify one in the course of our work. We have developed a framework to support the identification and management of significant concerns where these give rise to the need for a coordinated organisational response by NHS Resolution.

The framework is intended to be implemented in conjunction with, and not to replace, local protocols that might be in place with organisations with whom we work. NHS Resolution anticipates arrangements in NHS Wales Shared Services Partnership and the Department of Health to be compatible with and support the handling of significant concerns in line with this framework.

Principles
The following principles underpin our approach to identifying and responding to significant concerns:

- As an NHS body, our paramount concerns are patient and staff safety, and public protection.
- We are committed to using what we know to improve safety, and identifying opportunities for wider improvement and learning from the information we gather as part of our work.
- We operate within the law and within the parameters of our role, including being cognisant of requirements in relation to information governance

A significant concern can arise in the context of either advising on a case or assessing a practitioner.

Case advice
Indicators for a significant concern can include one or more of the following characteristics as a feature of the organisational response to managing individual performance concerns:

- a failure to take basic steps to understand/diagnose the nature of the performance concerns;
- a persistent failure to follow overarching HR processes/local procedures or other external frameworks, for example Maintaining High Professional Standards;
- the absence of a management plan or oversight leading to an uncoordinated approach, potentially exacerbated by the involvement of multiple staff/agencies;
- the behaviours of the practitioner/team in which the practitioner works have escalated beyond the employer's management capability;
- poor behaviours displayed by the employer/practitioner in response to the performance concerns;
- resistance to following the advice provided, with no clear rationale for alternative action and/or insufficient safeguards;
- information provided by a practitioner in the context of whistleblowing failure to involve appropriate authorities such as the police when there appears to be evidence of criminal action.

In addition to the specific indicators listed above, the scale of the concern and the urgency of need to act should be considered as additional factors when assessing a potential concern.

Assessments and other interventions

The concern identified requires urgent action to:

- safeguard a patient, patients and/or the public (including staff) and/or help to ensure the safety of the practitioner and/or • help to ensure the provision of a safe service

And

- if not addressed urgently, the concern poses an immediate or potential risk of significant harm to the individual(s) or service affected; or
- there is evidence that significant harm has already been caused.

It is also important to note that a significant concern:

- can arise at any stage of the process;
- may be indicated by any single assessment component or a combination;
- may or may not relate to the practitioner under assessment;
- may be in relation to a practitioner's performance, health or conduct, or in relation to wider service provision, organisational systems or equipment;
- may or may not relate to the care provided to an individual patient;
- may or may not relate to the overall care provided to a range of patients which, only when considered together, raise a significant concern about practice;
- may or may not necessarily mean that the practitioner's overall performance falls below the standard reasonably expected;
- may prompt the need for urgent advice, follow up and/or patient.

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Schedule 4: Contacts

Practitioner Performance Advice

Name: Clare Game
Business Support and Development Manager

Address: NHS Resolution
8th Floor, 10 South Colonnade, Canary Wharf, London, E14 4PU

Email: Clare.game1@nhs.net
Telephone: 07775 795084

NHS Wales Shared Services Partnership

Name: Nicola Philips
Director of Primary Care Services and Medical Examiner Service for Wales

Address: NHS Wales Shared Services Partnership
4 /5 Charnwood Court, Heol Billingsley, Parc Nantgarw CF15 7QZ

Email: Nicola.Phillips4@wales.nhs.uk

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TRUST BOARD

Digital Inclusion Plan

DATE OF MEETING	23/05/2024

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	Elin Griffiths, Head of Digital Programme Kate Mackenzie, AD Data and Insight David Mason-Hawes, Head of Digital Services
PRESENTED BY	Carl Taylor, Chief Digital Officer
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	Digital Inclusion continues to a key challenge in Wales and impacts on Health outcomes, with digitally excluded amongst the heaviest users of health and social care services, so risk being left behind in the digital health revolution. The Trust's Digital Strategy 2033 includes Digital Inclusion as one of its six key themes, this in an important foundation for our service users accessing our services.

	This paper sets out our existing achievements and the Trust's plan for Digital Inclusion activities including our accreditation against the standard Digital Inclusion Charter for Wales.

RECOMMENDATION / ACTIONS	Trust Board are asked to: • **Approve** the Digital Inclusion plan.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Digital Programme Board	28/02/2024
EMB Shape	18/03/2024
Strategic Development Committee	21/03/2024
EMB Shape	15/04/2024
Strategic Development Committee	15/05/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Digital Inclusion plan was discussed at the Digital Programme Board on the 28th Feb ahead of presentation to EMB Shape on the 18th March.

WBS SLT have reviewed.

For assurance of our activities, we have also been engaged directly with Digital Communities Wales and they have contributed to our Digital Strategy and our Digital Inclusion plan. The assessment from Digital Communities Wales is that our plan is ready for accreditation.

The plan was endorsed for approval at EMB Shape on 18th March. A further request was made at SDC on 21st March for completion of a Quality Impact Assessment. SDC endorsed the plan for approval subject to the Quality Impact Assessment being presented at the next meeting.

The Quality Impact Assessment was endorsed for approval by EMB Shape on the 15th April.

Strategic Development Committee received the Quality Impact Assessment for the April meeting.

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

APPENDICES	
Appendix 1	Full Digital Inclusion Plan for 24/25
Appendix 2	Digital Inclusion Plan Quality Impact Assessment

1. SITUATION

1.1 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 have been developing its capabilities and structures to support the future plans for the Trust. This has been articulated in the Board approved digital strategy for the Trust, "Digital Excellence: Our Strategy 2023-2033". We continue to change the way that Digital Services operate in the Trust in support of the Strategy.

1.2 Digital Inclusion is one of the key themes for the Digital Strategy where we continue to make good progress. We are now mature enough in our capabilities that we can set out the Trust's Digital Inclusion plan for approval. Section 3 of this document sets out the plan at a high level and Appendix 1 contains the detailed plan.

1.3 The Digital Inclusion plan will form the basis of our formal accreditation against Wales' Digital Inclusion Charter and will help to improve access to services for our stakeholders.

2. BACKGROUND

2.1 The Velindre Trust and the wider NHS in Wales is committed to enabling people to use digital technologies to manage their own health, wellbeing, care and enable donation. This is at the core of many of our strategies and operational plans across the Trust, such as building a sustainable donor base and a world class donor experience and moving cancer services to home. However, many of our service users who could most benefit from digital services are the least likely to be online and included.

2.2 Overall, 7% of adults in Wales are digitally excluded, but some sections of the population are more likely to be digitally excluded than others[1].

2.3 The 2017-18 National Survey for Wales[2] shows that those who are digitally excluded are more likely to be:

- Older (40% of people over 75 use the internet, compared with 97% of 16–49-year-olds)
- Have a disability or long-term condition (74% of people with a disability or long-term condition use the internet, compared with 90% of those without)
- Less well educated (53% of those with no qualifications use the internet, compared with 95% of those with higher education qualifications)

And that there are four pillars of Digital Inclusion for us to address in our plan.



Figure 1: The Four Pillars of Digital Inclusion

2.4 Digital Communities Wales (DCW). DCW is the Welsh Government's dedicated digital inclusion programme, managed by the Wales Co-operative Centre. In 2019 Digital Communities Wales set out the Digital Inclusion Guide for Health and Care in Wales[3] with an overview of the user of digital technology for health in Wales (Figure 1) which highlights challenges and opportunities we will face as we move forward with our Digital Inclusion plan for the Trust.

[1] https://audit.wales/sites/default/files/publications/digital-inclusion-eng.pdf
[2] Reference: National Survey for Wales https://www.gov.wales/sites/default/files/statistics-and-research/2019-01/national-survey-wales-internet-use-digital-skills-2017-18.pdf
[3] https://dhcw.nhs.wales/files/publications/digital-inc-guide-0619-english-pdf/

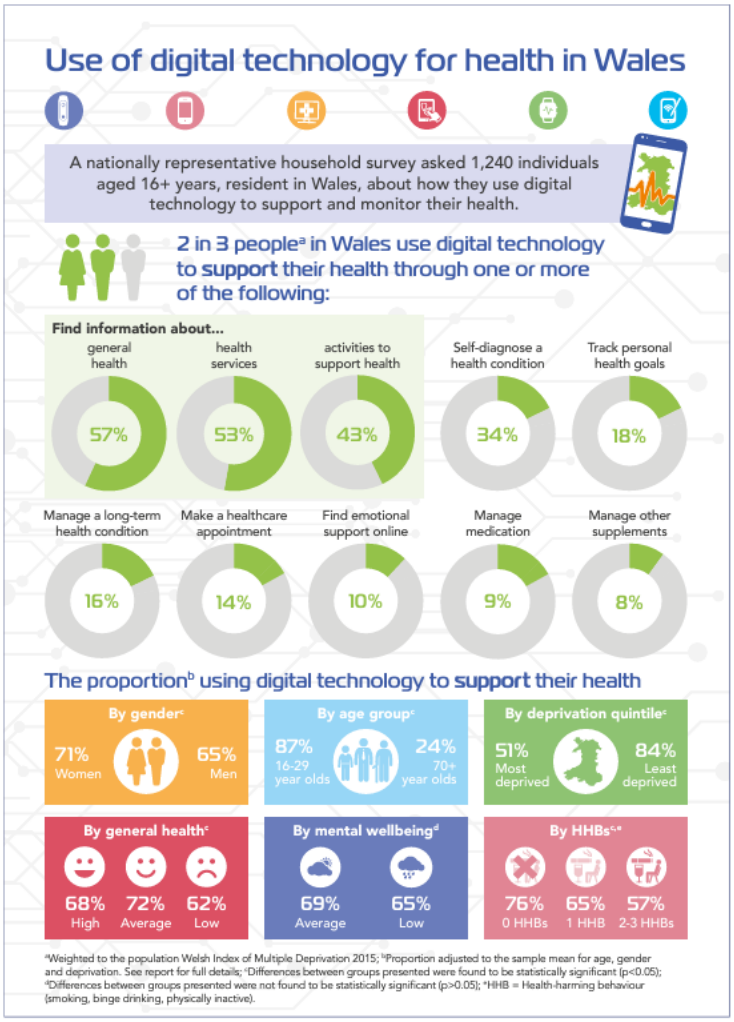


Figure 2: Use of Digital Technology for Health in Wales

2.5 The response to the Digital Inclusion challenge is set out in the Trust's Digital Strategy "Digital Excellence: Our Strategy 2023 – 2033". In recognition and support of the national digital inclusion challenges, Theme #2 in the strategy is *Digital Inclusion* and we have set the vision for the theme as:

"We will support people to become more digitally confident, included and connected."

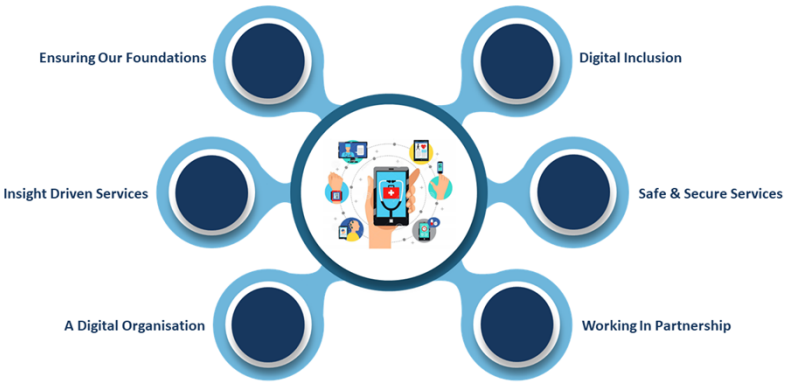


Figure 3: Digital Strategy Themes

2.6 The vision is supported by a set of objectives whose implementation form the Digital Inclusion plan set out in this paper. The objectives are:

- Digitally connect our donors, patients, and carers and staff to our services 24/7
- Place information which is uncomplicated and accessible information into the hands of patients and donors to enable them to make better decisions about the services and support they require.
- Deliver the technology which supports the provision of more services at home and as locally as possible.
- Provide our staff with the technology to work from a wide range of locations across Wales.
- Reduce digital exclusion of people across Wales.

2.7 To be successful the Digital Inclusion plan will also need progress in the Digital Organisation theme so that we can continue to upskill our colleagues in support of our objectives. Further, recognising that as we help to bring stakeholders into digital inclusion, which may include first time access/contribution to electronic records, cyber security of our services will be important and this is supported through our Safe and Secure Service theme in the Digital Strategy.

2.8 To demonstrate the Trust's commitment to the Digital Inclusion agenda in Wales in February '23 we became a signatory organisation to Digital Inclusion Charter (https://www.digitalcommunities.gov.wales/digital-inclusion-charter/) which sets out the six pledges below:

1. We ensure that all our staff and volunteers have an opportunity to develop basic digital skills, and that they take advantage of this opportunity.

2. We ensure that digital inclusion principles are embedded into our day-to-day activities and we support the role digital tools have in managing health and wellbeing.

3. We encourage and support our staff and volunteers to help other people to get online and have the confidence to develop basic digital skills, and help other organisations to embrace digital tools.

4. We commit support and resources for digital inclusion activities and initiatives in Wales in whatever ways we can, to ensure every citizen can engage digitally (if they choose).

5. We share best practice and activity around digital inclusion with the Digital Communities Wales – Digital Confidence, Health and Well-being programme so that our activities are co-ordinated for maximum impact and measured consistently.

6. We look to build local partnerships amongst organisations which want to share ideas and co-ordinate activities with others in their area.

2.9 The next step is to gain accreditation against the Charter. We have worked with Digital Communities Wales to assure that the plan set out in the Assessment section will give us the basis for this accreditation.

2.10 This builds on the work we have already completed for Digital Inclusion since we signed the charter last year. As brief examples, we were really pleased in August to donate eight Surface Pro devices to the Women Connect First charity in Cardiff. Women Connect First do great work to empower black and minority ethnic women with projects like Golden Years to enable Older BME women to feel more independent, empowered, and equipped with life skills including computer classes.

3. ASSESSMENT

3.1 For each of our patient, donor, colleague and citizen communities, 'Digital consumption, does not mean digital competence. Digital confidence, does not mean digital acceptability'.

3.2 The Trust's Digital Inclusion Plan 2024-25 seeks to build upon a series of pilot initiatives completed during the 2nd half of 2023-24. The activity planned will

provide the Trust with the opportunity to increase our digital engagement with our patient, donor, corporate colleague and wider citizen communities, supporting those on the edges of inclusion.

3.3 Specifically, the digital inclusion initiatives we are committed to delivering in 2024-25, will enable us to work towards and achieve accreditation of the Digital Inclusion Charter. These are to:

- engage, promote and deliver user-centred designed digital services and tools;
- consider accessibility and inclusive user needs;
- understand where and when digital can offer value;
- strive to successfully embed digital ways of working;
- build solid foundations ensuring digital adoption, considers all users across multi touch-points;
- understand our data and insight baseline position and what steps we need to take to successfully deliver a digitally enabled hospital, donor experience and clinical service in the future, which works for patients/donors and staff alike;
- champion the accessibility and acceptability of digitally enabled healthcare for our patients, donors, colleagues and wider communities;
- nurture mutually beneficial relationships, influencing the future design of digital patient and donor pathways;
- work regionally, as an active member of the Digital Inclusion Alliance Wales network;
- and to collaborate outside NHS Wales and the healthcare sector, identifying exemplar practice to inform our support of users on the edges of inclusion.

3.4 Digital Inclusion Charter accreditation demonstrates organisational commitment in supporting people on the edges of inclusion or those digitally excluded, to enjoy the benefits of engaging with user-centred designed digital services.

3.5 The summary of the Digital Inclusion plan below is in line with the agreed 2024-25 IMTPs for both Velindre Cancer Services and the Welsh Blood Service divisions of the Trust.

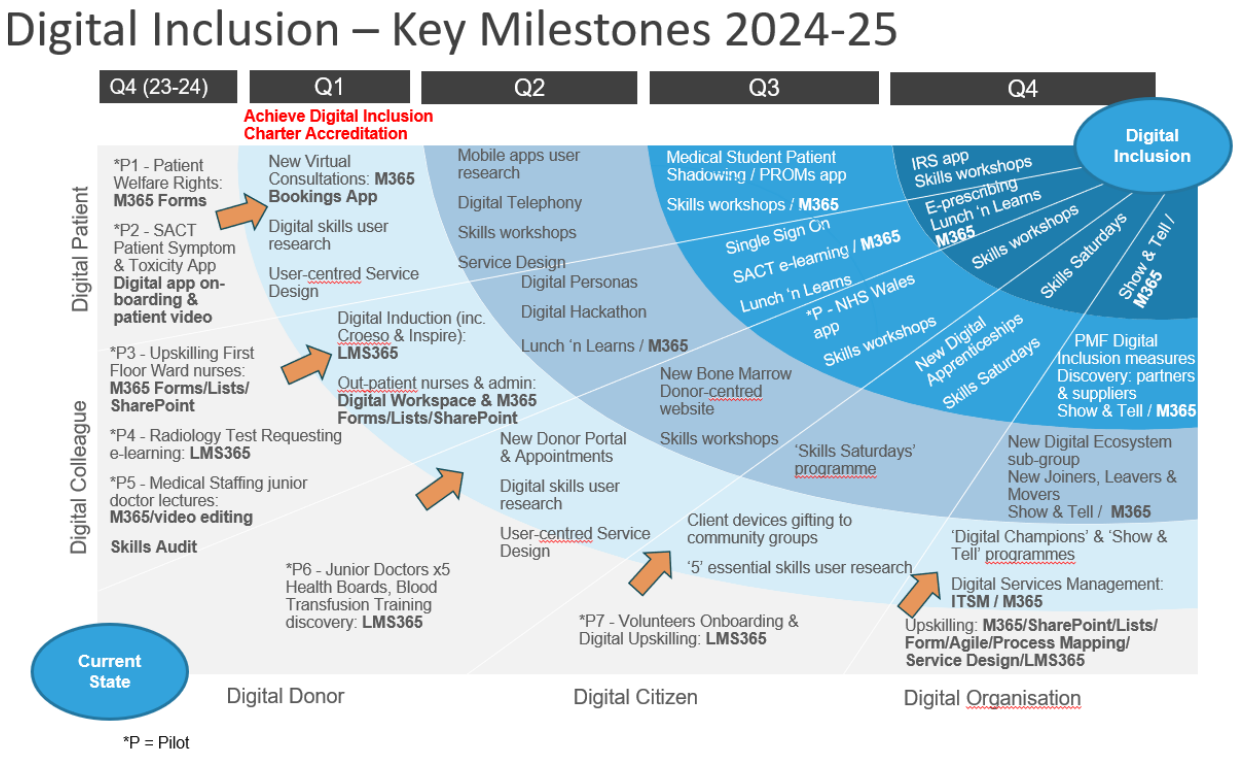


Figure 4: Trust Digital Inclusion Plan 24/25

A full version of the Digital Inclusion Plan, can be found in Appendix 1.

3.6 In this increasingly datafied society, Velindre has a role to ensure that all colleagues positively engage with data collection systems, have the critical thinking skills to analyse and interpret data to support decision-making and can use data as a means of supporting conversations with colleagues, patients and donors. Data Comfort is integrally linked to digital inclusion and reflects the need for skills and confidence to read, analyse, interpret and communicate with data. It is a foundational step in realising the themes of digital inclusion and insight-driven culture of the digital strategy.

3.7 The Plan for an Insight-driven organisation will be shared in full as part of the Data and Insight review (due April 2024), and will include:

- Evaluating our current data report / dashboard stock and retiring rare and unused products;
- Working with current users of Data and Insight products to simplify / redesign routine reports / dashboards using user-centred design principles

and modern Business Intelligence tools to improve clarity and acceptability of products;

- Supporting colleagues across the Trust with a range of formal and informal learning opportunities to improve their data comfort;
- Co-producing a plan to improve our sharing of data and information with our patients, donors and citizen communities.

3.8 Digital Inclusion Measures

To measure the impact of our Digital Inclusion plan we are proposing to adopt the following measures as we previously set out in the Digital Strategy. As we define these measures, we will include them within the Performance Management Framework for reporting and assurance. It is anticipated that we will have the measures in place as part of the PMF by Q3 24/25.

Digital Inclusion Measures
• % of patients/donors who believe health and well-being improved due to online services
• % of patients/donors seeking health/service information on-line
• % of patients using applications to monitor their health digitally
• % of consultations performed virtually
• % of donors booking on-line
• % of patients / donors notified with via their communication preference of choice (SMS, email, other approved comms channels etc.)
• Increase in Mobile 'app' usage / interactions
• % of buildings with free public wi-fi

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 As described in this plan, Digital Inclusion is important to improve the services that we offer our service users. Trust Board are asked to **Approve** the Digital Inclusion Plan.

4.2 Trust Board are asked to **Note** that as part of the Digital Inclusion plan, we will be seeking formal certification against DCW's Digital Inclusion Charter which will further strengthen the Trust's commitment to the Charter's pledges as set out in section 2.8.

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*	TAF 05: There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security. Key Control C7: Digital Inclusion in the wider community
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). **Click or tap here to enter text** Digital Inclusion plays an important role in the quality and safety for the services that the Trust provides: • Digital exclusion in Wales is higher than rest of UK. • 7% of the population, or 180,000 people do not use the internet. • Digital inverse care law whereby socially disadvantaged people receive less, and lower-quality, health care despite having greater need. • Heaviest users of health and social care services, so risk being left behind in the digital health revolution. The Trust's Digital Inclusion plan will contribute to the quality and safety of our services. Appendix 2 is the Quality Impact Assessment for the plan.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why) Click or tap here to enter text. Given that the overall aim of the duty is to deliver better outcomes for those who experience socio-economic disadvantage we would expect the plan to have a positive impact for our service users. An assessment will be made as part of the Digital Inclusion plan.

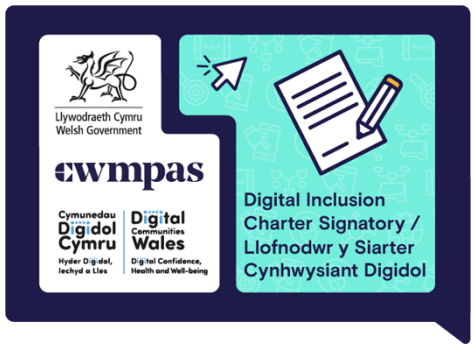
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	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: We are proposing to allocate £25k per annum to support the Digital Inclusion plan objectives. This would fund engagement activities and skills, making devices available to communities (WiFi, laptops) and materials to support the plan. **Type of Change** **Service Development** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT	**Choose an item**

For more information: *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	*[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

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?	The Digital Inclusion Risk is captured as part of the TAF05 Trust Assurance Risk.
WHAT IS THE CURRENT RISK SCORE	12
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?	Q4 24/25
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Support for the Digital Inclusion Plan Achieving Digital Inclusion Accreditation
All risks must be evidenced and consistent with those recorded in Datix	





Velindre University NHS Trust - Digital Inclusion Plan 2024-25

The following Velindre University NHS Trust (VEL) digital inclusion plan 2024-25 is supported through our collaborative partnership with Digital Health Care Wales (DHCW), Digital Communities Wales (DCW) and the Centre for Digital Public Services (CDPS).

Period	DI Charter Pledge No.	Proposed Activity	Details	Target Community	Progress Status	Outcome Measure	Owner
May '24	4	Establish 'Digital Inclusion Group'	Trust-wide steering group - Terms of Reference - Key Objectives - Action Plan - Reporting & Governance	Colleagues Partners Suppliers	Not started	Set-up and accountable to Digital Programme governance	VEL
June '24	2	Achieve 'Digital Inclusion Charter' accreditation	Prepare a summary of all digital inclusion achievements/pilots in 2023-24, for submission to DCW. 6 Digital Inclusion pledges https://www.digitalcommunities.gov.wales/digital-inclusion-charter/	Partner	In progress	Successful achievement of full digital inclusion accreditation	VEL DCW
Q1	3	Launch new Virtual Consultations system	Migration of virtual consultations capability form Attend Anywhere to	Colleagues Patients	In progress	Successful migration of existing virtual consultations service	VEL DHCW

			M365 Bookings App. Upskill clinicians and deliver a new adoption strategy.			users to M365 Bookings App	
Q1/Q2	4	Digital Skills Audit	DCW have created a digital skills audit which is based on the UK government National Standard for essential digital skills. It is hoped that every citizen has the following 5 essential digital skills: - Using Devices and handling information - Creating and editing - Communicating - Transacting - Being Safe and Responsible DCW has provided the digital skills audit to Velindre to carry out this audit with our user communities.	Colleagues Patients Donors Citizens	In progress - sample survey shared with VEL	VEL to review, add additional sections and agree timescales.	VEL
Q1	2	User-centred Service Design	Establish user-centred design principles and structures.	Colleagues Patients Donors	In progress - training and upskilling of key digital leads.	User-centred design/service mapping workshop blueprint.	VE CDPS
Q1	3	Digital Induction	Support People & OD division to migrate a) Croeso and b) Aspire programmes onto LMS365.	Colleagues	Scoping in progress.	Accessible e-learning modules for both programmes.	VEL
Q1	1	New Outpatients nurses & admin M365 Workspace	Development & launch of new Workspace, using M365 Forms/SharePoint/Lists and e-learning via LM365	Colleagues	Pilot in progress.	Adoption of new Workspace and full alignment with new ways of working.	VEL
Q1	4	New Donor Portal & Appointments	Re-development of public donor-facing portal	Donors	Infrastructure re-	Launch of new donor portal, with enhanced donor experience.	VEL

					platforming in progress.		
Q1	3	Digital gifting	Digital device support to community groups and partners, as part of Trust device refresh programme.	Citizens	Pilot completed in 2023/24.	Establishment of x4 community collaborations.	VEL
Q1	3 & 5	Digital Champions	Develop and launch 'Digital Champions' framework and recruit participants.	Colleagues Patients Donors Citizens	Scoping in progress. Digital champion profile defined.	Multi-disciplinary community of champions and supportive tools/e-learning content.	VEL DCW
Q1	4	Digital Services Management Tool	Procurement and launch of new IT Service Management tool, with accessible access for all users.	Colleagues	Procurement complete. Service design phase in progress.	Launch of new service to all Trust colleagues/users.	VEL
Q2	3	Digital Personas	Development of digital personas, including: - characteristics - national system requirements - clinical system requirements - appropriate digital devices/tools	Colleagues	First layer in progress.	VEL to consider M365 personas alongside.	VEL
Q2	5	Mobile apps user research	Review of existing Trust supported mobile apps and discovery work, to identify any new use cases.	Patients Donors Partners			VEL CDPS
Q1 – Q4	6	Working collaboratively with HEIW, support and train work force to feel more digitally confident and aware	Review the digital skills audit and would develop and create a suitable training package.	Colleagues	In progress.	Promote the access to the HEIW hosted Digital Skills Capability Framework.	DCW VEL HEIW

		of the importance of Digital Inclusion.					
Q2	6	Digital Days	Develop a concept of Digital Days and establish a pilot e.g. Skills Saturdays Concept - a patient/donor needs support with technology, they would be able to get that support in house in Velindre, this would be supported by volunteers. DCW would be able to provide the relevant training and support to set this up as this follows a model that has been used by a number partner organisation in a several counties.	Patients Donors Citizens	Not Started	Programme of internal and external skills events.	DCW VEL
Q2	2	Digital Telephony	Launch of new accessible patient and donor facing telephony services.	Patients Donors Citizens	Not started	Launch of new telephony service, with monitoring metrics and user experience feedback loops in place.	VEL
Q2	4	Service design mapping workshops	Publication of scheduled service design mapping sessions (across Trust-wide services).	Colleagues Patients Donors Citizens	Digital leads upskilling in progress.	Timely and relevant workshops, to support service mapping demand, across all user communities.	VEL
Q2	6	Digital Hackathons	Conduct a series of hackathons, to explore and develop at pace prototypes of new digitally included services.	Colleagues Citizens Patients Donors	Not started	Delivery of x2 hackathons, bringing multi-disciplinary teams together to explore user needs.	VEL DCW
		Digital 'Lunch 'n Learns'	Delivery of a rich programme of short, bite-sized digital sessions.	Colleagues	Pilot sessions developed.	Accessible sessions, across a wide cross-	VEL

Q2	5				Scoping in progress.	section of formats/channels, with user feedback and user-centred programme of events.	
Q2	2	New Bone Marrow Donor website	Re-development of new bone marrow donor facing website, with improved search engine optimisation, rich digital content and user experience.	Donors	Not started.	Launch of new and improved bone marrow donor website. Annual increase in bone marrow registrations.	VEL
Q2	5	New Digital Ecosystem sub-group	Establish a multi-disciplinary sub-group, including external partners/suppliers.	Colleagues	Not started.	Launch of new group with full Digital Programme governance.	VEL
Q2	1	New Joiners, Movers & Levers (JML) digital colleague service	Development and launch of robust JML service, ensuring the movement of colleagues is managed, controlled and considers the needs of end users, in a timely and relevant manner.	Colleagues	Scoping in progress.	Launch and adoption of new JML service.	VEL
Q3	5	Provide digital inclusion training for Cardiff University medical students	DCW would like to provide digital inclusion training for 300 students to ensure they understand what digital inclusion is, the importance of it and how they can support the patients they work with to be digital included and confident.	Patients	Not started	Digital Inclusion training module, as part of student induction/onboarding programme.	VEL
Q3	1	Single Sign On	Implementation of user authentication solution, to manage login/logout processes, for multiple systems simultaneously.	Colleagues	Procurement in progress.	Safe and secure access to 'core'	VEL DHCW

Sept '24	3	PROMs App	Procurement and implementation of digital PROMs collection national Value Based Health Care	Patients Colleagues	National procurement complete and supplier framework available.	Implementation and adoption of new digital PROMs data collection.	VEL
Q3	3	SACT e-learning	Development of new e-learning modules in line with new SACT digital systems, using LMS365.	Colleagues	Not started	100% completion of e-learning modules, to support implementation of new digital systems, as part of Service transformation/readiness for nVCC.	VEL
Q3	6	Launch 'Skills Saturdays' programme	Rolling programme offering opportunities to get involved in digital sessions/skills challenges.	Colleagues Citizens	Not started	Programme of quarterly digital sessions, supported by Digital Champions / volunteers.	VEL
Q3	3	Pilot – Donor Portal in NHS Wales app	Integration via API connectivity, of core WBS services, into the NHS Wales app.	Citizens Donors	Not started	Increased visibility of WBS services, including blood donation and Bone Marrow Donor Registry.	VEL DHCW
Q3	4	Digital apprenticeships	Development of new digital apprenticeships, within digital delivery, programmes and data & insight teams.	Citizens	Scoping in progress.	Successful recruitment / onboarding of x3 new digital apprentices.	VEL CDPS Universities
Oct '24	4	PMF Digital Inclusion measures	Commence reporting of new digital inclusion measures within the PMF.	Colleagues Patients Donors Citizens	In progress.	New PMF indicators for digital inclusion.	VEL

Q4	3	Launch Noona (IRS) app	Development and implementation of mobile app to support patient radiotherapy journey and PROMs reporting.	Patients	Not started	Patient download and active users volumes of app.	VEL
Q4	1	New e-Prescribing system	Implementation of ePMA solution, with full integration into national electronic prescribing solutions and patient demographics.	Colleagues	Procurement in progress.		

Quality-driven decision-making

Quality Impact Assessment

Part 1: Developing the QIA

Proposal / decision being assessed	Digital Inclusion Plan
QIA completed by / on date	Carl Taylor – 22nd March 2024
QIA agreed by / on date	EMB Shape 15th April 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	**Nicola Williams – EMB Shape 15th April**

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	Nicola Williams 15th April 2024
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
Digital Inclusion is one of the key themes for the Digital Strategy. We are now mature enough with our digital inclusion agenda that we have set out the Trust's Digital

Inclusion plan for approval. This is the basis of the proposal for the Quality Impact Assessment.

The Digital Inclusion plan will also form the basis of our formal accreditation against Wales' Digital Inclusion Charter who will independently review the quality of the plan.

2. Why is the proposal / decision needed?

The Velindre Trust and the wider NHS in Wales is committed to enabling people to use digital technologies to manage their own health, wellbeing, care and enable donation. This is at the core of many of our strategies and operational plans across the Trust, such as building a sustainable donor base and a world class donor experience and moving cancer services to home. However, many of our service users who could most benefit from digital services are the least likely to be online and included. The Digital Inclusion plan is needed to support service users.

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)

Overall, 7% of adults in Wales are digitally excluded, but some sections of the population are more likely to be digitally excluded than others

The 2017-18 National Survey for Wales shows that those who are digitally excluded are more likely to be:

- Older (40% of people over 75 use the internet, compared with 97% of 16–49-year-olds)
- Have a disability or long-term condition (74% of people with a disability or long-term condition use the internet, compared with 90% of those without)
- Less well educated (53% of those with no qualifications use the internet, compared with 95% of those with higher education qualifications)

Digital Communities Wales (DCW). DCW is the Welsh Government's dedicated digital inclusion programme, managed by the Wales Co-operative Centre. In 2019 Digital Communities Wales set out the Digital Inclusion Guide for Health and Care in Wales with an overview of the user of digital technology for health in Wales (Figure 1) which highlights challenges and opportunities we will face as we move forward with our Digital Inclusion plan for the Trust.

https://audit.wales/sites/default/files/publications/digital-inclusion-eng.pdf
Reference: National Survey for Wales https://www.gov.wales/sites/default/files/statistics-and-research/2019-01/national-survey-wales-internet-use-digital-skills-2017-18.pdf
https://dhcw.nhs.wales/files/publications/digital-inc-guide-0619-english-pdf/

4. Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected

The following stakeholder groups are set out in the plan proposal:

- Patients (and supporting teams)
- Donors
- Velindre Workforce
- Citizens (as the Digital Inclusion will have wider societal benefit)

5. How have you engaged with the people affected?
If you have not yet engaged, what are your plans?

We have been engaged with Digital Communities Wales on the preparation for the Digital Inclusion plan who lead on this agenda for Wales and have engaged wider with stakeholder groups.

6. What are the main benefits of this proposal / decision?

The main benefits from the Digital Inclusion Plan that have been set out in the Digital Strategy are below, the plan will run over multiple years, we have set out 24/25 at this stage.

- Digitally connect our donors, patients, and carers and staff to our services 24/7
- Place information which is uncomplicated and accessible information into the hands of patients and donors to enable them to make better decisions about the services and support they require.
- Deliver the technology which supports the provision of more services at home and as locally as possible.
- Provide our staff with the technology to work from a wide range of locations across Wales.
- Reduce digital exclusion of people across Wales.

7. What are the main risks of implementing this proposal / decision?

The main risks of implementing the Digital Inclusion plan:

- Placing more emphasis on digital channels for our stakeholder groups. This will need to be managed carefully and we will still follow the Welsh Service Design Standards (5. Make sure everyone can use the service)

https://digitalpublicservices.gov.wales/guidance-and-standards/digital-service-standards-wales

The disbenefit of not implementing the Digital Inclusion plan is that the Trust will not contribute to the Digital Inclusion agenda in a co-ordinated or measured way and patient experience improvement opportunities will be missed.

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 The plan also fulfils the Digital Inclusion theme of the Trust's Digital Strategy
9. Is the proposal / decision planned to be temporary or permanent?
The Digital Inclusion plan is set out for 24/25. Work on Digital Inclusion is intended to be a permanent part of the Digital Strategy set out to 2023.

beta

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	• Proposal is not directly related to patient/donor safety	Neutral
Timely	• Increasing Digital inclusion will improve stakeholders' ability to access digital services in a timely manner through improved access and skills when interacting with Digital services.	Positive
Effective	• The Digital Inclusion plan will support the effective and efficient delivery of services. • VUNHST is committed to enabling stakeholders to use digital technologies to manage their own health, wellbeing, care and donations. Increasing Digital Inclusion will mean that we do this in an effective and efficient way and do not drive further exclusion.	Positive
Efficient		Positive
Equitable	• The Digital Inclusion plan will provide our stakeholders with a more equal opportunity to access our services. Over 7% of adults in Wales are digitally excluded.	Positive
Person-centred	• Increasing Digital Inclusion for our stakeholders should improve the well-being as the digitally excluded are often those most in need of access to our services • The range of ways that stakeholders can access services will be widened through the Digital Inclusion plan.	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	• Improving the digital and data skills of our leaders will help create the conditions for an effective Quality Management System	Positive
Workforce	• The Trust's workforce is one of our stakeholder groups identified within the plan • The Digital Inclusion includes items specifically aimed at improving the digital skills and data confidence of our workforce which will benefit quality (e.g work with HEIW)	Positive
Culture	• Proposal is not directly related to the culture of the Trust	Neutral
Information	• Improved Digital Inclusion will make digital information more accessible to the identified stakeholders and build confidence in using the information	Positive
Learning, improvement and research	• Proposal is not directly related to learning/improvement and research	Neutral
Whole systems approach	• The Digital Inclusion plan will help the Trust to work in our wider communities. • Improving digital inclusion will be a positive benefit for our stakeholders that will give them access to digital services wider than just healthcare • Gifting digital equipment (e.g. WiFi, laptops) will provide wider access	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?

Digital Inclusion continues to be a key challenge in Wales and impacts on Health outcomes, with digitally excluded amongst the heaviest users of health and social care services, so risk being left behind in the digital health revolution. The Trust's Digital Strategy 2033 includes Digital Inclusion as one of its six key themes, this in an important foundation for our service users accessing our services. The Digital Inclusion plan is the Trust's plan for addressing this important area. The Digital Inclusion plan is not clinical in nature. It forms part of the Digital Strategy which been approved by Trust Board.
What are the proposed monitoring arrangements and frequency of QIA Review?
In Digital Inclusion Plan includes a set of measures that will be introduced into the Performance Management Framework over the period of the plan. Reporting on progress against the plan will go to Digital Programme Board and follow its agreed reporting arrangements from there. An annual submission will also be made to Digital Communities Wales as the accrediting body. It is proposed that Digital Inclusion plan is reviewed on an annual basis.

beta

TRUST BOARD

Surrender of Lease of Further Part Third Floor, Companies House, Cardiff

DATE OF MEETING	23 May 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	Carl James, Executive Director of Strategic Transformation, Planning and Digital Lauren Fear, Director of Corporate Governance and Chief of Staff
APPROVED BY	Matthew Bunce, Carl James, Executive Director of Strategic Transformation, Planning and Digital Lauren Fear, Director of Corporate Governance and Chief of Staff

EXECUTIVE SUMMARY	NWSSP wishes to bring this lease to an early end so that it expires in line with their other leases in Companies House on 23 June 2024. This is in accordance with the strategic approach regularly reported to the Shared Services Partnership Committee.

	The Landlord, Government Property Agency, and the Trust, are to enter into a Deed of Surrender to be completed on 23 June 2024. 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 Deed on behalf of NWSSP.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
NHS Wales Shared Services Senior Leadership Group	Nov 22 - date
Shared Services Committee	Nov 22 - date
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Strategic estates approach supported by NHS Wales Senior Leadership Group and Shared Services Committee and regularly updated by the Managing Director throughout 2023 to date.	

7 LEVELS OF ASSURANCE	
Not for assurance	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Not for assurance

APPENDICES	

1. SITUATION

This paper has been prepared to seek the approval of the Trust Board for the signing and sealing of a Deed for the surrender of a lease in relation to Further Part Third Floor, Companies House, Cardiff.

2. BACKGROUND

Velindre University NHS Trust entered into a lease on 1 April 2015 for NWSSP to occupy Further Part Third Floor, Companies House, Cardiff (710 sq mtrs).

Current Passing Rent - £61,132 per annum.

Surrender Premium - Nil

Dilapidations – The Landlord is a Government agency and has agreed that dilapidations will not be payable unless they are able to re-let the accommodation. This is unlikely though, as the property is likely to be sold and either redeveloped, or demolished.

Tenant Liabilities – The Tenant will be responsible for the payment of all outgoings up until 23 June 2024 including annual rent, business rates, building and estate service charge and utility consumption.

NWSSP will continue to occupy part of the 4th Floor of Companies House under a Memorandum of Terms of Occupation until they are able to relocate to their new accommodation in Cefn Coed, Nantgarw (end 2024 / early 2025).

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 and seal the Deed of Surrender 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**
	As set out above.

6. RISKS

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

TRUST BOARD

AMENDMENT TO STANDING ORDERS – SCHEDULE 3 ANNUAL REVIEW COMMITTEE TERMS OF REFERENCE:

DATE OF MEETING	23 May 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	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 outline the required changes to Schedule 3 of the Trust Standing Orders, resulting from the Annual Review of the Terms of Reference and Operating Arrangements in respect of the: • Research, Development & Innovation Sub-Committee ***(Appendix 1)***. • Strategic Development Committee ***(Appendix 2)***. • Charitable Funds Committee ***(Appendix 3)***

RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the revisions to the Terms of Reference for the following Committees/Sub-Committees which form part of Schedule 3 of the Trust's Standing Orders: • Research, Development and Innovation Sub-Committee ***(Appendix 1)*** • Strategic Development Committee ***(Appendix 2)*** • Charitable Funds Committee ***(Appendix 3)***

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Research, Development & Innovation Sub-Committee ***(Appendix 1)***	14/05/2024
Strategic Development Committee ***(Appendix 2)***	15/05/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

- **Appendix 1**
  The Research, Development & Innovation Sub-Committee **ENDORSED** the revisions to the Committee Terms of Reference for Approval by the Trust Board.

- **Appendix 2**
  The Strategic Development Committee **ENDORSED** the revisions to the Committee Terms of Reference for Approval by the Trust Board.

- **Appendix 3**
  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.

  The Trust Board requested the report be withdrawn and further content be added to the cover paper to include reference to the addition of the Advancing Radiotherapy Cymru (ARC) Programme Board in the updated Terms of Reference. The Board requested the Terms of Reference for the Advancing Radiotherapy Cymru (ARC) Programme Board be included as an appendix.

7 LEVELS OF ASSURANCE - N/A

APPENDICES	
Appendix 1	Research, Development & Innovation Sub-Committee Terms of Reference
Appendix 2	Strategic Development Committee Terms of Reference
Appendix 3	Charitable Funds Committee Terms of Reference

1. SITUATION

1.1 Velindre University National Health Service Trust is a statutory body that came into existence on 1st December 1993 under the Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838), as amended, "the Establishment Order".

1.2 Velindre University NHS Trust has a duty under Regulation 19(2) of the National Health Service Trusts (Membership and Procedure) Regulations 1990 to make Standing Orders for the regulation of their proceedings and business. It is important to note that the Trust is able to vary or suspend its own Standing Orders, providing that it is able to satisfy that it complies with the relevant regulations.

2. BACKGROUND

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

2.2 All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

3. ASSESSMENT

3.1 The purpose of this report is to outline the required changes to Schedule 3 of the Trust Standing Orders, resulting from the Annual Review of the Terms of Reference and Operating Arrangements in respect of the:

- Research, Development & Innovation Sub-Committee ***(Appendix 1)***.
- Strategic Development Committee ***(Appendix 2)***.
- Charitable Funds Committee ***(Appendix 3)***.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The amendments detailed in this report have been formally received and **ENDORSED** for Board **APPROVAL** by the Research, Development and Innovation Sub-Committee, the Strategic Development Committee and the Charitable Funds Committee.

4.2 **Tables 1 and 2** provide a high level summary of the key changes to the Research, Development and Innovation Sub-Committee and Strategic Development Committee Terms of Reference respectively.

Table 1: Research, Development & Innovation Sub-Committee

Terms of Reference & Operating Arrangements	Summary of Amendments
Research, Development & Innovation Sub-Committee	**3.2 Strategy & Policy Approval** Amendment to the following bullet point: • Scrutinise RD&I Business cases for any legal and / or ethical implications that need to be considered, ***accessed or financed. Ensure*** alignment of business cases with the Trust overarching ten-year strategy 'Destination 2033' including the benefit / impact it will make for patients / donors / staff and service users. The Committee is also supported by the Advancing Radiotherapy Fund (ARF) ***/ Advancing Radiotherapy Cymru (ARC) Programme Boards in scrutinising radiotherapy-based business case proposals and will assess, review and advise as appropriate.***
	3.3 Monitoring and Review Amendment to the following bullet point regarding assurance: • The diversity of the organisation's patients, service users, donors and staff are valued in the active development of Research, Development and Innovation ***activities*** as appropriate.

	• There is close collaboration with partner ***NHS Wales*** and ***higher education*** organisations to improve quality, promote joint working for best RD&I outcomes and avoid unnecessary duplication of functions. In this respect, the work of RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board. • When research or innovation findings have commercial potential, the Trust takes action to protect ***intellectual property (in accordance with Trust IP/commercialisation policy); and exploit research and innovation*** in collaboration with its Research and Innovation partners and where appropriate commercial Organisations.
	4. Membership *4.1* Members • Amendment to a minimum ***of two*** members
	7. Reporting and Assurance **7.1** The Committee Chair shall - addition to the following bullet point: • Strategic Development Committee Board on strategic development and updates to the RD&I Strategy quarterly **report…** **7.2** The Sub-Committee shall receive - addition to the following bullet point: • A quarterly Highlight Report from the Advancing Radiotherapy Fund (ARF) **and Advancing Radiotherapy Cymru (ARC) Boards on the activity of the programme.**

Table 2: Strategic Development Committee

Terms of Reference & Operating Arrangements	Summary of Amendments
Strategic Development Committee	**2 Purpose** **2.1** Addition of the following bullet points:

Terms of Reference & Operating Arrangements	Summary of Amendments
	• Strategic Workforce • Strategic Capital **3 Delegated Powers and Authority** 3.1 Addition of the following bullet point: • Review Strategic workforce plans to ensure alignment with service requirements.

4.3 Charitable Funds Committee

The Trust Board on 26th March 2024 requested the report be withdrawn and further content be added to the cover paper to include reference to the addition of the Advancing Radiotherapy Cymru (ARC) Programme Board in the updated Terms of Reference. The Board requested the Terms of Reference for the Advancing Radiotherapy Cymru (ARC) Programme Board be included as an appendix.

The Charitable Funds Committee Terms of Reference (ToR) have been updated from the extant version. Trust Board members are asked to review and provide comments or recommended changes prior to approval.

The key changes to the ToR are summarised below:

- **Section 5.4 Sub Committees**

  The inclusion of the establishment of the Advancing Radiotherapy Cymru (ARC) Academy 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 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.

- **Section 12.1 Chair's Urgent Action**

  The Membership of the Charitable Funds Committee is different to all other Sub-Committees of the Board whose Members are only made up of Independent Members, in that its Members include two Executive Directors. Therefore, the requirement that the Committee Chair may deal with an urgent out of committee decision by first consulting with two other "Independent Members" is not possible, as there are only two Independent Members on the Charitable Funds Committee. Proposed to change requirement to:

  '… after first consulting with two other Members of the Committee.'

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no socio-economic impacts linked directly to the activity outlined in this report.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
	There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	*There is no direct impact on resources as a result of the activity outlined in this report.*
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is essential that the Trust complies with its standing orders.

6. RISKS

The Trust's governance structure aims to identify issues early to prevent escalations and the Committee integrates into the overall Board arrangements.

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No**

Research, Development & Innovation (RD&I) Sub-Committee

Terms of Reference & Operating Arrangements

Reviewed:	29/04/2024
Approved:	
Next Review Due:	May 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 The Quality, Safety & Performance Committee, Strategic Development Committee and Charitable Funds Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare, strategic and organisational development and to make and monitor arrangements for the control and management of the Trust's charitable funds.

1.3 As part of the aforementioned Committee functions, the **Research, Development & Innovation (RD&I) Sub-Committee** has been established to act as the "front door" for all RD&I business at Board level and will perform the following functions on their behalf:

- oversee and maintains oversight of the RD&I Strategy on behalf of the Strategic Development Committee.
- oversee the development of an annual implementation plan that operationalises the Strategy and monitor the Division's performance and delivery on behalf of the Quality, Safety & Performance Committee.
- review and approve business cases for alignment with strategy and funding on behalf of the Charitable Funds Committee.

1.4 Research, Development and Innovation are defined as follows:

- **Research and Development**, from a healthcare perspective - refers to systematic investigation and study to generate new knowledge and insight to drive improved patient care.
- **Innovation**, from a healthcare perspective - refers to the application of original research into new or improved health policies, practices, systems, products and technologies, services or delivery methods for improved patient outcomes.

2. PURPOSE

2.1 The purpose of the RD&I Sub-Committee is to:

- Provide strategy and policy oversight for RD&I activities undertaken by the Trust reporting to the Strategic Development Committee.

- Provide assurance on the performance of RD&I activity reporting to the Quality, Safety & Performance Committee.

- Promote and encourage a RD&I ethos and culture which is integral to the Trusts vision, mission and values including the identification of new and enhanced funding opportunities to grow the significance and reach of the Trust's RDI activities.

- Provide assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the UK Policy Frameworks for Health & Social Care Research as amended from time to time.

- Consider relevant matters with reference to the parameters identified for risk appetite in relation to RD&I as set by the Board.

- The RD&I Sub-Committee is underpinned and informed through the work of a number of Management Groups and Assurance Processes as set out in ***Appendix 1***.

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Board, the Committee will fulfil the following functions:

3.1 Strategy & Policy Development

- Promote and encourage a RD&I ethos and culture within the Trust.

- Oversee the development of all RD&I strategies and implementation plans ensuring the conduct of good quality projects within the Trust's portfolio of RD&I activity.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

- Ensure that matters of strategic development are escalated as appropriate to the Trust Strategic Development Committee and on to Trust Board for assurance and approval as required.

3.2 Strategy & Policy Approval

- Approve policies relevant to the business of the Committee as delegated by the Board.

- Scrutinise RD&I Business cases for any legal and / or ethical implications that need to be considered, accessed or financed. Ensure alignment of business cases with the Trust overarching ten-year strategy ***'Destination 2033'*** including the benefit / impact it will make for patients / donors / staff and service users. The Committee is also supported by the Advancing Radiotherapy Fund (ARF) / Advancing Radiotherapy Cymru (ARC) Programme Boards in scrutinising radiotherapy-based business case proposals and will assess, review and advise as appropriate.

3.3 Monitoring and Review

- The Sub-Committee will, in respect of its assurance role, seek assurance that research governance and innovation arrangements are appropriately designed, implemented and are operating appropriately to ensure the provision of a high-quality RD&I service.

- To achieve this, the Sub-Committee will need assurance that the following aspects of RD&I are being effectively managed:

    - The safety, rights, dignity and wellbeing of participants in Innovation and Research development projects is above all other considerations.

    - There is clear, consistent strategic direction, strong leadership and transparent lines of accountability

    - The diversity of the organisation's patients, service users, donors and staff are valued in the active development of Research, Development and Innovation activities as appropriate.

    - There is close collaboration with partner NHW Wales and higher education organisations to improve quality, promote joint working for best RD&I outcomes and avoid unnecessary duplication of functions. In this respect, the work of RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board.

    - The organisation ensures compliance with appropriate legislation and regulation such as the UK Policy Framework for Health and Social Care Research 2017; the EU Clinical Trials Directive 2004 as amended; Good Laboratory Practice; Good Manufacturing Practice in manufacturing products for clinical trials; and Good Clinical Practice; in the conduct of all clinical Research and Innovation activities as appropriate.

    - Systems are in place to monitor compliance with regulatory requirements of the Trust as well as organisational standards and to investigate complaints and deal with irregular or inappropriate behaviour in the conduct of Research and Innovation activity.

    - Research and Innovation investment and expenditure is accounted for and complies with audit requirements as well as the requirements of external funders or sponsors as appropriate.

    - The Committee will scrutinise research and/or innovation proposals and/or business cases that are seeking charitable funding PRIOR to submission to the Charitable Funds Committee, in order to provide assurance on the quality and safety of RD&I related activity.

    - When research or innovation findings have commercial potential, the Trust takes action to protect intellectual property (in accordance with Trust IP/commercialisation policy); and exploit research and innovation in collaboration with its Research and Innovation partners and where appropriate commercial Organisations.

3.4 **Access**

The Chair of the RD&I Sub-Committee shall have reasonable access to Executive Directors and other relevant senior staff.

4. MEMBERSHIP

Members

4.1 A minimum of two members to include:

Chair — Independent Member of the Board (University) or delegated Independent Board member.

Two Independent Members of the Board.

Attendees

4.2 In attendance

- Executive Director with responsibility for RD&I currently Medical Director
- Executive Director of Finance or nominated officer with RD&I funding responsibilities
- Associate Medical Director with responsibility for R&D
- Clinical Director (or Nominated Deputy) – Velindre Cancer Centre
- Executive Director of Nursing AHP and Health Sciences
- Director of Corporate Governance
- Trust Head of Innovation
- Head of Velindre Cancer Research Strategy
- Trust Head of Research & Development
- Research Delivery Manager
- Research, Development and Innovation Finance Business Partner
- Representative - Velindre Cancer Centre Strategic Leadership Team
- Representative – Welsh Blood Service SMT Lead for RD&I
- Representative – Welsh Blood Service Lead Clinician for RD&I
- WBS RD&I Facilitation Lead
- Service User/Lay Representatives

4.3 **By invitation**

The Sub-Committee Chair may extend invitations as required to the following:

- Head of Information Governance (in advisory capacity)
- Divisional Directors
- Representatives of stakeholder organisations

As well as others internal or external to the Organisation who the Sub-Committee consider should be in attendance, taking account of the matters under consideration at each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

4.6 Support to Committee Members

The Director of Corporate Governance on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

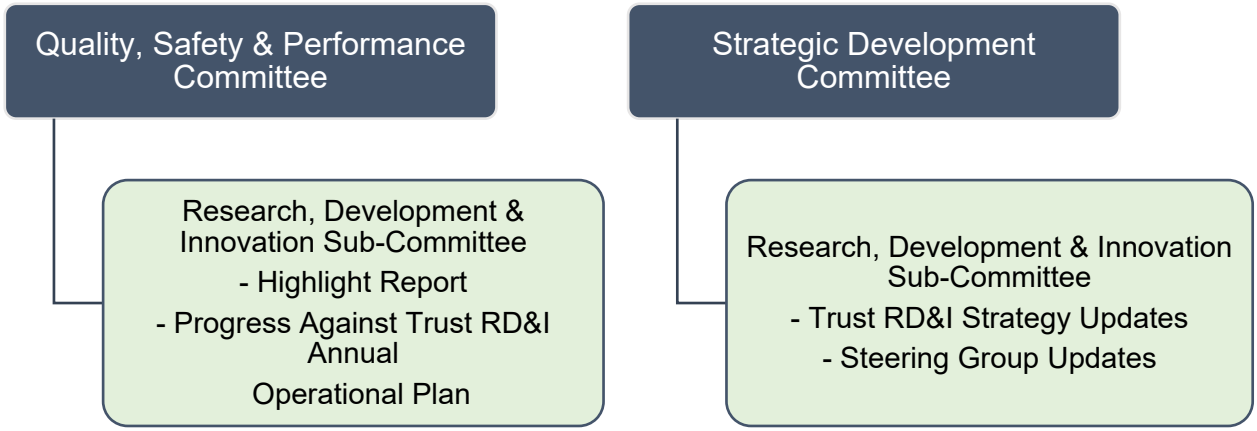
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. SUB-COMMITTEE MEETINGS

5.1 The Committee has, with approval of the Trust Board, established the:

- Research, Development & Innovation Sub-Committee

The Sub-Committee will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as follows :



Although the Research, Development & Innovation Sub-Committee, is a sub-committee with dual reporting lines, it will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee is also accountable to the Trust Charitable Funds Committee in relation to ensuring business cases are aligned with RD&I strategy and Trust's strategic objectives. Further details are set out in each of the respective Terms of Reference. In addition, the wider governance and accountability reporting arrangements in place at a divisional level that feed upwards into the RD&I Sub-Committee structure are also summarised at **Appendix 1.**

5.1 Quorum

At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair. If the Chair is not present an agreement as to who will Chair from the Independent Members in their absence.

5.2 **Frequency of Meetings**

Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business.

5.3 **Withdrawal of individuals in attendance**

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Sub-Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.

6.2 The Sub-Committee is directly accountable to the Quality, Safety and Performance Committee, Strategic Development Committee and Charitable Funds Committee for its performance in exercising the functions set out in these terms of reference.

6.3 The Sub-Committee shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

Report formally, to the:

i. Quality, Safety & Performance Committee on the performance and delivery of RD&I quarterly.
ii. Strategic Development Committee on strategic development and updates to the RD&I Strategy quarterly report and
iii. Charitable Funds Committee to recommend for approval business cases aligned with the RD&I Strategy and Trust's overarching strategic objectives.

7.2 The Sub-Committee shall receive:

i. A briefing from the Executive Medical Director with responsibility for RD&I
ii. A quarterly RD&I Integrated Performance Report (following presentation at EMB)
iii. A quarterly Highlight Report from the Advancing Radiotherapy Fund (ARF) and Advancing Radiotherapy Cymru (ARC) Boards on the activity of the programme.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Sub-Committee.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee with reference to the Board.

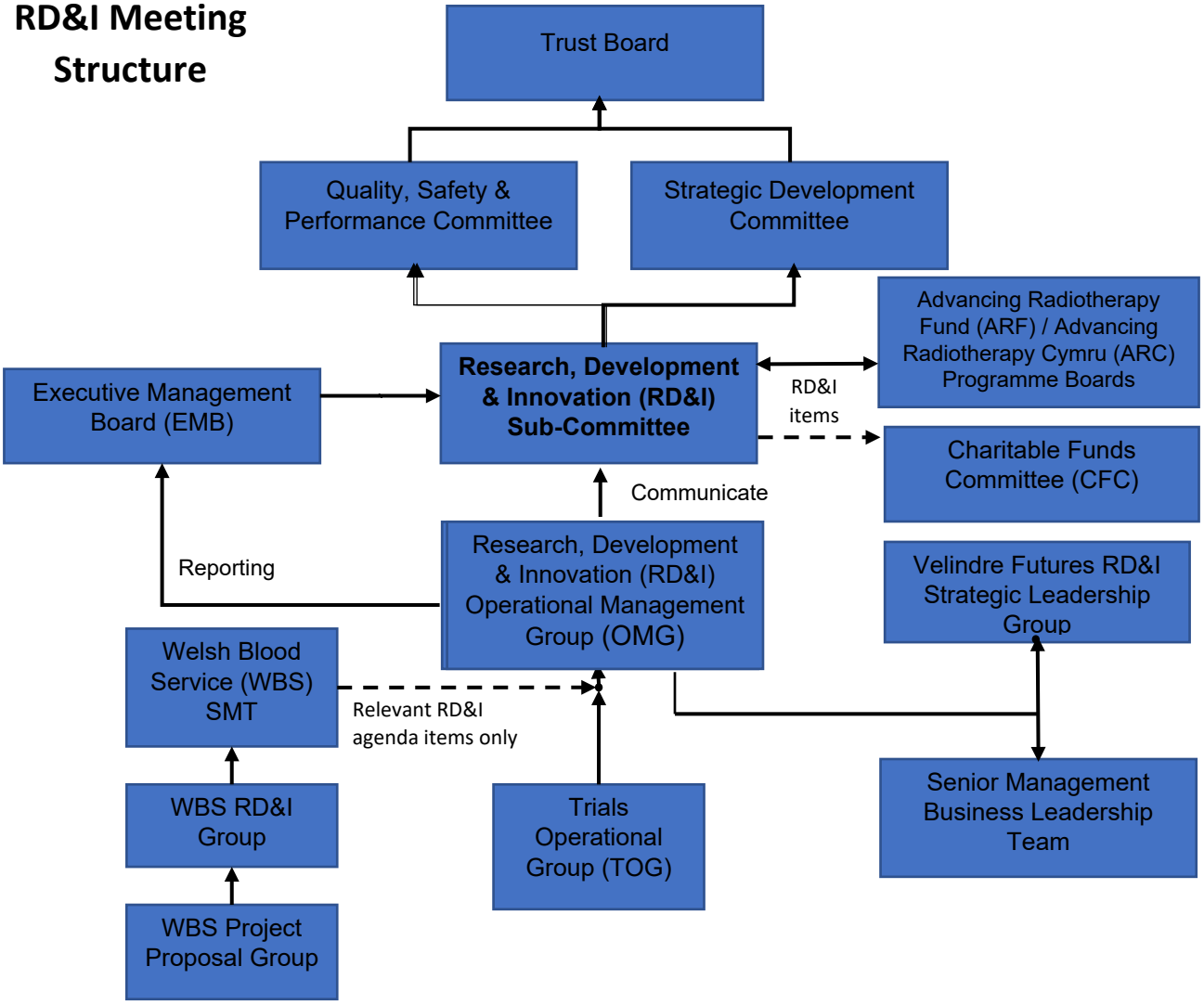
10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which would normally be made by the Sub-Committee need to be taken between scheduled meetings. In these circumstances, the Sub-Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Sub-Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Sub-Committee for consideration and ratification.

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

APPENDIX 1

RD&I Meeting Structure



Strategic Development Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2024
Approved:	
Next Review Due:	May 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 line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Strategic Development Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Strategic Development Committee "the Committee" is to provide:

- Evidence based and timely **advice** to the Board to assist it in discharging its functions and responsibilities with regard to the:
  - Strategic direction
  - Strategic planning and related matters
  - Strategic Workforce
  - Strategic Capital
  - Organisational development
  - Digital services, estates and other enabler services
  - Sustainable development and the implementation of strategy through the spirit and intention of the well-being of future generations act
  - Investment in accordance with Value-based healthcare

- **Assurance** to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board on strategic direction and organisational development, the Committee will:

- Oversee the development of the Trust's strategies and plans which set out how plans the delivery of high quality and safe services, consistent with the

Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

- Review Strategic workforce plans to ensure alignment with service requirements.

- Regularly review whether the Trust is developing a strategic approach, which provides it with the greatest opportunity to fulfil its duties under the Well-being of Future Generations (Wales) Act 2015 by means of the application of the Act's Sustainable Development Principle.

- Review the arrangements and contents of key plans to ensure alignment with the Trusts strategic goals and objectives, including the Trust's Integrated Medium-Term Plan (IMTP) in accordance with above.

- Review the Trust's Capital Plan to ensure alignment with key Trust strategies, plans (IMTP) and sustainable development principles.

- Review Trust developments involving significant investment or modernisation.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

3.2 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is clear, consistent strategic direction, strong leadership and transparent lines of accountability.

Authority

3.3 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committees remit and ensuring patient/service user, client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- Employee (and all employees and directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee, or group set up by the Board to assist it in the delivery of its functions.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

- To approve policies relevant to the business of the Committee as delegated by the Board.

Access

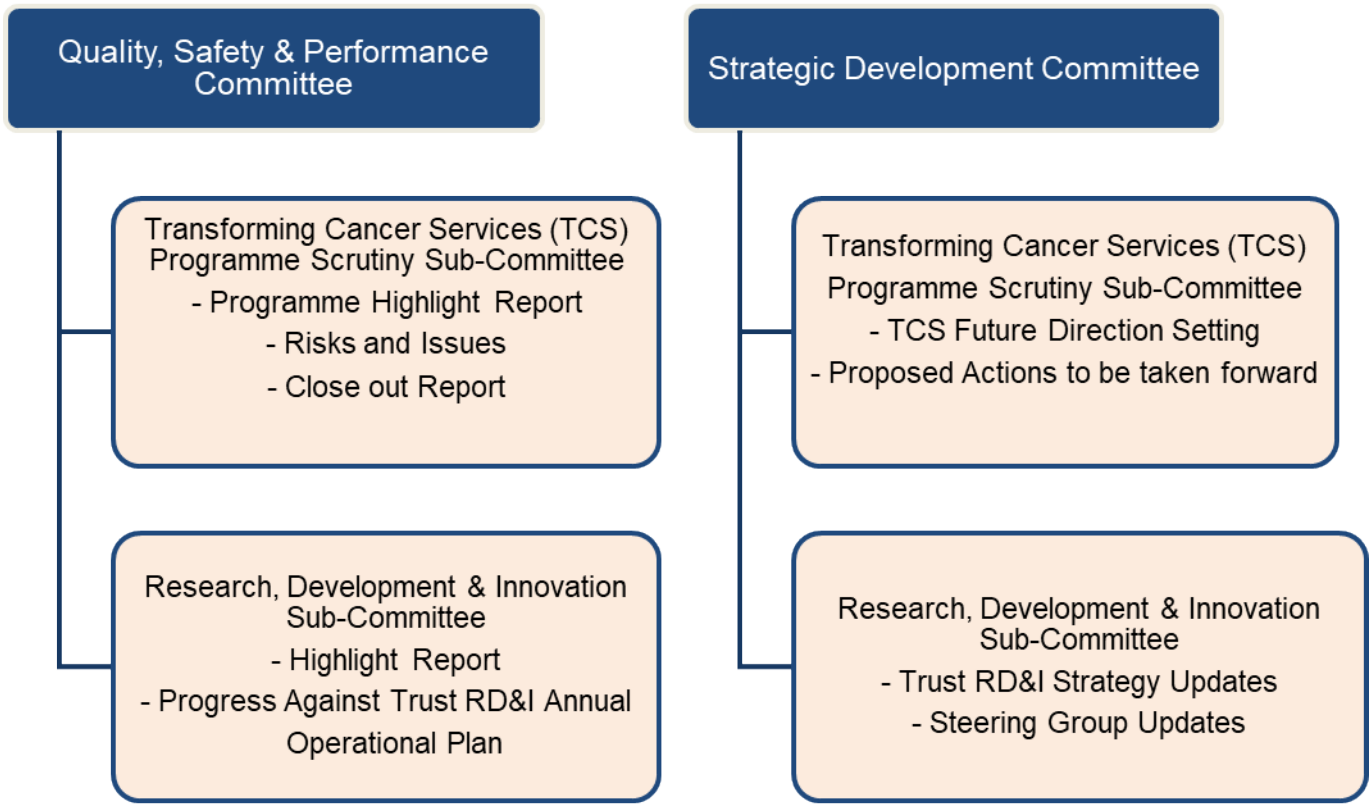
3.4 The Chair of the Strategic Development Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee:



Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-

committees with dual reporting lines, they will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4. MEMBERSHIP

4.1 **Members**

A minimum of two (2) members comprising:

Chair Independent member of the Board (Non-Executive Director)

One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.2 **Attendees:**

- Chief Executive Officer
- Director of Strategic, Transformation, Planning & Digital
- Executive Director of Nursing, Allied Health Professionals and Health Scientists
- Executive Medical Director
- Chief Operating Officer
- Divisional Directors
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Commercial and Strategic Partnerships
- Chief Digital Officer

The Committee welcomes attendance at Committee meetings by staff from within the organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Llais (Citizens Voice Body)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.3 **Secretariat**

As determined by the Director of Corporate Governance and Chief of Staff.

4.4 **Member Appointments**

The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

4.5 **Support to Committee Members**

The Director of Corporate Governance and Chief of Staff on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

5.1 **Quorum**

At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the Independent Members in their absence.

5.2 **Frequency of Meetings**

Meetings shall be held bi-monthly, consistent with the Trust's annual plan of Board Business.

5.3 **Withdrawal of individuals in attendance**

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS

COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its staff, patients, donors and citizens through the effective governance of the Organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5 The Committee shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written Highlight Reports.

- Bring to the Board's and the Accountable Officer's specific attention any significant matters under consideration by the Committee; and

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or the reputation of the Trust.

7.2 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

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

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2024
Approved:	
Next Review due:	March 2025

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1. INTRODUCTION

1.1 The Trust's Standing Orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In 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**

Charitable Funds Investment Performance Review Sub Committee

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

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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.

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Research, Development & Innovation Sub-Committee

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.

Advancing Radiotherapy Fund (ARF) Programme Board

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.

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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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Advancing Radiotherapy Cymru (ARC) Academy

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.

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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 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.

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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.

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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.

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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
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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.

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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:

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- 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.
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- 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**

Charitable Funds Investment Performance Review Sub Committee

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.

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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:

- 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

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.

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.

Advancing Radiotherapy Cymru Academy Board

Terms of Reference

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Date of Approval:
Date of Review:

ARC Academy Summary	Advancing Radiotherapy Cymru (ARC) is 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 programmes overarching purpose is to improve outcomes for cancer 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 is underpinned by financial contributions made by The Moondance Foundation and Velindre University NHS Trust (VUNHST) Charitable Funds Committee (CFC), totalling £3 million across a five-year period (£300,000 per annum from each organisation commencing in 2023). Financial contribution is also anticipated from the South West Wales Cancer Centre (SWWCC) and The North Wales Cancer Treatment Centre (NWCTC). ARC will prioritise, but not limit its activity to, the following key areas: • Supporting innovation within radiotherapy treatment, delivering improvement to treatments and service benefitting patients across Wales. • Training the multi-disciplinary radiotherapy workforce across Wales, supporting service developments within the radiotherapy treatment pathway across Wales. • Supporting clinically focused radiotherapy research projects. • Expanding patient access to the SABR service. • Expanding the stereotactic radiosurgery service.
ARC Academy Board Responsibilities	The ARC fund will be overseen by a multidisciplinary Programme Board. 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 and any

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	subsequent funding. The ARC Programme Board has been established by Velindre University NHS Trust's Charitable Funds Committee, in order to govern and manage the fund, that will be used to improve outcomes for cancer patients in Wales, reducing variation and inequalities in provision. The ARC Programme Board will assure, advise and scrutinise all aspects of programme activity and expenditure, ensuring that funding is allocated appropriately to ensure delivery of the aims of the ARC Academy on behalf of the Charitable Funds Committee. 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 Terms of Reference, as part of good governance arrangements. The ARC 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 Board will consider funding applications from partners across Wales that align within one or more of the key areas of work (listed above in the ARC Academy Summary) of the above listed areas. All applications will go through a process of required governance and scrutiny prior to ARC Board consideration. The Board will: - Receive and consider applications for new projects, evaluate their eligibility based on established criteria. - Consider and authorise where appropriate, deviations from agreed project objectives and facilitate escalation where required. Receive and scrutinise budget / spend profiles. - Identify key interdependencies within and between the projects and other key VUNHST or partner projects and programmes, providing strategic direction and clear impact assessment of arising priority conflicts.

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	- Ensure the project team develop a robust communication / engagement plan with key stakeholders, ensuring its successful delivery. - Review risks associated with the projects via a risk log, providing timely mitigations and controls. - Receive milestone reports at touchpoints from project leads / teams including approving end of project reports and lessons learned reports. - Monitor performance reports. - Obtain assurance of external or ethical review of project proposals when required. - Approve end of project reports. including lessons learned reports. - Resolving deviations from plans or escalating as necessary. - Ensuring the programme strives for an all-Wales approach. - Strive to provide equitable distribution of funding to support projects, both on a geographical basis and across the key areas identified above. - Making recommendations for adjustments or changes in funding allocation as needed. - Ensuring compliance with relevant laws and regulations. - Ensure active engagement with the three relevant health organisations: SBUHB; BCUHB; & VUNHST. The Board will work to actively promote the ambitions and activities of the ARC to support further fundraising / financial opportunities. The Terms of Reference and Board membership are to be reviewed should the ARC be in receipt of further financial awards. Applications for less than £5,000 can be reviewed and approved independently of the ARC Board by the ARC Clinical Lead as appropriate, if aligned to the key objectives of ARC. A log of these is to be maintained and brought to the Board so that all interdependencies and alignments can be managed. 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

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	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.
Accountable to	The ARC Board are accountable to Velindre University NHS Trust Charitable Funds Committee submitting quarterly progress / highlight reports or as requested. In addition, anannual report will be required by VUNHST Charitable Funds Committee, or as requested, in line with the funding agreement.
Informs	The ARC Board will provide information to a range of stakeholders including: - Advancing Radiotherapy Fund - Senior Leadership Team of relevant health trusts / boards - The Moondance Foundation - RD&I or similar in associated health organisations - Other stakeholders as deemed appropriate.
ARC Board Membership	The ARC Board will consist of the following core members who will be jointly responsible in assuring the delivery of programme ambitions: Chair / Independent Member, VUNHST Deputy Chair / Executive Director of Finance, VUNHST Medical Director, VUNHST ARC Clinical Lead, VCC VUNHST Chair Southwest Wales Cancer Centre Clinical Representative Betsi Cadwaladr University Health Board Clinical Representative Betsi Cadwaladr University Health Board Radiotherapy Representative The Moondance Foundation Representative Clinical Director, Wales Cancer Network Clinical Oncology Subcommittee (COSC)

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	Representative Head of Radiation Services, VCC Head of Innovation, VCC HEIW Representative At least two Board members must be present to ensure the quoracy of the Board. Of the two, one must be an Independent Member and one must be a VUNHST Director or a Nominated Representative. In the event a Board member is unable to attend, a Nominated Representative can be sent in their place by agreement of the Chair.
Meeting Frequency	The ARC Board will meet on four monthly a basis / three times a year. The Chair may request a meeting at any time, provided that suitable notice is given to Board members to ensure a quorate meeting.
ARC Academy / Board Administration	Project and administrative support for ARC will be hosted by VCC. The ARC administrative / project support will be responsible for ensuring accurate and efficient organisation and support of the ARC Board meetings. This will be supported by the ARC Clinical Lead. The administrative / project roles will provide ad-hoc support to the ARC Board members as required to support the delivery of the ARC Academy objectives. The agenda and associated papers for ARC Board meetings shall be issued no less than five working days before the Board convene. ARC Board meeting and submission dates for agenda items will be circulated to stakeholders in advance. Papers submitted after such dates will be accepted pending the Chair / Deputy Chairs' agreement. Minutes of all meetings will be formally recorded by the administrative / project roles, verified by the Chair / Deputy Chair and submitted for approval at the next meeting. Documentation will include but not be limited to:

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	- Risk register - Action log - Financial report - Highlight report

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TRUST BOARD

TRUST QUALITY & SAFETY FRAMEWORK & QUALITY PRIORITIES UPDATE

DATE OF MEETING	23rd May 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	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	The Trust Board approved the Quality & Safety Framework in July 2022. The plan was to review the framework by March 2024 to reflect the requirements of the Duty of Quality and that this would be informed by an external peer review. A peer review was undertaken by the Quality and Safety Lead at Hywel Dda University Health Board to inform this review. Key changes made to the framework are: • Inclusion of the approved Quality Management System • Inclusion of the Duty of Quality and Duty of Candour

	• Feedback from the peer review included defining your reader (employees), so wording amended to us and we, in the framework to reflect the audience • Enhanced alignment with other newly developed Learning and Incident Management Frameworks. • Inclusion of revised governance reporting structures.

RECOMMENDATION / ACTIONS	To **APPROVE** the revised Trust Quality and Safety Framework.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Committee	25/03/24
Request to send to both divisional leadership teams for comment.	
Executive Management Board (Endorsed for Approval)	02/04/24
Quality, Safety & Performance Committee (Endorsed for Approval)	09/05/24

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	N/A

APPENDICES	
Appendix 1	Quality and Safety Framework

1. BACKGROUND

The Trust Board approved the Quality & Safety Framework in July 2022. The Quality Framework was refreshed in March 2024, to reflect the requirements of the Duty of Quality and the outcome of the Quality & Safety Lead at Hywel Dda University Health Board.

2. FEEDBACK FROM THE PEER REVIEW

The feedback from the external review quality and safety framework peer review is summarized below:

- Be clear on your intended reader,
- Reorder some sections for easier reading.

- Improve the document flow.

3. QUALITY & SAFETY FRAMEWORK REFRESH

Changes made to the Trust Quality & Safety Framework during this review include:

- Inclusion of the approved Quality Management System
- Inclusion of the Duty of Quality and Duty of Candour
- Feedback from the peer review included defining your reader (employees), so wording amended to us and we, in the framework to reflect the audience
- Enhanced alignment with other newly developed Learning and Incident Management Frameworks.
- Inclusion of revised governance reporting structures
- Reordering framework in line with peer review feedback to improve readability and flow.

Following approval of the refreshed Quality and Safety Framework, it will be sent to the publisher for visual enhancement of the document.

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*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	The Quality Framework is an enabler for the delivery of the 6 domains of quality and the 6 enablers
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty- overview*	Not required
	Update report
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
	There are significant financial implications on the Trust if this framework is not implemented as it will increase the likelihood of patient harm which has associated costs
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 equality impact assessment not required on the framework refresh and no changes would have any impact on protected characteristics.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	The Duty of Quality is a legislative requirements implementation of which will be enhanced through this revised framework

Foreword

Velindre University NHS Trust provides specialist non-surgical cancer (Velindre Cancer Service), blood and transplantation services (Welsh Blood Service) and is the host organisation for Health Technology Wales and NHS Wales Shared Services Partnership. As a Trust we are highly motivated, and work tirelessly to provide high quality, responsive services to patients and donors. Our research is world class, and many of our clinicians and scientists are leaders in their field with international reputations.

As a Trust we are committed to achieving the vision clearly articulated in the Welsh Governments long term plan 'A Healthier Wales' which aims to develop a 'whole system approach to health and social care' which is focused on health, wellbeing, and the prevention of physical and mental illness. Every day in the NHS more than a million people are treated safely and successfully, however with the continuous advances in technology and knowledge, the healthcare system has become extremely complex and challenging. This complexity brings risks, with evidence showing that despite the level of staff dedication, skill and expertise at times things will and do go wrong, which can potentially cause harm to our patients and donors. Such incidents can have devastating emotional and physical impact upon patients, donors, their families, and the staff involved. Safety incidents also incur costs through litigation and extra treatment. However, as an organisation we are committed to making sure that when things do go wrong, we respond with transparency, openness, listening, learning and continuous improvement to prevent such situations re-occurring in the future.

Strategic Background

There is a considerable amount of legislation, national frameworks and best practice guidance documents that have been used to support the development of this Framework, (appendix 1) which include the Health and Social Care (Quality and Engagement) (Wales) Act (2020). The purpose of the Act is to ensure NHS bodies secure improvements in the quality of services they provide, to enable the achievement of ever- higher standards of person-centred care in Wales through the achievement of 4 key objectives to:

- Greatly strengthen the existing duty of quality on NHS bodies and extend this to Welsh Ministers (in relation to their health service functions).
- Institute a duty of candour which requires NHS bodies to be open, honest, and transparent with patients and service users (including donors) as soon as they are aware that things have gone wrong, or may have gone wrong, with their care or treatment.
- Strengthen the voice of citizens, by replacing Community Health Councils with a new, all-Wales Citizen Voice Body 'LLais' who represent the views and interests of people across the health and social care systems.
- Enable the appointment of vice chairs for NHS Trusts.

To ensure we meet our statutory and regulatory responsibilities This framework has been aligned with the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act, the Welsh Government long term plan 'A Healthier Wales' (2018), the Health and Social Care and Quality and Safety Framework (2021) 'Learning and Improving together'.

The framework aims to provide a strong foundation and structured approach to ensure every level of our organisation functions as an effective quality management system, ensuring the care and services we provide are high quality, consistent, person focused and aligned with the needs of the population we serve. To achieve this the framework has been developed in line with the six domains of quality (safe, timely, effective, efficient, equitable and person centred) and six quality enablers (leadership, workforce, culture, information, learning and improvement and whole systems approach) in line with the requirements of the Duty of Quality (Wales) (2023).



What is Quality?

Quality in healthcare is far more than simply meeting service standards. Quality in healthcare relates to both the effectiveness and safety of services provided, and the experience of those who have accessed services. As a Trust we are passionate that high quality care and services are provided and the needs of the population we serve are met. Key to our success is an ability to clearly understand and communicate 'what good looks like', the ability to measure our performance against these standards, the establishment of robust feedback and learning systems which enable us to continually learn and improve to ensure the services we provide are of high quality, achieve value and are fit for the future needs of our population.

Our Quality and Safety Vision

Our Quality and Safety Vision is for quality, patient / donor safety and experience to be firmly at the heart of everything we do, within every decision we make, enabling the active involvement of both the people who receive care / services and those who provide it, whilst placing a relentless focus on learning and improvement.'

For this vision to be successfully realised, enabling a just safety culture and compassionate leadership approaches are fundamental. To nurture this, we have aligned our organisational values and behaviours 'Caring, Respectful and Accountable', and organisational strategy 'Destination 2033' to support and enable the achievement of our Quality and Safety vision.



Quality and Safety is explicit within our organisational strategy 'Destination 2033' and this framework is recognised as a key enabler for achievement of goals 1 and 2:



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 the experiences patients and donors have 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 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 ensuring 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:

An Internationally Renowned Provider of Exceptional Clinical Services That Always Meet and Routinely Exceed Expectations



Our objectives are to:

- Achieve nationally 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 the needs of the public
- 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, and citizen engagement strategy to continuously hear what people need and what they value from our services
- Co-designing models of care in partnership with people from all parts of the community, with the aim of 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 donor 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 areas

Framework aims

This framework is developed to support the Trust in delivering its Quality and Safety vision and to meet its responsibilities in relation to the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the NHS Wales Quality & Safety Framework: Learning & 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
- Provide a structure within which Corporate Services, Divisions, Departments and teams can:

1. Engage and actively listen to donors, patients, their families, staff and other key stakeholders to improve experience, outcomes and therefore efficiency
2. 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
3. Promote a quality and patient / donor safety focused culture in all aspects of care delivery they are responsible for and beyond
4. 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
5. Be sufficiently aware of potential risks to quality in delivery of safe and effective care
6. Demonstrate effective processes for escalating, investigating, managing and reporting on concerns about quality and patient / donor safety
7. Use triangulated data to drive quality improvement, ensuring issues of equity are also identified and where appropriate addressed

This framework will use the six domains of Quality as defined by the Institute of Medicine (1999) as its core delivery mechanism:



1. **Safe:** Avoiding harm to patients / donors from the care / services intended to help them
2. **Effective:** Providing services based on scientific and evidence based knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively)
3. **Patient / donor centred:** Providing care that is respectful of and responsive to individual patient / donor preferences, needs, and values and ensuring that patient values guide all clinical decisions
4. **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care / services
5. **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy
6. **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

Roles and responsibilities

Quality and Safety is everybody's business, and if we are to successfully realise our quality and safety vision and objectives the whole workforce needs to be engaged in and recognise the importance of continuous learning and improvement, and understand their roles, responsibilities, and impact in providing safe, timely, effective, efficient, equitable and person-centred care. To support this, we have outlined key roles and responsibilities of all individuals across the organisation:

Individual Members of Staff

As members of staff you are excepted at all times to put quality, patient /donor safety and experience, learning and improvement at the heart of everything you do and every decisions you make, ensuring that you work within the Trusts values and behaviours (Caring, Respectful, Accountable) , regulatory Codes of Conduct, legislation i.e. Putting Things Right Regulations, and the Health and Social Care (Quality and Engagement) (Wales) Act (2020), relevant policies, procedures and guidelines, practicing within known evidence base, reporting any incidents, near misses, issues or concerns, and engagement and involvement in auditing and reviewing practices with a commitment to taking every opportunity to learn and improve both individually and within the team you work.

Managers and Clinical Leaders
Managers and clinical leaders are responsible for creating and enabling a positive patient / donor centred quality and safety culture within all areas of responsibility, enabling staff feel safe to speak up, report errors and issues whilst being nurtured to grow, develop, learn, and improve. This responsibility also includes ensuring our Trusts values and behaviours are met and practiced by all; sufficient fully trained and competent staff; quality and safety is owned.
Managers and clinical leaders are responsible for ensuring that 'what good looks like' within areas of responsibility is clearly described, known by all, and regularly reviewed in line with evidence based / best practice; and assessed through the development and reporting of a variety of Patient Reported Outcome Measures, Patient Reported Experience Measures and quality metrics that are used to improve services; escalate concerns; celebrate good practice; ensure regulatory and legislative requirements are met; and ensure compliance with policies, procedures and guidelines are complied with.

Divisional Senior Leadership Teams

Securing senior management commitment to quality and patient / donor safety is fundamental to the success of any organisation. Senior leaders are responsible for ensuring service learning and improvement are expressed through robust planning, resource allocation and the establishment and operation of a robust quality and safety governance frameworks and delivery structures. These responsibilities include: ensuring via clinical / non-clinical teams the delivery of high quality, safe service; ensuring service delivery areas commit the resources (staff, time, knowledge, skills, expertise, services, data, and equipment) necessary to meet its obligations; robust workforce planning; continuous quality improvement based on triangulated data; ensuring the support and interventions offered through education, training, learning and organisational development initiatives are readily available to individuals and teams to support improvement and build resilience. Divisional Directors and their teams are fully expected to fulfil the requirements of Putting Things Right Regulations, the Health and Social Care (Quality and Engagement) (Wales) Act (2020) and NHS Wales Quality and Safety Framework (2021) 'Learning and Improving together', in relation to being open, transparent, and embracing the duty of candour.

Executive Directors and Corporate Directors

Executive and Corporate Directors are collectively responsible for ensuring the Trust delivers its objectives safely, effectively, and efficiently in line with national and legislative requirements, which includes setting the strategic direction for areas of responsibilities and ensuring appropriate policies, procedures and guidelines are in place and followed. Specific leadership roles include:

Chief Executive Officer is the Accountable officer for the Trust and has overall responsibility for all areas of the Trust and the services it provides. Within our Trust the Chief Executive Officer has delegated the following responsibilities in respect of this framework to the following individuals:

Executive Director of Nursing, Allied Health Professionals and Healthcare Science.
Responsibility for the overall strategic direction and policy implementation in relation to Putting Things Right, the Health and Social Care (Quality and Engagement) (Wales) Act (2020), Patient and Donor Experience, Infection Prevention & Control, safeguarding and public protection, and for ensuring professional and regulatory standards for Nurses, AHP's & Healthcare Scientists are in place and followed.

Executive Medical Director.
Responsibility for clinical effectiveness, audit, Research and Development, Medicines Regulations and Safety, Ionising Radiation (Medical Exposure) Regulations (IRMER) and ensuring professional and regulatory standards for Pharmacists and Medical Staff are in place and followed.

Executive Director of Finance.
Responsibility for Value Based Health Care and to ensure that resources within the trust are used to best effect to enable compliance with legislative requirements e.g., the Nurse Staffing Levels (Wales) Act 2016, along with the resource allocation for the provision of safe care, services, and treatment to all cared for by the Trust.

Executive Director of Organisational Development and Workforce.
Responsibility for workforce planning and development, and for developing a sustainable workforce to deliver quality and patient safety.

Director of Strategic Transformation, Planning & Digital. Ionising Radiation (Medical
Responsibility for ensuring strategic planning is predicated upon quality and patient & donor safety, and that the measurement of performance is based on quality, safety, Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) and that the Trust is fully digitally optimised to deliver its quality and safety responsibilities and functions.

Director of Corporate Governance.
Responsibility for ensuring effective governance arrangements are in place including the development and delivery of the Trust Assurance Framework, effective Trust Communications and ensuring effective and agile service to board risk management systems and processes are in place.

Chief Operating Officer.
Responsibility for ensuring the delivery of safe and effective operational services across both Velindre Cancer Service and the Welsh Blood Service.

Trust Board.

The Trust Board is responsible for strategy, culture, and assurance. Based upon this the Board are therefore responsible for both creating the organisation quality and safety culture and for ensuring there is a robust infrastructure in place to embed

quality, safety, experience, learning and improvement across the whole Trust, and that all staff understand their role in respect of this. Members of the Board are required to scrutinise performance and outcomes related to quality and patient safety. The Board has 'a crucial' role in overseeing the aggregated risk accumulated data across the organisation. The Board is required to make all decisions through a quality lens and ensure the Trust is meeting and discharging its statutory responsibilities. Within the Board there is an identified Independent Member with an active leadership role in overseeing the quality and safety function, but overall responsibility and accountability is that of the Board's via the Board Chair and Chief Executive.

Trust and Divisional Quality, Safety, and Regulatory Teams

Trust and Divisional Quality, safety and regulatory teams have several key roles and responsibilities:

- To assist in identifying organisation / division wide themes and trends generated through hard (performance data) and soft intelligence data, listening to patients / donors, staff, and other stakeholders, and for the provision of triangulated exception reporting to enable the Trust to adopt an integrated risk management approach to cross cutting issues and concerns.
- Ensuring there is learning, and improvement focus in response to incidents, feedback, and concerns.
- To constructively challenge and support others to ensure that quality and safety are embedded in all decision making and at all points of the patient and donor pathway, including through the provision of data that is meaningful, can be triangulated and focusses on the quality metrics most useful to the services being provided.
- To proactively support and enable clinical teams to conduct robust investigations and root cause analysis when things go wrong, and to articulate the learning and quality improvements identified as a result.
- To lead and support the management of complex issues related to Putting Things Right Regulations including National Reportable Incidents, Duty of Candour procedures, incidents, concerns, redress, clinical negligence; the interface with His Majesty's Coroner, the Public Services Ombudsman for Wales, Medical Examiners Service, MHRA, Healthcare Inspectorate Wales and other external regulators.
- To support organisation wide reporting to Senior Leadership Teams, Integrated Quality and Safety Group, Board and its Committees and subgroups related to all quality and patient & donor safety.
- To utilise the findings and recommendations of external reviews, inspections and audits to shape the way in which teams can be supported to deliver high quality, safe care.

Trust Responsibilities.

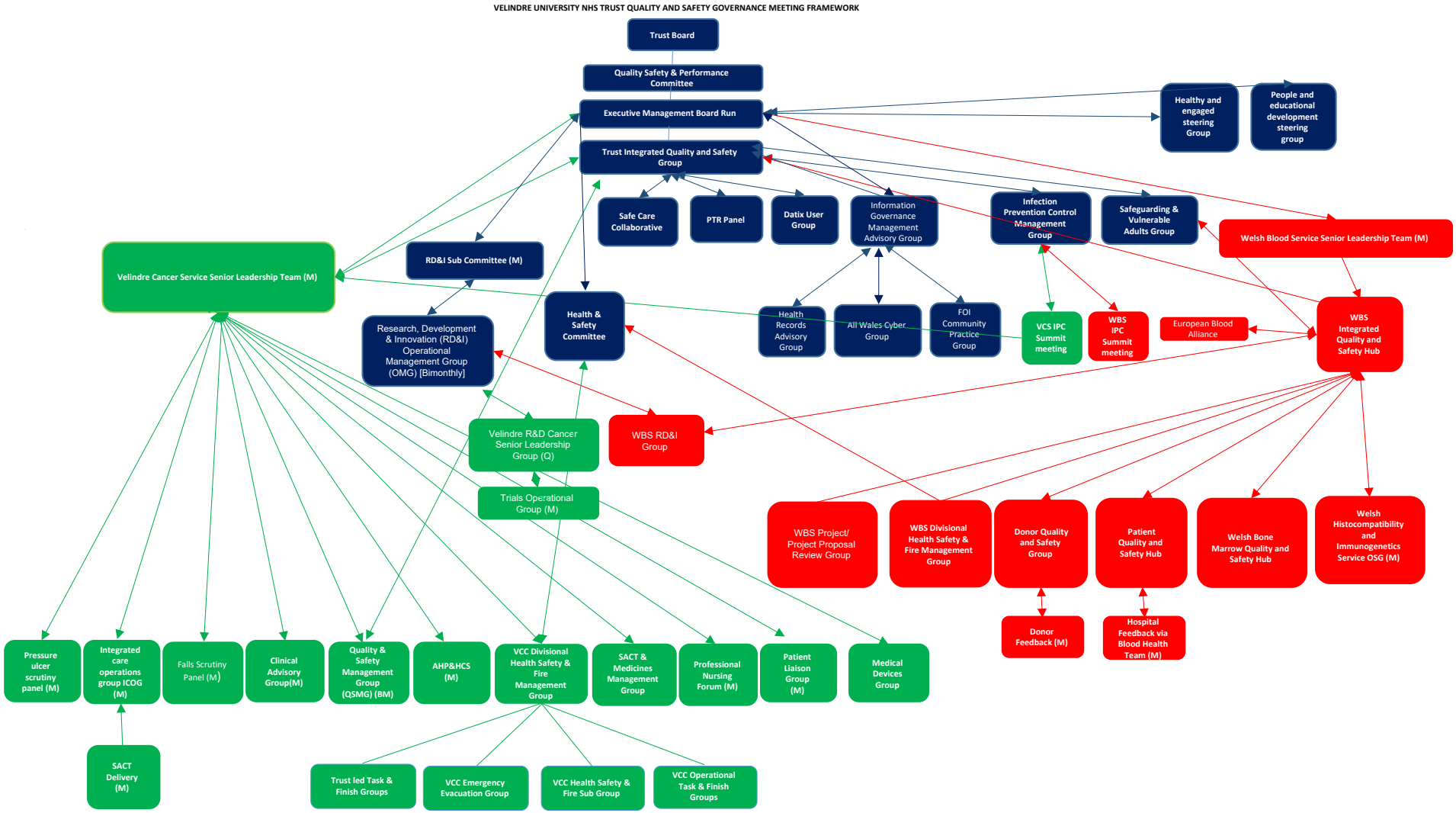
- Defining ‘what good looks like’ for the organisation.
- Ensuring the Trust fully meets and discharges its Quality and Safety legislative, statutory and regulatory responsibilities & legal duties through the development and implementation of Trust wide systems, processes, policies, procedures, strategies, frameworks, infrastructure, training, support, and direction.
- Developing and operating internal and external reporting and assurance mechanisms e.g., Annual Health and Care Quality Standards and Duty of Quality Always on reporting.
- Ensuring and assuring that learning and improvement is addressed and implemented into practice.
- Coordination and oversight external inspections / reviews e.g., Audit Wales, HIW, WRP, HCS reviews etc.
- The provision of support and interventions to ensure the Board can execute its responsibilities, including committee management, work plans and information provision.
- Identification of external learning and its translation into robust actions.
- Ensuring Putting Things Right and Duty of Candour procedures are legally executed.
- Reporting and oversight of National Reportable incidents, Duty of Candour incidents, and never events.
- Infection Prevention and Control, Safeguarding and Public Protection, Information Governance, and clinical audit management & delivery.
- Provision of Trust level triangulated Quality and Safety assurance reporting of divisional activity.

Divisional Responsibilities

- Defining ‘what good looks like’ for the division and its services and the development of associated quality and safety metrics.
- Ensuring Division fully executes its quality, safety, and regulatory compliance responsibilities,
- Ensuring robust learning, assurance, reporting & improvement systems, and mechanisms are in place.
- Management and oversight of local assurance / regulatory reviews / inspections e.g., MHRA
- Implementation of Health and Care Quality Standards
- Development of a psychologically safe and ‘Just safety culture’
- Ensuring staff are appropriately trained.
- Ensuring staff are aware of and work within agreed quality & safety policies, procedures, guidance, and frameworks.
- Ensuring incidents, serious incidents and complaints are robustly reported investigated and managed.
- Ensuring staff are engaged and supported through all investigations.
- Robust divisional mechanisms for the dissemination and sharing of quality, safety, learning outcomes and associated improvements.

- Delivery of a robust meeting, reporting, assurance, and escalation infrastructures.

Quality and Safety Assurance and Meeting Structure



Team Meetings
Individual team meetings involving as many staff as possible should be held at least monthly and include a robust communication mechanism to update individuals not in attendance. The team meetings need to consider all key quality and safety elements at a team level, which should include:

- Quality Metrics.
- Patient/ Donor Outcomes and Feedback.
- Audit Findings.
- Summary of incidents, concerns, and compliments
- Learning and improvement opportunities.
- Feedback from departmental meetings.

With all outputs and discussions being reported into departmental meetings.

Departmental Meetings

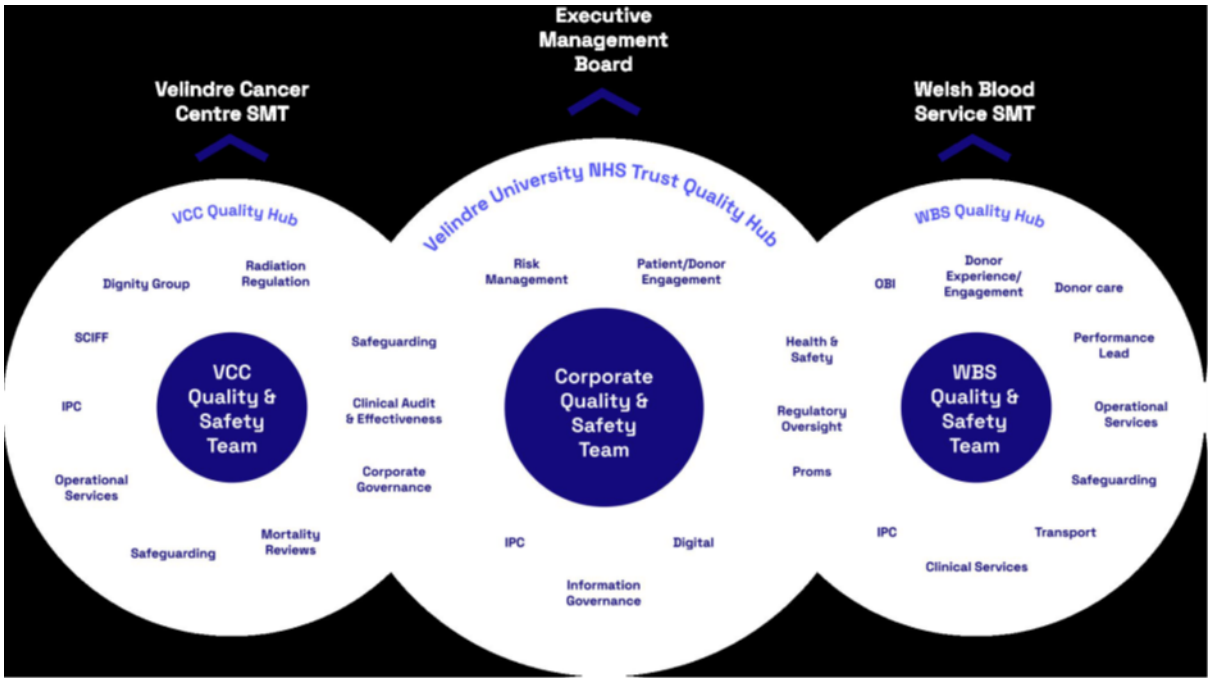
Formal meetings to review performance, outcomes, standards, experience, learning and improvement should be held at least upon a monthly basis, with all relevant service areas being represented. Minimal areas of key focus at these meetings will include:

- Identification of 'what good looks like' for the department through the consideration of clinical and best practice standards.
- Identification and monitoring relevant departmental quality and safety metrics/ performance data, including process, patient / donor outcomes, Datix reports (concerns, compliments, incidents, claims etc), experiential feedback (patient/ donor/staff) & benchmarking.
- Receipt of 'harm' investigation reports.
- Determining and actioning departmental audit plan /priorities aligned to data analysis and review audit outcomes and agree any points of learning and associated improvement actions are identified, disseminated, and addressed through an action planning approach.
- Agreeing and prioritising areas for improvement and development.
- Oversight of relevant workforce metrics (e.g., mandatory, statutory and clinical training, PDAR compliance)
- Agree and review quality & performance priorities.

Divisional Quality and Safety Meetings
Each Division will have a Quality & Safety hub that meets upon a monthly basis and is responsible for the oversight of quality, safety, and experience reporting and assurance. Minimal responsibilities of the divisional hub will include oversight of:

- Divisional quality, safety, and experiential outcomes, learning and improvement.
- Monitoring of quality, audit, and improvement standards
- Triangulation of evidence

- Infection Prevention & Control standards
- Health & Safety Standards
- Safeguarding and legislative / regulatory standards and compliance
- External / peer / internal reviews / audits and tracking completion of actions
- Ensuring learning and improvement opportunities are introduced within required timescales and embedded into practice
- Divisional implementation of the Duty of Quality, Duty of Candour, Putting Things Right Regulations, and this Quality& Safety Framework.



Divisional Senior Leadership Team Meetings

Divisional Senior Leadership Team meetings will be held on at least a monthly basis and attended by all members of the Senior Leadership Team (or nominated deputy) to ensure representation of all departments within the division. Minimal responsibilities of the Senior Leadership Team include:

- Oversight of the strategic planning and operational management of the Division.
- Oversight and reporting of divisional quality and safety key metrics.
- Oversight and assurance of divisional quality and safety action plans and improvement programmes.
- Ensuring the delivery of safe, effective, and high-quality services.
- Ensuring delivery of the divisional aspects of the Trust's strategic objectives.
- Review and discussion of the outputs from departmental meetings.

Integrated Quality and Safety Group

The Trust Integrated Quality and Safety Group provides operational oversight to support the Trust in meeting its Quality and Safety legislative and national requirements in relation to all areas of Quality and Safety, and the 'Duty of Quality', ensuring quality is at the centre of all decision making across the Trust.

To achieve this, the Group is responsible for reviewing, analysing, and triangulating information, outcomes, and metrics from across a broad range of Quality, Safety and Experience functions to identify themes, trends, areas for improvement, audit, and escalation and producing a quarterly assurance / escalation report for the Executive Management Board and Quality, Safety & Performance Committee. Oversight areas include:

- Divisional Quality, Safety, and regulatory outcomes
- Information Governance
- Putting Things Right, Incidents, Concerns, Claims, Inquests, Redress, and Ombudsman cases.
- Duty of Quality compliance
- Duty of Candor Compliance
- Safeguarding and Vulnerable Groups
- Infection Prevention and Control
- Health and Safety
- Risk (including Quality and Safety, Digital and Workforce)
- Learning and Improvement
- Clinical Audit
- Regulatory Compliance
- Health and Care Quality Standards (2023)
- Patient Reported Outcome Measures (PROMs)
- Patient / Donor Reported Experience Outcomes (PREMs)
- Mortality reporting.

The group are responsible for the provision of a formal highlight report to Executive Management Board upon a monthly basis.

Executive Management Board

Executive Management Board will meet upon a monthly basis and will be responsible for the provision of organisational quality and safety assurance through the receipt of a report from the Trust Integrated Quality and Safety group, which will detail:

- Divisional Quality and Safety updates
- Infection Prevention & Control updates
- Information Governance updates
- Safeguarding and Vulnerable Groups updates
- Safety Alerts

- Datix standards and activity
- Putting things Right activity (Concerns and incidents)
- Duty of Candour and Duty of Quality updates
- Claims, inquests, compliments
- Quality outcome metric overview
- Mortality Reporting
- Regulatory compliance
- Assurance visits / inspections
- Learning from external reports
- Oversight and monitoring of Quality and Safety action tracker.

Quality, Safety and Performance Committee.
The Trusts Quality, Safety and Performance Committee will be held upon a quarterly basis and provides:

- Evidence based and timely advice to the Board to assist it in discharging its quality and safety functions and statutory and legislative responsibilities in line with the Health and Social Care (Quality and Engagement) (Wales) Act and associated duties of quality and candour.
- Assurance to the Board in relation to the Trust's arrangements for safeguarding and improving the quality, safety and performance of patient and service user centred healthcare, workforce matters, digital delivery and information governance in accordance with its stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales.

Enabling Quality

To achieve our Quality and Safety vision and meet our legislative requirements in line with the Duty of Quality we need to take a system wide approach that actively involves patients, donors, colleagues, and other key stakeholders. To achieve this, we have developed and implemented a robust Quality Management System.
A Quality Management System enables us as an organisation to focus upon understanding what a quality service looks like, knowing whether we are delivering the services that our population needs and ensuring a strong focus continuous learning and improvement.
The key to the success of our quality management system is ensuring and enabling everyone across the Trust to be engaged and dynamic in ensuring quality is at the heart of everything we do:



Every Quality Management System is based upon the continuous Quality Cycle which consists of 4 parts: **Quality Planning: Quality Control: Quality Assurance: and Quality Improvement**, which are all underpinned by provision of a **learning** environment.



Daily Management to monitor quality and sustain results by creating and maintaining the culture and processes for those closest to the work to undertake action to keep the system in control and escalating where appropriate.

Effective structures and standards to provide a clear line of sight across the Trust giving assurance internally and externally to stakeholders, that improvements are being achieved and sustained.

Consistent implementation of strategic and everyday improvements by those closest to the work, using a standardised methodology to learn implement, scale and spread improvements in the quality of services and outcomes.

Planning to improve the quality of services and outcomes for our patients and donors through effective design of strategies, frameworks, policies, structures, systems, and processes.

Through the develo ement Sy

- Enable a po nd Just qu provision of

- Enable a shared responsibility and voice for Quality to ensure the provision of safe, timely, effective, efficient, equitable and person-centred care.
- Embed Quality Driven Decision Making at all levels of the Trust.
- Demonstrate a quality approach based upon learning and continuous improvement.



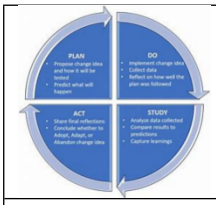
Quality Planning

Aim

The Trust will ensure that all service planning and development is undertaken through a quality and continuous improvement lens which is supported by the feedback of patients, donors, staff, and other key stakeholders at all levels of the Trust to ensure the provision of services which meet the requirements of our population and optimise patient and donor outcomes.

How we achieve this	How we can improve this
Significant focus upon quality within our Trust Strategy 'Destination 2033'	Availability of Quality Metrix and dashboard to improve information available to support decision making
Development of Trust Values that support the quality culture that we require.	Expansion of service User feedback systems and approaches to gain service user insights.
Alignment of Intermediate Medium-Term Plan (IMTP) with Quality requirements	Expansion of always on reporting metrics
Ensuring identification of robust annual quality priorities that align with the Trust IMTP.	Further development of staff feedback mechanisms.
Quality Management Framework	
Introduction of quality-based decision making tool for all strategic decisions across the Trust.	
Introduction of Quality Impact Assessments to determine impact of proposed service changes, business cases and organisational change upon Quality.	
Development and Implementation of Robust Quality reporting and assurance structures.	
Quality and Safety Policies, procedures, and guidance.	
Development of Incident Management Framework.	

Implementation of CIVICA service User feedback system.	
Introduction of always on reporting	



Quality Improvement

Aim

Every year, following triangulated analysis and staff consultation, the Trust will identify annual Quality improvement goals as part of the IMTP process. Each Quality Improvement goal will be managed through a project management infrastructure, with an identified operational lead and Executive Director sponsor and monitored through the relevant Quality Hubs and by exception through to Executive Management Board and Quality, Safety & Performance Committee.

How we achieve this	How we can improve this
Development of Annual Quality Improvement Priorities.	Review of Trust Quality Improvement Infrastructure
Clinical and Scientific Strategy Board	Development of post learning clinical audit to ensure improvements are achieved and sustained.
Annual Clinical Audit Plan	Source a single trust wide clinical audit system.
Implementation of Clinical Audit systems to support activity.	Identification a single Quality Improvement Methodology
Development and Publish of Patient Reported Experience Measures.	Expanding Patient Reported Experience and Outcome Measures
5-minute improvement programme at the Welsh Blood Service.	Roll out of 5-minute improvement programme across the Trust
Safe Care Collaborative Improvement Projects.	
Service Improvement team support and training.	
Duty of Candour and National Reportable Incident Procedures.	

Learning associated with Incidents, concerns and feedback from staff and service users.	
Quality and Safety Learning System Framework.	
Reflective Learning Events.	



Quality Control

Aim:
We will develop a quality control infrastructure across the organisation that there are robust arrangements in place to monitor services provided and to detect and respond to quality variances and a culture that supports its delivery through a positive learning and improvement culture.

How we achieve this	How we can improve this
Identified Quality Priorities based upon data findings and quality variance.	Development of Quality Always on Reporting Measures to enable real time reporting.
Clinical Guidance, policies, and procedures	Further development of feedback reporting mechanisms.
Harm Reporting Systems	Enhanced staff training programmes
Duty of Candour and National Incident Reporting procedures.	Enhancing thematic analysis
Incident and Concern Management processes and policies.	
Incident Management Framework	
Harm Reporting Systems	
Patient, Donor, and Staff Feedback Systems	
Quality and Safety Key Metrics	
Trust Values	
Building our Future Together Programme	

Speaking Up Safely Framework	
Compassionate Leadership	
Staff training and education	



Quality Assurance

Aim: We will understand the quality of our commissioned and provided, how our services compare with others and if our improvement work is making a difference.

How we achieve this	How we can improve this
7 Levels of Assurance	
Clinical and Quality Audits	Development of Quality Measure Reporting Dashboard
Regulatory Inspections	Further development of Always on reporting Metrics.
Peer Reviews and Benchmarking Exercises	
Always on Reporting Measures	
Performance Management Framework	
Quality and Safety Policies, procedures, and Standard Operating Procedures	
Quality and Safety Regulatory Tracker	
Quality and Safety assurance structures	
Building our Future Together Programme	
Speaking Up Safely Framework	
Compassionate Leadership	
Staff training and education	

To enable the successful implementation of our quality management system leadership, beliefs, attitudes, skills, and behaviors that support collaboration, psychological safety, responsibility, accountability, continuous improvement, and a person centred approach are key.

Culture, Values and Psychological Safety.
Studies have demonstrated that the establishment of an effective and Just safety

culture based upon psychological safety have a direct correlation with improved patient outcomes and a reduction in staff injuries.

Psychological safety is defined as "a shared belief held by members of a team that the team is safe for interpersonal risk-taking" and is based upon an open and transparent organisational culture that supports and enables us to speak up, admit mistakes and take appropriate risks, and it is considered that for teams to be effective psychological safety is key.

Psychological safety plays a role in staff wellbeing by creating a working environment which embraces change and effectively resolves conflict. Psychological safety is also beneficial in supporting learning from those times when care doesn't turn out as expected, through providing space and opportunity for reflection without the fear of unjust blame.

When something fails or goes wrong it is vital that patients, donors, and staff feel safe, supported, and able to speak up, and have their concerns or views listened to, acknowledged, and acted upon. Such psychological safety is of paramount importance if the aim of a learning and continuously improving organisation is to be realised.

When errors do occur, we need to ensure that we undertake investigations to both fully understand how the error or system failure occurred, to identify opportunities for learning and improvement to prevent such situations arising again. However, if a culture based upon learning and improvement is to be realised it is vital that this process does not apportion blame, as a punitive environment is a powerful barrier to fair and authentic reflection, learning and improvement. In such situations it is important that adequate support is not only provided to the patient / donor and their loved ones but also to the staff involved. A just and learning culture balances fairness, justice and learning with responsibility and accountability.

Over recent years, enabling such a culture has been a significant focus within the Trust which has been supported by the implementation of our working together to build our future programme, the refinement of our organisational values ‘Caring, Respectful, Accountable’, the implementation of national frameworks and resources such as ‘Speaking Up Safely’, the development of a Trust incident management framework and associated learning system. All of which are underpinned by compassionate leadership approaches and equality, diversity, and inclusion.

Leadership

In support of NHS Wales Compassionate Leadership approach, as a Trust we are committed to enabling and developing compassionate quality and safety leadership approaches. To support this our People and Education Strategies identifies and describes how we will support and develop competent, capable, and compassionate leaders that possess the skills and competencies required to deliver service and care excellence at all levels of the organisation.
Leader’s need be present and prepared to disrupt and encourage open feedback from citizens and colleagues as to how care can be improved. Leaders need to be relentlessly focused on a sense of common purpose, values, and quality, continually

improving, and showing compassion to all. Compassionate leadership has been vital during the pandemic. Healthcare workers have faced unprecedented pressures both in terms of the risk and fear of getting COVID-19 from the workplace but also the desire to provide the best possible care in difficult circumstances. Strong leadership has never been more important and now needs to continue with everyone contributing.

Equality, Diversity, and Inclusion.

As part of our everyday work, we aim to build a culture within the organisation that recognises and embraces inclusion, equality, and human rights, and we are dedicated to:

- Strengthening leadership, governance and accountability via our strategies, policies, practices, and processes.
- Improving engagement with staff, patients, donors, carers, and visitors so that everyone is empowered and able to participate in the development of meaningful services and support.
- Embedding the principles of the Anti-Racist Wales Action Plan and other national action plans to ensure that all patients, donors, and staff are empowered to have their voice heard and are not subject to discrimination in any part of their interaction with the Trust.
- Capturing the voice of the public in the design, planning and delivery of services, to ensure that the services we provide are meeting the needs of the communities that we serve.

To achieve this we use several engagement methods, which include:

- Patient Liaison group
- Patient and carer representation on Trust
- Wide strategic groups, such as Patient Dignity group, Equality Impact Assessment group, Quality and Safety committee
- Public events such as BME Health Fair, Pride, National Eisteddfod
- Public engagement forums – Welsh Blood stakeholder sessions
- Staff newsletter, surveys, and feedback sessions
- Monthly Patient and donor surveys
- Community stakeholder and partnership engagement events
- Collaboration with Llais.

Staff Wellbeing

The Trust recognises the commitment of our dedicated staff and the vital role they play in the delivery of quality, care, and excellence. As an employer, we encourage a culture of fairness, dignity, and respect. Over the past few years, the mental health and wellbeing of staff because of the pandemic has been even more crucial and will continue to be for many years as the long-term impact is realised. Supporting staff with their health and wellbeing through initiatives such as:

- Stress assessments.
- Mindfulness programs - including the use of digital applications.
- Respite care funding.

- Childcare School Holiday funding.
- Flexible working opportunities.
- Annual leave purchase schemes.
- Complementary Treatments.
- Staff Psychology Service.
- Provision of an Employee Assistance Programme.
- Managerial and self-referral services to Occupational Health services.
- Access to free counselling.
- Mentoring and coaching services.
- A number of staff networks in place, which play a pivotal role in raising awareness and understanding of protected characteristics.

Patient and Donor Voice

The voice of the patient/donor, whether expressed through compliment, concern, face to face, in writing or by a third party, at any stage in the care pathway, must be a central consideration to all decision making in terms of quality and patient/donor safety. Soft intelligence is invaluable as an early quality trigger where something is potentially of concern. Therefore, it is essential that staff feel empowered to voice and escalate concerns, and that patient / donor experience, both real-time and retrospective, is central to quality and service improvement. Soft intelligence can also be attained through leadership walkabouts and other internal assurance activities which further enables well informed assessment. Experience has shown that where these does not exist, risk is increased and the opportunity to provide safe care is reduced.

Within the Trust the Integrated Quality and Safety Group has responsibility for the triangulation and oversight of patient and donor experience and for reporting highlights, assurance, exceptions, and escalations to the Executive Management Board and Divisional SLT's/SMT's monthly, with significant exceptions and points of serious escalations being provided to the Quality, safety & Performance Committee.

Quality Based Decision Making

All decisions must be made through a Quality lens supported by robust triangulated quality information. This requirement is supported by the Trust wide monthly Integrated Quality and Safety Group that will formally reports to the Executive Management Board and Quality, Safety & Performance Committee.
It is important that all staff, patient / donor facing & leadership teams think of all aspects & factors (the big picture) impacting patient / donor care and view all decisions as an opportunity to positively impact upon quality provision. Teams should focus on providing excellent care and services, ensuring the required resources are able to eliminate distractions before they become problematic or result in preventable error or an adverse event. Mechanism for supporting this include:

- Safety walk arounds, which enable operational staff to directly discuss safety issues with senior managers / Senior Trust Officers
- Forums, such as operational meetings, handovers, and patient/donor/carer representative meetings, to act as sources of intelligence on the safety of services
- Day-to-day conversations between teams and managers
- Patient safety officers actively seeking out, identifying and resolving patient safety issues in their clinical departments /divisions.
- Briefings and debriefings, such as at the start / end of a theatre list / SCAT/ Collections clinic, to reflect on learning.
- Patient / donor experience feedback and stories to identify good practice, and any threats to safety.
- Staff experience feedback.

Harm

The reduction or elimination of harm is one of the overarching aims of this framework. It is therefore critical that the Trust understands and tracks the harm that can / does occur through its functions. Understanding past harm is important i.e., has patient / donor care been safe in the past? There are many ways in which it can go wrong. Therefore, the Trust needs to understand the different types and causes of Patient / Donor harm, which can be caused by:

- Delayed or inadequate diagnosis – misdiagnosis or delay in diagnosis or treatment
- Failure to provide appropriate treatment – rapid thrombolytic treatment for stroke, donors being over bled or prophylactic antibiotics before surgery.
- Treatment –e.g., the adverse effects of chemotherapy
- Over-treatment –painful / toxic treatments of no benefit to those at end of life
- General harm – incorrect pre-blood-donation screening outcomes, harm to recipients caused by blood borne infection/virus, or post donation cannulation nerve damage.
- Psychological harm – depression following diagnosis.
- Multiple types of harm require more than just a single measure. A range of measures may include mortality statistics, systematic record review, selective case note review, reporting systems and existing data sources.

Monitoring, Reporting and Assurance Arrangements

Robust monitoring, reporting and arrangements are key in enabling us to continually review our performance to both ensure we meet our required quality standards and goals, and to assess whether our improvement activities are positively impacting upon our patients and donors.

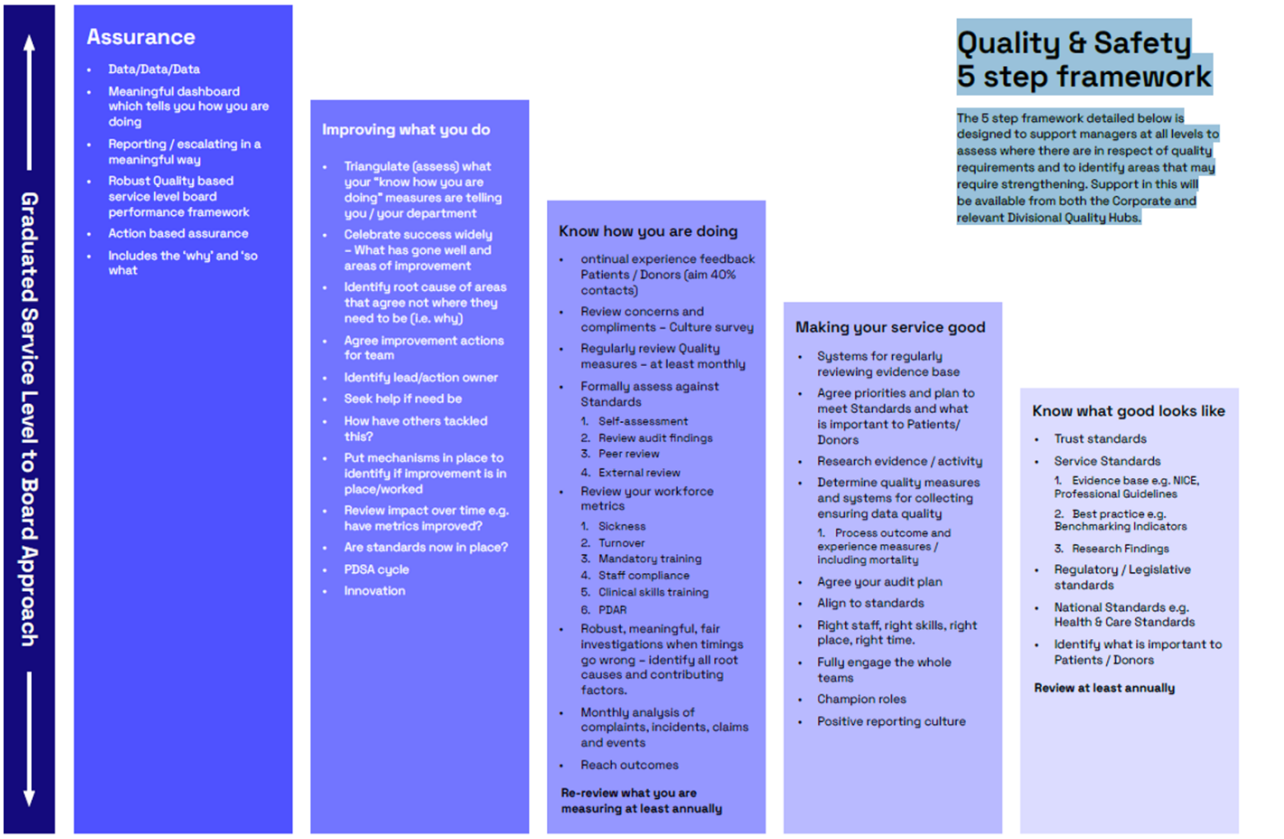
To enable this, we have developed and implemented a range of monitoring, reporting and assurance arrangements which include:

- Defined quality and safety metrics to measure against agreed ‘What Good Looks Like’ standards.
- National quality indicators.
- Clinical Incident / harm metrics.

- Mortality indicators.
- Clinical Outcome measures.
- Harm Measures.
- Patient Reported Outcome Measures (PROMS).
- Patient experience metrics.
- Recommendation rates (from patients / donors/ carers & staff).
- Patient and Donor Feedback (stories, concerns, compliments, and feedback).
- 'A Day in The Life of' (staff's lived experience stories).
- 15 step challenge visits (which enable discussion with staff and patient/ donors about their experience of giving and receiving care with an appreciative enquiry approach focussed on quality and safety of care.
- Peer Reviews.
- Regulatory inspections.
- Clinical Audit.

Triangulated Evidence.

To identify wider systematic issues, required actions and improvements incident analysis needs to go further than simply explaining the nature of the event. Within the Trust there are a range of local feedback mechanisms in use. The challenge for the Trust is to ensure that at all levels of the organisation is to ensure that feedback through these multiple mechanisms is collected and utilised to enable the identification of learning, and improvement opportunities that can be shared across the organisation, without losing the granularity that makes information real for individuals. To achieve this, access to and analysis of meaningful quality and safety datasets informed by national quality and performance indicators are key. To support an extensive work programme has been completed to develop key Quality and Safety Metrices and dashboards which will be available at all levels of the organisation and supported by the Quality and Safety 5 step and safety monitoring frameworks:


Graduated Service Level to Board Approach
Assurance
Data/Data/Data
Meaningful dashboard which tells you how you are doing
Reporting / escalating in a meaningful way
Robust Quality based service level board performance framework
Action based assurance
Includes the 'why' and 'so what
Improving what you do
Triangulate (assess) what your "know how you are doing" measures are telling you / your department
Celebrate success widely – What has gone well and areas of improvement
Identify root cause of areas that agree not where they need to be (i.e. why)
Agree improvement actions for team
Identify lead/action owner
Seek help if need be
How have others tackled this?
Put mechanisms in place to identify if improvement is in place/worked
Review impact over time e.g. have metrics improved?
Are standards now in place?
PDSA cycle
Innovation
Know how you are doing
ontinual experience feedback Patients / Donors (aim 40% contacts)
Review concerns and compliments – Culture survey
Regularly review Quality measures – at least monthly
Formally assess against Standards
1. Self-assessment
2. Review audit findings
3. Peer review
4. External review
Review your workforce metrics
1. Sickness
2. Turnover
3. Mandatory training
4. Staff compliance
5. Clinical skills training
6. PDAR
Robust, meaningful, fair investigations when timings go wrong – identify all root causes and contributing factors.
Monthly analysis of complaints, incidents, claims and events
Reach outcomes
Re-review what you are measuring at least annually
Making your service good
Systems for regularly reviewing evidence base
Agree priorities and plan to meet Standards and what is important to Patients/ Donors
Research evidence / activity
Determine quality measures and systems for collecting ensuring data quality
1. Process outcome and experience measures / including mortality
Agree your audit plan
Align to standards
Right staff, right skills, right place, right time.
Fully engage the whole teams
Champion roles
Positive reporting culture
Know what good looks like
Trust standards
Service Standards
1. Evidence base e.g. NICE, Professional Guidelines
2. Best practice e.g. Benchmarking Indicators
3. Research Findings
Regulatory / Legislative standards
National Standards e.g. Health & Care Standards
Identify what is important to Patients / Donors
Review at least annually
Quality & Safety 5 step framework
The 5 step framework detailed below is designed to support managers at all levels to assess where there are in respect of quality requirements and to identify areas that may require strengthening. Support in this will be available from both the Corporate and relevant Divisional Quality Hubs.


Monitoring & measuring
Safety monitoring framework
One of the recommendations made by Don Berwick in his 2013 review into patient safety was that all NHS organisations should:
'.....routinely collect, analyse and respond to local measures that serve as early warning signals of quality and safety problems such as the voice of the patients and the staff, staffing levels, the reliability of critical processes and other quality metrics. These can be 'smoke detectors' as much as mortality rates are, and they can signal problems earlier than mortality rates do'.
By using the Framework and considering these questions, the Trust and its staff will be able to understand and discuss more clearly what it means to be safe. The framework shifts the emphasis away from focusing solely on past cases of harm, and more on real-time performance and measures that relate to future risks and the resilience of organisations.
The Trust will have a safety foundation visit from the Institute of Healthcare Improvement (IHI) in July 2022, which will assess the Trust in respect of its safety culture and infrastructure and inform the development of the Trust Safety Monitoring framework.
Has patient care been safe in the past? Ways to monitor harm include:
Mortality statistics
Record review (including case note review harm review)
Staff reporting (Including incident report and 'Never Events')
Routine Databases
Are we responding and improving? Sources of information to learn include:
Automated information management systems highlighting key data at a clinical unit level (e.g. medication errors and hand hygiene compliance rates)
At a board level, using dashboards and reports with indicators, set alongside financial and access targets
Are our clinical system and processes reliable? Ways to monitor reliability include:
Percentage of all inpatient admissions screened for MRSA
Percentage compliance with all elements of the pressure ulcer care bundle.
Past harm
Integration & learning
Safety measurement & monitoring
Reliability
Anticipation & preparedness
Sensitive to operations
Will care be safe in the future? Possible approaches for achieving anticipation and preparedness include:
Risk registers
Safety culture analysis and safety climate analysis
Safety training rates
Sickness absence rates
Frequency of sharps injuries per month
Human reliability analysis (e.g. FMEA) safety cases.
Is care safe today? Ways to monitor sensitivity to operations include:
Safety WalkroundsTM
Using designated patient safety officers
Meetings, handovers and ward rounds
Day-to-day conversations Staffing levels
Patient interviews to identify threats to safety.

There are many different sources of quality and safety information available across the organisation, however it is key that such information is integrated and weighted to ensure risks and hazards are identified, understood, and prioritised at all levels of the organisation, so that appropriate action, mitigation, and escalation can be undertaken.

To achieve this, a robust and effective system for incident reporting, analysis, learning, feedback, and action is needed. To support this the Trust has developed Incident Management and learning frameworks to support colleagues in ensuring the robust management of incidents and associated learning opportunities.

Our approach to quality improvement will mean consistent and well understood use of methods and tools to continuously improve the way we do things. Studies have shown that board commitment and a leadership focus on quality improvement is linked to higher quality care. The Trust will undertake a review of its quality improvement infrastructure and mechanisms. It is vitally important that all clinical improvements are made through a value based and prudent healthcare lens. Growing demand on NHS services and increased complexity is putting a huge strain on the money available to deliver services. By ensuring that the right care is delivered first, each and every time, to all our patients and donors, we will see improvements in quality, efficiency and effectiveness and therefore achieve better value from the services we provide. Understanding the outcome of each intervention or treatment, its cost and what it means to patients /donors is fundamental to value-based health care. This will mean that we will ensure that we take every opportunity to improve value by tackling variations in care across our services, reducing waste and implementing known best practice. We believe that this approach will benefit our patients, donors, our staff, and all healthcare services.

The Kings Fund (2017) provides a starting point for NHS leaders to embed Quality Improvement:

- Make quality improvement a leadership priority for board.
- Share responsibility for quality improvement with leaders at all levels.
- Don’t look for magic bullets or quick fixes.
- Develop the skills and capabilities for improvement.
- Have a consistent and coherent approach to quality improvement.
- Use data effectively.
- Focus on relationships and culture.
- Enable and support frontline staff to engage in quality improvement.
- Involve patients, service users and carers.
- Work as system.

Quality and Safety Implementation Plan

This Framework will be delivered through an implementation plan. It is recognised that implementing this Quality Framework will take time. Work undertaken over the last four years has laid some of the foundations for this work, both culturally and organisationally, however further development is required. This work is crucial if the Trust is to meet the legislative requirements set by the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the NHS Wales Quality & Safety Framework: Learning & Improving (Welsh Government 2021).

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Trust Board

Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act (2016) – for National Reporting

DATE OF MEETING	23rd May 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Rhian Wright, Nurse Staffing Programme Lead
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
EXECUTIVE SUMMARY	This paper is to provide the Trust Board with the assurance that all statutory requirements of the Nurse Staffing Levels (Wales) Act 2016 are being met. The report provides the position from the 6th of April 2021 to the 5th of April 2024, however, due to the timeframe for closing serious incident reports the three-yearly reports that go to Boards in May 2024 will only include data relating to serious incidents closed by 31st January 2024. This report also provides the 2023/24 annual information that, due to timelines has not been reported separately. The report highlights that: • Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for the one Velindre Cancer Service 25B area: First Floor Ward. There are no financial concerns in relation to the staffing of this area. There has been no change in the planned roster

	since 2022. • The First Floor Ward establishment includes the required 26.9% headroom, the ward manager remains supernumerary to the planned roster. A nurse coordinator also remains surplus to the planned roster on each day shift. • There has been a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 (2022/23) to 88.2% in Year 3 (2023/24). • ***There has been no reportable harm in relation to the quality indicators during the 3-year period in respect of nurse staffing levels on the First Floor Ward.*** • All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Act. • The October 2023 establishment review process highlighted three 25A areas where it was deemed the establishment was insufficient to provide sensitive care to patients: SACT, Clinical Nurse Specialist Team and Assessment Unit. A detailed financial oversight meeting in respect of these areas took place on the 16th April 2024 where detailed financial information was considered. It was concluded that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist (CNS) Team. A CNS review has been undertaken and a development plan instigated. Due to the work plan modernisation required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.
RECOMMENDATION / ACTIONS	The Trust Board is asked to ***DISCUSS*** the 3-yearly assurance report 2021-2024 and ***APPROVE*** the report prior to submission to Welsh Government.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nurse Forum	07/03/2024
Executive Management Board	02/04/2024
Executive Management Board	29/04/2024
Quality, Safety & Performance Committee	09/05/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Executive level consideration in respect of headroom in the identified 25A areas. Endorsed for onward approval	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full ***In respect of 25B area***

1. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

- Enable the provision of safe nursing care to patients at all times.
- Improve working conditions for nursing and other staff and
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Section 25B of the Nurse Staffing Levels (Wales) Act 2016 requires organisations to have sufficient staff to provide appropriate patient centred care. Section 25A places a duty on Health Boards/Trusts to take due regard to have sufficient nurses to allow nurses time to care sensitively for patients wherever nursing services are provided or commissioned.

Section 25E of the Nurse Staffing Levels (Wales) Act 2016 requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward and paediatric inpatient wards.

This report provides the position from the 6th April 2021 to the 5th April 2024. However, due to the timeframe for closing serious incident reports, the three-yearly reports that go to Boards in May 2024 will only include data relating to serious incidents closed by 31st January 2024. A final, updated version of the report - including all serious incident reports that occurred prior to April 5th 2024 -

which should by then be closed - will be presented to the Board in September 2024 and then Welsh Government in October 2024.

There is only one area of the Trust that sits under the requirements of 25B of the Act, First Floor Ward at Velindre Cancer Service. This was re-classified in April 2021 as meeting the wider definition of a 'medical ward' as it is a specialist oncology medical ward and therefore, the ward and Trust are now required to meet the full reporting requirements of the Nurse Staffing Levels (Wales) Act (2016).

Bi-annual nursing establishment reviews of both 25A and 25B areas are carried out 6-monthly utilising a triangulated approach.



2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Nurse Staffing Levels Act Reporting

Section 25E of the Act states that for each three-year reporting period, Health Boards/Trusts with wards where section 25B of the Act is applicable must submit a report outlining the extent to which nurse staffing levels have been maintained.

The three-yearly report is attached. This report highlights:

- During the COVID pandemic in 2020 the ward bed capacity was reduced to 20 beds, the ward was reinstated to full capacity of 32 beds in September 2022.
- Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 the biannual nursing establishment reviews for first floor ward (25B area) have taken place using a triangulated approach.
- Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor.
- Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas.
- There has been no change in the planned roster since 2022.
- The first-floor establishment includes the required 26.9% headroom, the ward

manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift.

- The HCMS was used to record and extract data in Year 1 and 2 of the reporting period. Year 3 data has been extracted from the SafeCare system which was fully implemented in March 2023.
- There has been a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 (2022/23) to 88.2% in Year 3 (2023/24).
- There has been no reportable harm in relation to the quality indicators during the last 3-year period.
- There have been 7 complaints in total during the last 3 years relating to nursing care. There have been no complaints where nurse staffing levels were considered to be a contributing factor.
- All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Act.
- Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, international nurse recruitment and student streamlining has been undertaken and the nurses have commenced employment (between November 2023 and March 2024).
- The October 2023 establishment review process highlighted three 25A areas where it was deemed the establishment was insufficient to provide sensitive care to patients: SACT, Clinical Nurse Specialist Team and Assessment Unit. A detailed financial review took place on the 16th April 2024. The deficits within SACT are negatively impacting on morale in the 25B area due to the frequent requirement for risk-based staff reallocation.

Following the October 2023 establishment reviews a comprehensive review of financial establishment verses required approved rosters was undertaken across all Nursing areas of Velindre Cancer Services by Nurse Leaders and finance colleagues and detailed spreadsheets developed. A meeting was held on the 16th April 2024 where these were scrutinised in detail attended by: Executive Director Nursing, AHP & Health Science; Executive Finance Director, Head of Nursing & Deputy Head of Nursing VCC, Senior Nurse SACT VCC, Deputy Head of Finance Business Partnering and Head of Professional Standards and Digital. The outcome of the meeting was:

- Overall, there is sufficient budget currently to cover the establishment requirements and headroom across all nursing areas at VCC with the exception of the Clinical Nurse Specialist (CNS) Team.
- Budgets do require realignment across a number of departments to achieve

this and a plan agreed to deliver this.

- Additional HCSW resource required in some SACT Units to ensure 2 per shift in all units apart from Neville Hall. Only one required there due to unit size. This is now being enacted.
- The CNS review is complete, and a development plan being worked through following discussion with each SST. Significant role review is required as the review identified that, at the time, 40% of time was being spent on non-CNS related work. It is anticipated that it will be Autumn 2024 before the full workforce requirement is known after the job planning and role modernisation work is completed. In the interim, plans are being enacted to two generic CNS roles to the team to increase resilience and provide headroom cover to enhance the service cover pending this work being completed.

2.2 Establishment Reviews

Following each national benchmarked acuity review (twice yearly) an establishment review is undertaken across all areas of the Trust that employs registered nurses. The establishment reviews include all front-line care/treatment delivery (both Divisions) chaired by the Executive Director of Nursing, AHP & Health Science and relevant Head of Nursing. The establishment reviews are reported on a template for agreement at each level. Each establishment review includes an overview of:

2.2.1 Current funded establishments
2.2.2 Vacancies and staff in post
2.2.3 Datix Incidents – related to service delivery and staffing
2.2.4 Complaints relevant to establishment or staffing
2.2.5 Training compliance
2.2.6 PADR compliance
2.2.7 Review of Roster
2.2.8 Patient Feedback (CIVICA)
2.2.9 Audits (Tendable)
2.2.10 Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
2.2.11 KPI review
2.2.12 Quality Indicators (25B)
2.2.13 Service plans or Clinic Templates as applicable (not all areas)

In summary, there were no incidents of harm relating to the quality indicators or complaints effecting care linked to nurse staffing levels for the 3-year reporting period.

2.3 Electronic Rostering

Health roster is fully utilised in six nursing areas and for the nurse bank. Rostering Key Performance Indicators (KPI's) are produced electronically which are scrutinised locally to assess rostering efficiency and effectiveness. An overview of these KPI's is also undertaken as part of establishment reviews. Health Roster also facilitates rapid and robust assurance that staffing levels are safe across all nursing areas. These rosters are legible, auditable and viewed in one centralised location for visibility of responsible staff.

3. FUTURE REPORTING

Based on a national review of the Health Boards/Trusts first 3-yearly reports and feedback from operational leads on their experience of completing the reports; a report was presented to the Executive Directors of Nursing & Midwifery and the Chief Nursing Officer for Wales in 2021 requesting a review of the current reporting process. A sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process; standardise reporting in line with the Duty of Candour set out in the Health and Social Care (Quality & Engagement Act) (Wales) Act 2020 and broaden the reporting scope of incidences of harm to provide more meaningful data. The findings and recommendations of the Reporting Sub-Group were presented to the Executive Nurse Directors in August 2023 who approved the recommendations to take effect from the next reporting period i.e., 6th April 2024 – 5th April 2025. The agreed quality indicators for the adult acute medical and surgical inpatient wards from 6th April 2024 will be as follows:

- *Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).*
- *Falls resulting in moderate harm, serious harm or death (i.e., level 3, 4 and 5 incidents).*
- *Medication errors resulting in moderate harm, severe harm, death & never events (i.e., level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

The data to be reported for each of the above from 6th April 2024 will be:

- *Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.*
- *Total number of incidents/complaints not closed and to be reported on/during the next year.*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had not been maintained.*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor.*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained.*
- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
	Select all relevant domains below

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Nurse Staffing Levels (Wales) Act 2016 covers all aspects of safe, timely and effective care. Rostering of staff against demand considers equitable and efficient care to deliver patient centred delivery. **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Socio-economic disadvantage and inequality of outcome is not relevant to this paper
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	To enable us to achieve a Healthier Wales and our organisational goals we need a sufficient workforce with the right skills and in the right place to be able to provide safe, timely and effective care to our patients and donors.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There is a cost implication if additional headroom resources are required for the Clinical Nurse Specialist Team.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required for this type of report
	There is no evidence to suggest that the information in this paper could benefit or disadvantage any particular group of people.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Risk that we cannot deliver timely and sensitive care to our patients if there is insufficient headroom within the Clinical Nurse Specialist Team to provide cover during periods of absenteeism.
WHAT IS THE CURRENT RISK SCORE	9
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Detailed Clinical Nurse Specialist team development work is required to determine the long term required staffing model and headroom requirements
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	March 2025
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Traditional ways of working
All risks must be evidenced and consistent with those recorded in Datix	

	Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government		
Health board	Velindre University NHS Trust		
Reporting period	The reporting period is from the 6th of April 2021 to the 5th of April 2024. However, due to the timeframe for closing serious incident reports, the three-yearly report that go to Board in May 2024 will only include data relating to serious incidents closed by 31st January 2024 (A final, updated version of the report - including all serious incident reports that occurred prior to April 5th 2024 - which should by then be closed - will be presented to the Board in September 2024 and then Welsh Government in October 2024).		
	2021/2022	**2022/2023**	**2023/2024**
Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Board	28/7/2022 P:\board papers\Annual Assurance Report May NSA 2021-2022.docx	25/5/2023 Annual Assurance Report NSL 2023 NT Final.docx	Caveated report to be presented in March 2024 with full report to be submitted in May 2024 Annual assurance report 23-24 ver1.docx
Number of adult acute medical inpatient wards where section 25B applies	1	1	1
Number of adult acute surgical / Paediatric inpatient wards where section 25B applies	0	0	0
Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**

Changing the purpose of section 25b wards to support the management of COVID or opening new COVID wards.	• During the COVID pandemic in 2020 bed capacity was reduced from 32 to 20 beds (to meet required bed spacing standards given patient vulnerability). There was no change in the primary purpose of the ward during this time. Due to the fact that there is only one inpatient ward there was no specific COVID ward. Suspected COVID patients were nursed in cubicles or cohorted to help reduce any spread of infection. • The ward was reinstated to full capacity of 32 beds in September 2022. • Nurse staffing was not a significant problem on the ward during this period due to the reduction in bed capacity.
Informing patients	• Bilingual All Wales 'Informing Patients Posters' are displayed at the entrance of the ward, informing patients and relatives of the nurse staffing numbers calculated for the identified period, and the date that the calculation was undertaken and signed off by the designated person. The posters are updated following each bi-annual re-calculation. Bilingual easy read FAQ's are displayed alongside the informing patients posters. In addition, bilingual copies of the All-Wales FAQs for Nurse Staffing Levels are available for patients and visitors to view on the ward. The Nurse Staffing Programme Lead regularly checks and updates the information displayed. • Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.

Section 25E (2a) Extent to which the nurse staffing level is maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

	Required establishment (WTE) of adult acute medical and surgical inpatients wards at the end of the last reporting period – (as of 5th April so data from the annual presentation of the NSL to the report in Nov 2020)	**Number of wards: 1**		
		RN: 23.68		
		HCSW: 23.68		
Extent to which the required establishment has been maintained within adult acute medical and surgical inpatients wards		**2021/2022**	**2022/2023**	**2023/2024**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during first cycle (May)	**Number of wards: 1**	**Number of wards:1**	**Number of wards:1**
		RN: 23.68	**RN: 23.68**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 23.68**	**HCSW: 14.21**
	WTE of required establishment of adult acute medical and surgical inpatients wards funded following first (May) calculation cycle	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 23.68**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 23.68**	**HCSW: 14.21**

	Required establishment (WTE) of adult acute medical and surgical inpatients wards <u>calculated</u> during second cycle (Nov)	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 28.42**	**RN:28.42**
		HCSW: 23.68	**HCSW: 14.21**	**HCSW: 14.21**
	WTE of required establishment of adult acute medical and surgical inpatients wards <u>funded</u> following second (Nov) calculation cycle	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 28.42**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 14.21**	**HCSW: 14.21**

		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 1**	**WTE: 1**	**WTE: 1**

The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels on First Floor Ward. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews are carried out bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas.

The first-floor establishment includes the required 26.9% headroom to account for sickness, study leave and annual leave.
The ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift. The designated person asks each ward/unit manager during the establishment review process if they have sufficient establishment to provide sensitive care to patients.

- The planned roster was reduced during the pandemic to reflect reduced bed capacity.
- There has been no change in the planned roster since 2022.
- The band 7 ward manager is supernumerary and not included in the required establishment figures. First floor has a nurse co-ordinator role that is also additional to the planned roster.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the planned roster has been maintained within adult acute medical and surgical inpatients wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
2021/2022	*4745*	*3773* *80%*	*0*	*972* *20%*	*0*	*100%*
2022/2023	*652*	*414* *64%*	*36* *5%*	*72* *11%*	*130* *20%*	*89%*
2023/2024	*562*	*496* *88.2 %*	18 3.2%	10 1.8%	38 6.8%	*93.4%*

Year 1 and 2 data was extracted from the Health Care Monitoring System (HCMS). Year three data has been extracted from SafeCare. SafeCare was fully implemented and has been utilised to record nurse staffing and acuity data since March 2023.

The data highlights a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 88.2% in Year 3. There has also been an improvement in the number of shifts where the planned roster was not met and not appropriate reducing from 20% in Year 2 to 6.8% in Year 3.

Process for maintaining the nurse staffing level for Section 25B wards

There are established risk escalation processes in place to enable real time nurse staffing levels risk escalation. Concerns regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. Operational teams are taking "all reasonable steps" to maintain the nurse staffing level required. Reasonable steps are considered and staff redeployment from other areas as well as bank and agency are utilised if staffing levels are deemed insufficient. SafeCare is utilised to help determine whether staffing levels are appropriate for the acuity of patients and staff can raise red flags to highlight any concerns. Operational steps to maintain the nurse staffing level include:

- Clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills.
- Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse coordinator and practice educator to provide direct patient care.
- Utilising bank and agency.

During the October 2023 establishment review process, it was highlighted that three 25A areas were possibly under established and that one area was carrying several nursing vacancies. These areas are 25A, however, this situation has impacted the ward (25B) area as staff have had to cover the service and it has adversely affected staff morale. A meeting was held in April 2024 to scrutinise the financial establishments verses the required roster in three 25A areas. It was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernization required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.

	Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, Velindre University NHS Trust has had to rethink the workforce planning strategy and has joined student streamlining for the first time and has recently recruited three newly qualified nurses to a new 18-month rotation programme. The Trust has also for the first time signed up to the All-Wales International Recruitment Programme. The Trust has successfully recruited 14 nurses from Kerala in India who are currently undergoing their OSCE training in Swansea. These posts will fill a large proportion of vacancies in the Cancer Centre although it will take time to embed the new staff into the organisation.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards (years 1 & 2)

Incidents of patient harm with reference to quality indicators and complaints about nursing care		Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e., 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
		TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	Year 1	0	0	0	5
	Year 2	0	0	0	1
	Year 3	0	0	0	1
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	TOTAL	1	0	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	Year 1	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	Year 1	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0

There has been no reportable harm in relation to the quality indicators during the last 3-year period. There have been no complaints or harm caused where nurse staffing levels were considered to be a contributing factor. There were 7 complaints about nursing care which were managed through the putting things right framework: 5 in year one, one in year 2 and one in year 3.	
Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate	
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	When nurse staffing levels have not been maintained, there is evidence that operational teams are taking 'all reasonable steps' to maintain the nurse staffing levels e.g., the utilisation of temporary workforce and using a risk-based approach to redeploy staff. On occasions the ward manager or the ward coordinator have stepped in to assist with direct patient care on the ward. Staff can raise a red flag in SafeCare to indicate concerns in relation to staffing levels and the senior nurse is contactable via a bleep system. In addition: • All incidents related to inpatient falls and pressure damage are reviewed by monthly learning panels, nurse staffing levels are considered as a possible contributing factor of the investigations conducted. • The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. • Regular Trust wide complaints meetings are conducted to discuss complaints, concerns and compliance with the Putting Things Right process.
Conclusion & Recommendations	• During the COVID pandemic in 2020 the ward bed capacity was reduced to 20 beds, the ward was reinstated to full capacity of 32 beds in September 2022 • Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 the biannual nursing establishment reviews for first floor ward (25B) have taken place using the triangulated approach • Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor • Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas • There has been no change in the planned roster since 2022. • The first floor establishment includes the required 26.9% headroom, the ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift • HCMS was used to record and extract data in Year 1 and 2 of the reporting period. Year 3 data has been extracted from the SafeCare system which was fully implemented in March 2023 • There has been a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 88.2% in Year 3. • There has been no reportable harm in relation to the quality indicators during the last 3-year period • There have been 7 complaints in total during the last 3 years relating to nursing care. There have been no complaints where nurse staffing levels were considered to be a contributing factor • All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Act

	• Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, international nurse recruitment and student streamlining has been initiated. • In relation to 25A areas it was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernization required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.

TRUST BOARD

ALL WALES FLEXIBLE WORKING POLICY

DATE OF MEETING	23 May 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	**APPROVE FOR TRUST ADOPTION**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Amanda Jenkins, Head of Workforce
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The policy has been developed in partnership and the final version was agreed by the Welsh Partnership Forum on 16 November 2023 and now becomes the contractual policy for the application of flexible working within the NHS in Wales and can only be amended through agreement by the Welsh Partnership Forum.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE THE ADOPTION** of the All Wales Flexible Working Policy for implementation in the Trust.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	01/02/2024
Quality, Safety and Performance Committee	27/03/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board **ENDORSED** the Flexible Working Policy for submission to the Quality, Safety and Performance Committee.

The Quality, Safety & Performance Committee **ENDORSED** the Flexible Working Policy via Chair's Urgent Action for Approval by Trust Board.

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
Appendix 1	All Wales Flexible Working Policy

1. SITUATION

This report provides an update made to Workforce and OD Policies, bringing them up to date with current employment legislation and best practice.

2. ASSESSMENT

2.1 The All Wales Flexible Working Policy has been developed in partnership and the final version was agreed by the Welsh Partnership Forum on 16 November 2023 and now becomes the contractual policy for the application of flexible working within the NHS in Wales and can only be amended through agreement by the Welsh Partnership Forum.

2.2 The policy will be reviewed in accordance with the All Wales Policy Development Protocol at intervals determined by the Welsh Partnership Forum.

3. SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The All Wales Flexible Working Policy is a new policy that:

- Encompasses legislative changes for day one rights.

- Incorporates the Principles of hybrid working within NHS Wales.
- Has a detailed process for managing flexible working requests.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning 04 – Organisational Culture Having appropriate people related polices ensure staff know the expectations upon them to deliver the role they are employed to undertake.
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 ☒
	When staff have clear guidance and expectations set through relevant policies and procedures there is improved impact on the work undertaken.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes
	Ensuring the trust has adequate policies and procedures that are full assessed against the impact on equality and socio-economic duty ensure that there are no adverse impacts on people who may be at a disadvantage. There are no identified impactors in any of the policies or procedures outlined in the paper.
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
	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Having a set of standards and principles that all staff work towards, that have been full assessed for their socio-economic impact and equality impact ensures people are clear on the expectations set for them by the Trust. This will provide a healthier workplace where people feel they have physical and mental well-being in the workplace.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	All Wales Policy Development Group undertook assessment in line with national guidance. No identified issues but in fact data demonstrates the positive impact of flexible working on protected characteristics.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not having relevant policies and procedures could lead to employment law challenges because people won't know the expectations upon them from the Trust.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

NHS Wales Employers
Cyflogwyr GIG Cymru

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

NHS Wales Employers is hosted by and operates as a part of the Welsh NHS Confederation

LHB/Trust/SHA Chief Executives
LHB/Trust/SHA Chairs
LHB/Trust/SHA Directors of Workforce & Organisational Development
WPF Members

4th January 2024

Dear colleague,

NHS Wales Flexible Working Policy

Please find attached the Flexible Working Policy for NHS Wales. Text boxes are included in the document for the organisation's name to be inserted.

The policy has been developed in partnership and the final version was agreed by the Welsh Partnership Forum on 16 November 2023 and now becomes the contractual policy for the application of flexible working within the NHS in Wales and can only be amended through agreement by the Welsh Partnership Forum.

I should be grateful if you would make arrangements for the revised policy to be adopted by your Board (or sub-committee) and implemented at the earliest opportunity. Individual organisations will need to consider, in partnership, their own implementation arrangements including the development of joint training programmes and awareness raising for staff at all levels.

The policy will be reviewed in accordance with the All Wales Policy Development Protocol at intervals determined by the Welsh Partnership Forum.

Yours sincerely



Sue Green
Director
NHS Wales Employers
On behalf of the Joint Chairs of the Welsh Partnership Forum

Ty Phoenix, 8 Cathedral Road, Cardiff, CF11 9LJ
Tel: 029 2034 9850



All Wales

Flexible Working Policy

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Approved by: Welsh Partnership Forum

Issue Date: December 2023

01 & 02

Policy Statement and Scope

Approved by: Welsh Partnership Forum

Issue Date: December 2023

1. Policy Statement

1.1 Within NHS Wales we know that to meet the health and care needs of our population effectively it is important to have a workforce which is healthy, engaged and motivated. We are committed to being a great place to work and learn and to the delivery of a quality service, acknowledging that our workforce is fundamental to our success.
We recognise our responsibility to attract, retain, deploy and develop people to maximise their potential.

One of the ways of achieving this is to develop and maintain a culture where flexible working is seen as an enabler for effective and efficient provision of services which has benefits for colleagues, patients and the organisation. NHS Wales is committed to promoting and encouraging different ways of working in order to recruit excellent people and retain the wealth of knowledge, skills and experience of its current workforce.

1.2 Flexibility in employment helps people to balance work responsibilities with other aspects of their lives and to meet the needs which may arise at different stages of their lives. Key to achieving this is the provision and availability of flexible working opportunities which allow employees to make choices about how and when they wish to work accompanied by policies which support managers to take the time to understand what each person needs.

1.3 The NHS Wales Approach to Flexible Working is set out in statement which was developed and agreed in partnership. The aim of this approach is to support managers to make a cultural shift so that rather than "We can't do this because…" the question becomes "How can we make this happen"?

This means that the default position will be that a request for flexible working will be approved, and every possible avenue explored to facilitate this, unless there are clear business reasons in policy and law to decline it. This Policy sets out the principles underpinning flexible working arrangements that allow people to balance work responsibilities with other aspects of their lives and describes the processes to be followed when making or considering a request.

1.4 Flexibility in employment is a key factor in demonstrating NHS Wales commitment to fair and equal treatment in the workplace and in attracting the highest calibre of employees to work for the organisation. Flexible working opportunities should be considered for all employees and made available as far as practicable, regardless of role, shift pattern, team or pay band and should also be considered for employees who work on rotation.

It is not sufficient for departments who have a traditional way of working to reject an application for flexible working just because it has not been tried before or because 'this is how it has always been done'.

1.5 All NHS organisations should proactively encourage and promote opportunities to work flexibly and use the resources available to them e.g., education, management and leadership programmes to advocate for the benefits of flexible working and move towards a culture which accepts it as the norm. Wherever possible, managers should consider how work can be undertaken flexibly and be supportive of flexible working requests from employees to better manage their work life balance, while maintaining service standards.

1.6 To support a positive culture of flexible working, organisations will need to consider how they support and encourage open conversations about flexible working. Examples of opportunities to talk about flexible working include at one-to-one line management / supervision meetings, team / departmental meetings, as part of wellbeing conversations, or as part of recruitment, induction, and annual appraisal processes.

When advertising a job, employing organisations also need to consider how they promote the right to request flexibility from day one and the availability of flexible working options.

1.7 NHS Wales is committed to treating all people equally and with respect irrespective of their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, or sexual orientation. An Equality Impact Assessment of this Policy has been completed.

2. Scope

The policy applies to all employees of the

from day one of their employment. However, flexible working arrangements for doctors in training are arranged by and subject to the approval of the Medical Deanery, HEIW.

03

Principles

03 Principles

3. Principles

3.1 The NHS in Wales is committed to a flexible working culture, which means that a request for flexible working will be approved, and every possible avenue explored to facilitate this, unless there are clear business reasons as set out in this Policy to reject it.

Good flexible working arrangements should balance the needs of the individual with three key organisational factors: patient/service-user experience, service delivery and employee experience.
It may not be possible to agree to the exact request, but managers are expected to discuss alternative arrangements with the individual to ensure that all avenues have been explored before rejecting the request.

3.2 All employees should have equal access to flexible working, as far as practicable, regardless of role, shift pattern, team or pay band and all posts can be considered for flexible working. Although it is recognised that some posts may not be suitable for all types of flexible working arrangements in their entirety, managers should consider whether certain elements of the role can be worked flexibly.

3.3 Employees can request to work flexibly from day one of their contractual employment and can make more than one flexible working request per year regardless of the reasons for them.

3.4 Employees will be treated fairly when having requests for flexible working considered. Each request for flexible working will be received openly by the appropriate line manager and considered individually on its own merits. Any request for flexible working should be approached on the assumption that it will be granted unless there is a legitimate business reason for refusal. However, consideration should be given to any potential impact on other employees and service delivery, including potential additional costs.

3.5 It is important that it is agreed from the outset whether the new working arrangements are permanent or temporary and this must all be documented in writing. Where the arrangement is temporary or for a fixed period, they must be reviewed regularly to ensure the needs of the service and of the individual are still being met.

3.6 Employees who are working flexibly will not be treated less favorably in relation to access to training and development opportunities or promotion opportunities.

3.7 No form of flexible working will allow employees to work in breach of the Working Time Regulations.

3.8 Although there is no limit on the number of requests an employee can make within a 12-month period, employees are asked to not simply re-submit requests that have been rejected without modification and/or a change in circumstances within the department. Instead, they are encouraged to maintain a regular conversation with their manager so that if anything changes both parties are aware and can respond to that change.

3.9 Changes to an employee's contract of employment must be confirmed in writing.

04 Benefits of Flexible Working

04 Benefits of Flexible Working

4. Benefits of Flexible Working

Flexible working benefits individuals not only in allowing them to balance their personal life with their working life but in enhancing general health and wellbeing.

Individuals that are happier with their balance between life in and out of work are generally more productive, produce better quality work and are more caring. For managers, flexible working can help retain employees– and holding onto experienced and skilled people is important in maintaining quality and containing costs.

Offering flexible hours widens the talent pool, so managers should be able to recruit people with more skills; it can also increase commitment and loyalty of employees and can benefit through reducing levels of absenteeism and stress.

Flexible working can also support service redesign through the creation of new blended roles and the reshaping and development of existing roles, in consultation with employees. The creative use of new and redesigned roles can result in improved services for patients and more rewarding careers for our workforce.

05 Flexible Working Request Process

05 Flexible Working Request Process

5. Flexible Working Request Process

5.1 There may be a number of reasons why employees may need to adopt a more flexible working arrangement for a short period (i.e., up to 8 weeks) to address a particular issue. Where this is the case, it may be appropriate for the employee and the manager to discuss and agree this informally, particularly where the change has no impact on their other terms and conditions (e.g., pay). However, the outcome of the discussion should be documented and confirmed in writing.

5.2 Making the request

Where the employee wishes to apply for a form of flexible working on a permanent or longer-term basis, they should complete a Flexible Working Request Form (Appendix 1) or complete the request on ESR and submit it to their line manager. The employee may wish to have an informal discussion with their manager before submitting a formal request and managers are encouraged to facilitate this when requested to do so. However, the request will not be formally considered until it is put into writing.

The request form must contain the following information: -

- It must be dated and specify the change to working arrangements that they are seeking, and when they would like this change to come into effect

- Where applicable, the applicant is encouraged to state if they are making the request in relation to the Equality Act 2010, for example, as a reasonable adjustment for a disability, or on return from maternity leave, or when it is for childcare or dependants care.

5.3 Responding to a Request

5.3.1 Managers should be aware that there is a legal requirement to consider the application and inform the individual of the outcome within 2 months and should take this into consideration to ensure they have an adequate time frame to give the request due consideration.

5.3.2 The manager should arrange to discuss the application with the employee as soon as possible after receiving their request form (this can be in person, by telephone or via MS Teams). This will allow them to get a better understanding of the changes their employee is looking for and how they see things working in practice. The discussion should explore how the proposed working arrangement will work in practice, any potential positive and negative impact it may have on service provision and how it may affect other team members.

Employees have the right to be accompanied by a workplace colleague or a trade union representative at this meeting.

If the manager intends to approve the request, this meeting is not a requirement, but it may still be helpful to discuss practical arrangements.

5.3.3 Managers must consider whether the request is in relation to a reasonable adjustment related to a disability or another protected characteristic. Employees are encouraged to identify where this is the case. Managers should also consider any health and safety issues that might result from the change and identify ways to mitigate them (e.g., if the working arrangements will mean the employee or their colleagues would become lone workers). Advice can be sought from People Services/Human Resources/W&OD, Health and Safety and Occupational Health as appropriate.

5.4 Considering the Request

5.4.1 All requests should be approached with a can-do attitude, with the presumption that they will be granted unless it is genuinely not possible to do so for one of the business reasons set out below. The request should be considered carefully and the benefits of implementing the change should be weighed against any costs. In considering the application line managers must ensure that they do not directly or indirectly discriminate against the employee. If there is any doubt about what that might entail, then advice can be sought from the local EDI or People Services/Human Resources/ W&OD team.

Once a decision is made the manager should inform the employee in writing using part 3 of the request form or via ESR.

5.4.2 If it is decided to approve the employee's application, or accept it with modifications, a discussion should take place to determine how and when the changes might be best implemented. This may include a trial period. The line manager is responsible for ensuring that Payroll are notified if there are any changes to pay.

The employee must discuss and agree how they will organise their work and achieve deadlines in conjunction with their manager. Arrangements must be made between the employee and their manager to ensure that they are informed of the employee's current duties and where / how they will be working.

5.4.3 All endeavours must be made to accommodate the request in full or in part, or by providing an alternative. If, after discussing with the employee and considering all of the alternatives available, the manager feels they are unable to support flexible working in a particular post, they should discuss the application with People Services/Human Resources/ W&OD.

If following this conversation, they still do not feel able to approve the request and cannot find a mutually agreeable alternative they must meet with the employee to explain this to them and provide written, objectively justified reasons for this and give a clear operational reason why this is not practicable. The manager must provide details of the business grounds for refusing the request and how they apply in this case. The only acceptable reasons are:

- Burden of additional cost
- Detrimental effect on ability to meet customer/patient needs
- Inability to re-organise work among existing employees
- Detrimental impact on quality
- Detrimental impact on performance
- Detrimental impact on the ability to meet service demands
- Insufficient work for the periods the employee proposes to work
- Planned structural changes to the department.

5.4.4 There may be occasions when the manager is unsure whether a flexible working arrangement is sustainable, or where there is concern about the possible impact on others in the department. In these cases, the manager may agree to the flexible working arrangements on a temporary or trial basis rather than rejecting the request. Advice should be sought from People Services/Human Resources/W&OD.

5.5. Escalation Stage

5.5.1 This stage should be used if a line manager has not been able to reach agreement on a solution in the exploratory stage. The purpose is to check for other possible solutions including whether the form of flexibility the individual is seeking could be accommodated in a different team, location or role.

If a request for flexible working has not been accommodated, and they no longer feel able to continue to work in that department as they are unable to balance their work / life responsibilities, managers are expected to support the individual in identifying any alternative roles within the organisation which may be more supportive of the individual's circumstances and in line with their request.

5.5.2 When a meeting is arranged to discuss the application, or to consider an appeal, and the employee fails to attend it or one further rearranged meeting without good reason, the manager is able to consider that the request is withdrawn. If the manager regards the application as withdrawn, they must inform the employee of this.

5.6 Timescales

When the manager receives the formal request for flexible working this must be considered and decided on within a period of 2 months from first receipt of the request. This two-month time limit is a legal requirement and cannot be extended unless mutually agreed by the manager and employee.

Managers must be mindful of this 2-month time period when arranging the initial meeting/conversation with the employee to ensure that all applications are dealt with within the required timescales.

NHS Wales employees also have the right to request an appeal if their request is turned down. The timescales for an appeal are set out below.

5.7 More than one request received at around the same time.

It is important that managers consider requests to work flexibly in a fair way but there is no statutory requirement to consider them strictly in the order in which they are received. If they receive more than one request to work flexibly at around the same time it may not be possible to support all the requests received. The manager must then look closely at the impact supporting the requests would have on the service and the potential impact that refusal would have on each employee before coming to a decision.

In deciding how to deal with competing requests, the manager should bear in mind the different legal obligations that apply and can seek advice from the local EDI or People Services/Human Resources/W&OD team.

It will be helpful to have an individual discussion with both (or all) of the applicants to understand the exact nature of their request and to see if any mutually agreeable arrangement can be found.

5.8 Appeals

5.8.1 Where the flexible working request is refused, the employee may lodge an appeal within 14 days of being notified of the refusal of their request by contacting their manager's line manager.

This must be in writing and clearly state the grounds on which they are appealing. These may be:

- Where new information is now available in relation to the request
- Where the employee feels that the application was not handled in line with the policy
- Where the employee may have a proposal that has not been fully considered in relation to a business reason for refusal.

5.8.2 An appeal meeting will be held, normally within one month of receipt of the written appeal. This will be dealt with impartially by a more senior person than the manager who made the original decision.

Employees should be given the opportunity to be accompanied by a trade union representative or work colleague at any appeal meeting. The outcome of the appeals will be communicated in writing within seven days of the appeal meeting. This is the end of the procedure and there is no further appeal, although further requests for flexible working can be submitted.

5.9 Review of Flexible Working Arrangements

5.9.1 Before a final decision is reached about whether or not a flexible working arrangement can be supported, it may be beneficial to have an initial trial period of 3 months and to review the arrangement after this period to ensure that it is working for both the employee and the service.

5.9.2 When a flexible working arrangement has been agreed on a temporary basis, it is important to review it at agreed intervals to determine if it should be extended or come to an end at the agreed date.

In all cases, it is recommended that the flexible working arrangement is discussed annually (e.g., at appraisal) to ensure that it is still working for both parties. Where the arrangements are agreed as permanent from the outset or following the recommended three-month trial, it may not always be possible for the employee to resume their previous working arrangements as other colleagues may have been appointed to cover the shortfall created by the flexible working arrangement or service redesign may have taken place.

This must be explained to the employee during the initial discussions. However, any request to revert to the former working arrangements should be considered by the manager and agreed where it is possible to do so.

5.9.3 Where the manager believes that the flexible working arrangements are no longer sustainable and need to be changed this may be agreed informally between the manager and the employee as part of the ongoing conversation between them. Where the agreement is to be terminated/changed reasonable notice should be given to enable both parties to make the appropriate transitional arrangements however, wherever possible a meaningful discussion should take place and a mutually agreeable arrangement found.

06 & 07

Correspondence & Terms and Conditions Considerations

06 & 07 Correspondence & Terms and Conditions Considerations

6. Correspondence

Copies of all correspondence in relation to requests should be kept on the employee's personal file and details of the arrangements agreed should be recorded on ESR to enable monitoring of the flexible working arrangements in place at an organisational level.

7. Terms and Conditions Considerations

Listed below are the general terms and conditions which apply to flexible working arrangements. Managers should ensure that they discuss them with employees who are interested in working flexibly to ensure that they understand any potential implications. In addition, employees considering making a request for flexible working should consider the effect of the arrangement on their salary and pension and take advice from the NWSSP Payroll/ Pensions Department where necessary.

- **Hours of Duty**
  Where flexible working arrangements are put into place the exact hours and how they are worked should be discussed and agreed before the change is put into place

- **Annual Leave**
  Annual leave will be calculated on a pro rata basis, as appropriate

- **Sick Pay**
  Sick pay entitlement is pro rata and dependent on length of service. Employees working on any flexible arrangements must report sick in the same way as if they were not working flexibly

- **Maternity/ New parent /Adoption/ Shared Parental Leave**
  Pay is pro rata (as appropriate) and is dependent on length of service. Following maternity /adoption or shared parental leave an employee may wish to return to work on adjusted working arrangements to accommodate their changed circumstances. The NHS Organisation has a duty to accommodate this where at all possible. If it is agreed that the employee will return to work on a flexible basis, including changed or reduced hours, for an agreed temporary period this will not affect the employee's right to return to their job under their original contract at the end of the agreed period

- **Pensions**
  Pension contributions will be pro rata for employees working less than full-time hours

- **Expenses**
  All expenses incurred (e.g., subsistence, travelling) will be paid in the same way as for full-time employees. All employees will retain a NHS Organisation base for the purpose of claiming travel expenses

- **Pay**
  Salary will be pro rata for employees on less than full-time contracts. Those on Term Time working and seasonal contracts will be paid in 12 equal instalments each year

- **Additional Hours**
  If employees work beyond their normal hours (but not outside normal full-time hours) this must be by agreement with the line manager and will be paid at plain time rate or taken as time off in lieu

- **Policies and Procedures**
  Employees working flexibly remain subject to all Policies and Procedures of the Health Board/Trust.

08 & 09

Other Associated Documents & Monitoring and Review

8. Other Associated Documents

This Policy should be read in conjunction with other All Wales and local policies on:

- Managing Attendance at Work
- Retirement
- Special Leave
- Maternity/Adoption /Shared Parental Leave
- Home Working
- Agile Working
- Employment Break.

It should also be read in conjunction with:

- ACAS Code of Practice on Flexible Working Requests
- NHS Wales Flexible Working – briefing and guidance.

9. Monitoring and Review

Each Department will keep a record of all formal applications for Flexible Working and a record of approvals/ rejections and appeals.

Organisations should ensure that data relating to applications for flexible working and outcomes of decisions are recorded and regularly reported through the usual joint partnership and governance structures. This information should be included in an organisation's published annual statutory public sector duty reports. The published information should demonstrate outcomes for flexible working applications disaggregated by each protected characteristic of the Equality Act 2010. In addition, organisations should consider reporting outcomes by occupational group and also by department.

10

Appendix 1

Definitions

Flexible working describes a type of working arrangement which gives a degree of flexibility on how long, where, when and at what times employees work. Flexible working aims to accommodate employee's personal needs and meet their unique requirements.

Agile working is the ability to work in the place and at the time most appropriate for the task in hand. While agile working and flexible working may be similar in how they achieve their aim, for example both approaches may allow an employee to work from home, flexible working focuses on the employee, while agile working is focused on the impacts on the business including performance and productivity.

It may be a tool which can supplement or support a Flexible Working arrangement, but it is not a contractual change to an employee's terms and conditions. Agile working offers flexibility for employees that allows them to work in a way that suits them, provided the work happens.

Working remotely is when employees work all or part of their working week at a location remote from their base. This can be at home or elsewhere. Working remotely can be a flexible working arrangement (e.g., if requested by the individual and agreed as a regular, ongoing way of working), but it can also be a form of agile working.

Most NHS Organisations have local procedures to enable employees to request to work remotely. If this is not the case the processes set out in this Policy can be applied

Hybrid working is a mixture of remote working and working from a base.

Types of Flexible Working Covered by this Policy

There are many types of flexible working which employees may be able to apply for. Managers should consider how these options are communicated to all employees at recruitment, induction, and in regular one-to-one meetings. This list is not exhaustive, and organisations will consider other models of flexible working as requested to do so.

Part Time Working
Part-time working is a well-established form of flexible working which means that the employee reduces their contracted working hours below full time (37.5 hours) in order to work less days or shorter days in a pre-arranged, regular pattern. Salary, annual leave and bank holidays are reduced pro rata.

Job Sharing
This is where two employees share the responsibilities, duties and benefits of a single full-time post between them. The combined salary and conditions of service are equivalent to that of a single full-time post and are divided in accordance with the number of hours worked by each job sharer.

The principle of job sharing usually reflects an integrated pattern of working, where some of the work may be shared and other tasks distributed evenly to each sharer. The total hours should not normally exceed those of a full-time post.

In the case of job-sharing, if one sharer leaves, the existing job-sharer should be offered the full-time post (where accepted the manager must complete a changes form). If the existing job sharer does not want to work full-time, the vacant hours of the post must be advertised.

Term Time Working
Term time working is a form of part time working where the employee works only during the school terms and is off work during the school holidays. Time off is made up of a combination of annual leave and unpaid leave. Salary is based on the number of weeks in work and is paid in 12 equal instalments. It is calculated on an individual basis to take account of annual leave entitlement based on length of service and any protection arrangements. Salary, annual leave and related benefits are reduced pro rata. and salary is paid in 12 equal instalments.

Seasonal Hours
Employees work their contracted hours over an agreed period, rather than a set number of days. These are often annualised hours but can be bi-annual, quarterly or monthly.

Compressed Hours
Employees are able to work their full contracted hours over a shorter period than is standard. Contracted hours and pay remain unchanged, but employees are able to have more days or half days off. Examples include a 4½ day week or 9-day fortnight. The non-working day/half day must be mutually agreed and can be flexible to suit the needs of the service.

Voluntary Temporary Reduction in Hours
Employees are able to reduce their contracted hours by between 5 and 50% for a period of no less than 3 months, and no more than one year. At the end of the agreed time, they return to their original contracted hours. Salary/annual leave etc. will be reduced pro-rata for the period of the agreement. Employees are advised to contact payroll to determine whether a change in hours will affect their pension entitlements. If the employee wishes to extend this arrangement for longer than 12 months, they are required to submit a new flexible working request.

Flexi Time
Flexitime is a scheme which allows employees some discretion around the start and end time of the working day, based around core working times.
To benefit from this a department would need to have a Flexi-time arrangement in operation (not all departments would be in a position to accommodate this option).

Employees can build up a debit or credit of hours worked within an agreed period (usually 4 weeks) and consolidate the extra hours into a day or half day off. Flexitime schemes are usually based on detailed, locally agreed procedures which set out:

- the core hours
- limits on early and late working
- the minimum lunch break to be taken
- the maximum number of credit and debit hours which can be accrued
- limits on the number of hours which can be carried over to the next month
- limits on the number of days off allowed in any one period
- limits on the number of employees allowed off at any one time.

Flexible and Partial Retirement
There are a number of ways in which an employee can ease themselves into retirement in a flexible way. Details of the types of flexibilities available and the processes to be followed are set out in the Pension Flexibilities Policy.

Staggered Hours
This allows employees to determine their work pattern on a planned weekly basis. Hours can be staggered through the week or on just one or two days, within specified arrival and departure times, on a permanent or temporary basis.

Split Shifts
This allows employees to complete their working hours in two or more separate shifts, e.g., working between 7am – 11am, then returning to work between 4pm and 7pm.

Employment Breaks
An opportunity to leave the workplace for a specific period of time (usually between one and five years) and to return to the same or a similar position inside the organisation at the end of that period. For further details see the All-Wales Employment Break Policy.

Team based / Self Rostering
Team-based rostering starts from the premise that everyone has work-life balance needs and preferences, and that these need to be openly and collectively negotiated, among all those on each ward roster, within the constraints of service and financial needs. Self-rostering asks individuals to put their personal requirements into the roster each month, often on a 'first come, first served' basis. Team and Self Rostering are rolled out on a department wide basis.

Although it addresses work life balance needs, and the principles of flexible working apply, the request process set out in this Policy will not usually be appropriate for this purpose.

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Appendix 2

Flexible Working Request Form

PART 1 - Employee information	
Name of employee:	
Post:	
Band:	
Employee number:	
Email address:	
Department:	
Service Group:	
Line Manager:	
I would like to make a request to work a flexible working pattern that is different to my current working pattern.	
Requested start date of change:	
I would like this change to be Permanent/ Temporary (please delete as appropriate):	Permanent/Temporary* *For a period of……
Please describe your current working pattern e.g., location/days/hours/ worked etc.:	
Please describe the working pattern you would like to work e.g., days/hours/times worked/at home / in the office etc.	
Is your request for flexible working in relation to the Equality Act 2010 e.g. (disability, maternity, caring responsibilities)? *n.b., You do not have to give this information, but it will help your manager to make a decision on your application.*	Yes/No
If yes, please provide details:	
Employee signature:	
Date of application:	

NOW PASS THIS APPLICATION TO YOUR LINE MANAGER

Flexible Working Request Form

PART 2 - Receipt of request	
Date of receipt:	
Line Manager Name (please print)	
Line Manager Title:	
Date meeting/ conversation has been arranged for:	

Part 3 - Acceptance or Rejection Form
Either: Further to the meeting that took place on (Date) ……. I have considered your request for a new flexible working pattern. ☐ I am pleased to confirm that I am able to grant your request. With effect from (date). This will be a permanent / temporary change (please delete as appropriate). If temporary to end on (date). ☐ I am able to accommodate your request as a trial basis with effect from (date) to be reviewed on (date) (usually 3 months). ☐ I am unable to accommodate your original request. However, I am able to offer the alternative pattern which we have discussed and which you agreed would be suitable to you. Please set out how the service will be maintained and how any impact on other employees can be mitigated.
Your new working pattern will be as follows: Or: I am sorry but I am unable to accommodate your request for the following business ground(s) (please tick): ☐ The burden of additional costs ☐ Detrimental effect on ability to meet service user/patient needs ☐ An inability to reorganise work amongst existing employees ☐ A detrimental impact on quality ☐ A detrimental impact on performance ☐ Detrimental effect on ability to meet service demands ☐ Insufficient work for the periods the employee proposes to work ☐ A planned structural change to the department These grounds apply in the circumstances because (you should explain why any work patterns you may have discussed at the meeting are inappropriate. Please continue on a blank sheet, if necessary, **n.b this section must be completed to describe how the reason selected above applies in this case).**

Start date of new working arrangements (if applicable):	
Line Manager Signature:	
Line Manager Name (in Full):	
Date:	

Please confirm which applies: **This change in working pattern will be a permanent change to your terms and conditions of employment unless otherwise stated and you have no right in law to revert back to your previous working pattern unless previously agreed.** OR: This will be a temporary change to your working arrangements and will be until …… at which time the arrangements will be reviewed.
If you are unhappy with the decision, you may appeal against it. Details of the appeal procedure are set out below.

Line Manager Signature:	
Line Manager Title (in full):	
Date:	

If you accept the change outlined above, please sign and confirm receipt of the decision.

Employee Signature:	
Date:	

To The Employee:

If you are unhappy with the decision, you may appeal against it. Details of the appeal procedure are set out below.

Appeal Process

If an application for flexible working is turned down, the employee has the right to appeal against the decision. Appeals should be in writing, setting out the grounds for appeal, as soon as possible after receiving notice of the decision to reject the application (within 14 days).

The appeal should be submitted to your line manager's manager and heard by a more senior manager than the one who rejected the original application.

The employee has the right to be accompanied at this meeting and should be given advance notice of when it will take place.

Notes:

Part 1 - to be completed by Employee and forwarded to Line Manager.

Part 2, and 3 - to be completed by Line Manager.

Form should be returned to the Employee when completed and a copy kept on their personal file.

A PIF must be completed and submitted to NWSSP where there is a change in hours.

Designed by the NWSSP Communications Team


Cymru Gyfan
Polisi Gweithio Hyblyg

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01 & 02
Datganiad Polisi a Cwmpas

03
Egwyddorion

04
Manteision Gweithio Hyblyg

05
Y Broses Gwneud Cais Am Weithio Hyblyg

06 & 07
Gohebiaeth a Ystyriaethau Telerau ac Amodau

08 & 09
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Cymeradwywyd gan: Fforwm Partneriaeth Cymru

Dyddiad cyhoeddi: Rhagfyr 2023

01 & 02

Datganiad Polisi a Cwmpas

1. Datganiad Polisi

1.1 O fewn GIG Cymru, rydym yn gwybod, er mwyn diwallu anghenion iechyd a gofal ein poblogaeth yn effeithiol, ei bod yn bwysig cael gweithlu sy'n iach, yn ymgysylltiedig ac yn llawn cymhelliant. Rydym wedi ymrwymo i fod yn lle gwych i weithio a dysgu ac i ddarparu gwasanaeth o ansawdd, gan gydnabod bod ein gweithlu yn hanfodol i'n llwyddiant. Rydym yn cydnabod ein cyfrifoldeb i ddenu, cadw, defnyddio a datblygu pobl i wneud y mwyaf o'u potensial.

Un o'r ffyrdd o gyflawni hyn yw datblygu a chynnal diwylliant lle mae gweithio'n hyblyg yn cael ei ystyried yn alluogwr ar gyfer darparu gwasanaethau effeithiol ac effeithlon sydd â manteision i gydweithwyr, cleifion a'r sefydliad. Mae GIG Cymru wedi ymrwymo i hyrwyddo ac annog gwahanol ffyrdd o weithio er mwyn recriwtio pobl ragorol a chadw cyfoeth o wybodaeth, sgiliau a phrofiad ei weithlu presennol.

1.2 Mae hyblygrwydd mewn cyflogaeth yn helpu pobl i gydbwyso cyfrifoldebau gwaith ag agweddau eraill ar eu bywydau ac i ddiwallu'r anghenion a allai godi ar wahanol adegau yn eu bywydau. Yn allweddol i gyflawni hyn mae darparu ac argaeledd cyfleoedd gweithio hyblyg sy'n caniatáu i weithwyr wneud dewisiadau ynghylch sut a phryd y maent yn dymuno gweithio, ochr yn ochr â pholisïau sy'n cefnogi rheolwyr i gymryd yr amser i ddeall beth sydd ei angen ar bob person.

1.3 Mae Ymagwedd GIG Cymru tuag at Weithio Hyblyg wedi'i nodi mewn datganiad a ddatblygwyd ac a gytunwyd mewn partneriaeth. Nod y dull hwn yw cefnogi rheolwyr i wneud newid diwylliannol fel bod y cwestiwn yn mynd yn "Sut gallwn ni wneud i hyn ddigwydd" yn hytrach na "Ni allwn wneud hyn oherwydd…"? Mae hyn yn golygu mai'r sefyllfa ddiofyn fydd y bydd cais am weithio hyblyg yn cael ei gymeradwyo, a phob llwybr posibl yn cael ei archwilio i hwyluso hyn, oni bai bod rhesymau busnes clir mewn polisi ac o ran y gyfraith dros wrthod. Mae'r Polisi hwn yn nodi'r egwyddorion sy'n sail i drefniadau gweithio hyblyg sy'n caniatáu i bobl gydbwyso cyfrifoldebau gwaith ag agweddau eraill o'u bywydau ac yn disgrifio'r prosesau i'w dilyn wrth wneud neu ystyried cais.

1.4 Mae hyblygrwydd mewn cyflogaeth yn ffactor allweddol wrth ddangos ymrwymiad GIG Cymru i driniaeth deg a chyfartal yn y gweithle ac wrth ddenu'r gweithwyr o'r safon uchaf i weithio i'r sefydliad. Dylid ystyried cyfleoedd gweithio hyblyg ar gyfer pob gweithiwr a sicrhau eu bod ar gael cyn belled ag y bo'n ymarferol, waeth beth fo'u rôl, patrwm sifft, tîm neu fand cyflog a dylid eu hystyried hefyd ar gyfer gweithwyr sy'n gweithio ar gylchdro. Nid yw'n ddigonol i adrannau sydd â ffordd draddodiadol o weithio wrthod cais am weithio'n hyblyg dim ond am nad yw wedi cael ei roi ar brawf o'r blaen neu oherwydd mai 'dyma sut y mae wedi cael ei wneud erioed'.

1.5 Dylai holl sefydliadau'r GIG annog a hyrwyddo cyfleoedd i weithio'n hyblyg a defnyddio'r adnoddau sydd ar gael iddynt e.e. rhaglenni addysg, rheolaeth ac arweinyddiaeth i eirioli dros fanteision gweithio hyblyg a symud tuag at ddiwylliant sy'n ei dderbyn fel y norm. Lle bynnag y bo'n bosibl, dylai rheolwyr ystyried sut y gellir gwneud gwaith yn hyblyg a bod yn gefnogol i geisiadau i weithwyr weithio'n hyblyg i reoli cydbwysedd eu bywydau gwaith yn well, gan gynnal safonau gwasanaeth.

1.6 Er mwyn cefnogi diwylliant cadarnhaol o weithio'n hyblyg, bydd angen i sefydliadau ystyried sut maent yn cefnogi ac yn annog sgyrsiau agored am weithio'n hyblyg. Mae enghreifftiau o gyfleoedd i siarad am weithio'n hyblyg yn cynnwys mewn cyfarfodydd rheoli/goruchwylio llinell un-i-un, cyfarfodydd tîm/adrannol, fel rhan o sgyrsiau llesiant, neu fel rhan o brosesau recriwtio, ymsefydlu ac arfarnu blynyddol.

Wrth hysbysebu swydd, mae angen i sefydliadau sy'n cyflogi hefyd ystyried sut maent yn hyrwyddo'r hawl i ofyn am hyblygrwydd o'r diwrnod cyntaf ac argaeledd opsiynau gweithio hyblyg.

1.7 Mae GIG Cymru wedi ymrwymo i drin pawb yn gyfartal a chyda pharch, waeth beth fo'u hoedran, anabledd, ailbennu rhywedd, priodas neu bartneriaeth sifil, beichiogrwydd neu famolaeth, hil, crefydd neu gred, rhyw, neu gyfeiriadedd rhywiol. Mae Asesiad Effaith o'r Polisi hwn ar Gydraddoldeb wedi'i gwblhau.

2. Cwmpas

Mae'r polisi yn berthnasol i holl weithwyr o'r diwrnod cyntaf o'u cyflogaeth. Fodd bynnag, trefnir trefniadau gweithio hyblyg ar gyfer meddygon dan hyfforddiant gan ac yn amodol ar gymeradwyaeth y Ddeoniaeth Feddygol, AaGIC.

03

Egwyddorion

03 Egwyddorion

3. Egwyddorion

3.1 Mae GIG Cymru wedi ymrwymo i ddiwylliant gweithio hyblyg, sy'n golygu y bydd cais am weithio'n hyblyg yn cael ei gymeradwyo, ac y bydd pob llwyr posibl yn cael ei archwilio i hwyluso hyn, oni bai bod rhesymau busnes clir fel y nodir yn y Polisi hwn i'w wrthod.

Dylai trefniadau gweithio hyblyg da gydbwyso anghenion yr unigolyn gyda thri ffactor sefydliadol allweddol: profiad cleifion/defnyddwyr gwasanaeth, darparu gwasanaethau a phrofiad gweithwyr. Efallai na fydd yn bosibl cytuno i'r union gais, ond mae disgwyl i reolwyr drafod trefniadau amgen gyda'r unigolyn a sicrhau bod pob llwybr wedi'i archwilio cyn gwrthod y cais.

3.2 Dylai fod gan bob gweithiwr fynediad cyfartal at weithio'n hyblyg, cyn belled ag y bo'n ymarferol, waeth beth fo'i rôl, patrwm sifft, tîm neu fand cyflog a gellir ystyried pob swydd ar gyfer gweithio hyblyg. Er y cydnabyddir efallai na fydd rhai swyddi'n addas ar gyfer pob math o drefniadau gweithio hyblyg yn eu cyfanrwydd, dylai rheolwyr ystyried a oes modd gweithio elfennau penodol o'r rôl yn hyblyg.

3.3 Gall cyflogeion ofyn am weithio'n hyblyg o'r diwrnod cyntaf o'u cyflogaeth gontractiol a gallant wneud mwy nag un cais gweithio hyblyg y flwyddyn, waeth beth fo'r rhesymau drostynt.

3.4 Bydd gweithwyr yn cael eu trin yn deg wrth ystyried ceisiadau am drefniadau gweithio hyblyg. Bydd pob cais am weithio'n hyblyg yn cael ei dderbyn yn agored gan y rheolwr llinell priodol ac yn cael ei ystyried yn unigol ar sail ei rinweddau ei hun. Dylid ystyried unrhyw gais am weithio'n hyblyg gan dybio y bydd yn cael ei roi oni bai bod rheswm busnes dilys dros wrthod. Fodd bynnag, dylid ystyried unrhyw effaith bosibl ar weithwyr eraill a darparu gwasanaethau, gan gynnwys costau ychwanegol posibl.

3.5 Mae'n bwysig cytuno o'r cychwyn cyntaf a yw'r trefniadau gweithio newydd yn barhaol neu dros dro a rhaid dogfennu hyn i gyd yn ysgrifenedig. Pan fo'r trefniant dros dro neu am gyfnod penodol, rhaid ei adolygu'n rheolaidd i sicrhau bod anghenion y gwasanaeth a'r unigolyn yn dal i gael eu diwallu.

3.6 Ni fydd gweithwyr sy'n gweithio'n hyblyg yn cael eu trin yn llai ffafriol mewn perthynas â chyfleoedd hyfforddi a datblygu na chyfleoedd i gael eu dyrchafu.

3.7 Ni fydd unrhyw fath o weithio'n hyblyg yn caniatáu i weithwyr weithio yn groes i'r Rheoliadau Oriau Gwaith.

3.8 Er nad oes cyfyngiad ar nifer y ceisiadau y gall cyflogai eu gwneud o fewn cyfnod o 12 mis, gofynnir i weithwyr beidio ag ailgyflwyno ceisiadau sydd wedi'u gwrthod heb eu haddasu a/neu newid mewn amgylchiadau o fewn yr adran. Yn hytrach, fe'u hanogir i gynnal sgwrs reolaidd gyda'u rheolwr fel bod y ddwy ochr yn ymwybodol os bydd unrhyw beth yn newid ac yn gallu ymateb i'r newid hwnnw.

3.9 Rhaid cadarnhau newidiadau i gontract cyflogaeth gweithiwr yn ysgrifenedig.

04 Manteision Gweithio Hyblyg

04 Manteision Gweithio Hyblyg

4. Manteision Gweithio Hyblyg

Mae gweithio hyblyg o fudd i unigolion nid yn unig o ran caniatáu iddynt gydbwyso eu bywyd personol â'u bywyd gwaith ond hefyd o ran gwella iechyd a llesiant cyffredinol.

Mae unigolion sy'n hapusach gyda'u cydbwysedd rhwng bywyd i mewn ac allan o'r gwaith yn fwy cynhyrchiol yn gyffredinol, yn cynhyrchu gwaith o ansawdd gwell ac yn fwy gofalgar.
I reolwyr, gall gweithio hyblyg helpu i gadw gweithwyr – ac mae dal gafael ar bobl brofiadol a medrus yn bwysig o ran cynnal ansawdd a rheoli costau. Mae cynnig oriau hyblyg yn ehangu'r pwll talent, felly dylai rheolwyr allu recriwtio pobl â mwy o sgiliau. Gall hefyd gynyddu ymrwymiad a theyrngarwch gweithwyr a gall greu manteision trwy leihau lefelau absenoldeb a straen.

Gall Gweithio Hyblyg hefyd gefnogi ailgynllunio gwasanaethau trwy greu rolau cymysg newydd ac ail-lunio a datblygu rolau presennol, mewn ymgynghoriad â gweithwyr. Gall defnyddio rolau newydd a rolau sydd wedi'u hailgynllunio yn greadigol arwain at well gwasanaethau i gleifion a gyrfaoedd mwy gwerth chweil i'n gweithlu.

05

Y Broses Gwneud Cais Am Weithio Hyblyg

05 Y Broses Gwneud Cais Am Weithio Hyblyg

5. Y Broses Gwneud Cais Am Weithio Hyblyg

5.1 Efallai y bydd nifer o resymau pam y gallai fod angen i weithwyr fabwysiadu trefniant gweithio mwy hyblyg am gyfnod byr (h.y. hyd at 8 wythnos) i fynd i'r afael â mater penodol. Os felly, gall fod yn briodol i'r cyflogai a'r rheolwr drafod a chytuno ar hyn yn anffurfiol, yn enwedig lle nad yw'r newid yn effeithio ar ei delerau na'i amodau eraill (e.e. cyflog). Fodd bynnag, dylid dogfennu a chadarnhau canlyniad y drafodaeth yn ysgrifenedig.

5.2 Gwneud y cais

Os yw'r gweithiwr yn dymuno gwneud cais am fath o weithio'n hyblyg yn barhaol neu yn y tymor hwy, dylai gwblhau Ffurflen Gais Gweithio Hyblyg (Atodiad 1) neu gwblhau'r cais ar ESR a'i gyflwyno i'w reolwr llinell. Efallai y bydd y gweithiwr am gael trafodaeth anffurfiol gyda'i reolwr cyn cyflwyno cais ffurfiol ac anogir rheolwyr i hwyluso hyn pan ofynnir iddynt wneud hynny. Fodd bynnag, ni fydd y cais yn cael ei ystyried yn ffurfiol hyd nes y caiff ei gyflwyno'n ysgrifenedig.

Rhaid i'r ffurflen gais gynnwys yr wybodaeth ganlynol: -

- Rhaid iddo gael ei ddyddio a datgan pa newid i'w drefniadau gweithio y mae'n gwneud cais amdanynt, a phryd yr hoffai i'r newid hwn ddod i rym

- Lle bo'n berthnasol, anogir yr ymgeisydd i ddatgan a yw'n gwneud y cais mewn perthynas â Deddf Cydraddoldeb 2010, er enghraifft, fel addasiad rhesymol ar gyfer anabledd, neu ar ôl dychwelyd o absenoldeb mamolaeth, neu pryd y mae ar gyfer gofal plant neu ddibynyddion.

5.3 Ymateb i gais

5.3.1 Dylai rheolwyr fod yn ymwybodol bod gofyniad cyfreithiol i ystyried y cais a rhoi gwybod i'r unigolyn am y canlyniad o fewn 2 fis ac fe ddylid ystyried hyn i sicrhau bod ganddynt amserlen ddigonol i roi ystyriaeth ddyledus i'r cais.

5.3.2 Dylai'r rheolwr drefnu i drafod y cais gyda'r gweithiwr cyn gynted â phosibl ar ôl derbyn ei ffurflen gais (gall hyn fod yn bersonol, dros y ffôn neu drwy MS Teams). Bydd hyn yn ei alluogi i gael gwell dealltwriaeth o'r newidiadau y mae ei gyflogai'n chwilio amdanynt a sut y gallai pethau weithio'n ymarferol. Dylai'r drafodaeth archwilio sut y bydd y trefniant gweithio arfaethedig yn gweithio'n ymarferol, unrhyw effaith gadarnhaol a negyddol bosibl y gallai ei chael ar ddarparu gwasanaethau a sut y gallai effeithio ar aelodau eraill o'r tîm. Mae gan weithwyr yr hawl i ddod i'r cyfarfod hwn gyda chydweithiwr yn y gweithle neu gynrychiolydd undeb llafur.

Os yw'r rheolwr yn bwriadu cymeradwyo'r cais, nid yw'r cyfarfod hwn yn ofyniad, ond gall fod yn ddefnyddiol trafod trefniadau ymarferol o hyd.

5.3.3 Rhaid i reolwyr ystyried a yw'r cais mewn perthynas ag addasiad rhesymol sy'n gysylltiedig ag anabledd neu nodwedd warchodedig arall. Mae gweithwyr yn cael eu hannog i nodi lle mae hyn yn wir. Dylai rheolwyr hefyd ystyried unrhyw faterion iechyd a diogelwch a allai ddeillio o'r newid a nodi ffyrdd o'u lliniaru (e.e. os bydd y trefniadau gweithio yn golygu y byddai'r gweithiwr neu'i gydweithwyr yn dod yn weithwyr unigol). Gellir gofyn am gyngor gan y Gwasanaethau Pobl/Adnoddau Dynol/ Gweithlu a Datblygu Sefydliadol, Iechyd a Diogelwch ac Iechyd Galwedigaethol fel y bo'n briodol.

5.4 Ystyried y cais

5.4.1 Dylid ymdrin â phob cais gydag agwedd 'gallu ei wneud', gyda'r rhagdybiaeth y bydd yn cael ei rhoi oni bai nad yw'n wirioneddol bosibl gwneud hynny am un o'r rhesymau busnes a nodir isod. Dylid ystyried y cais yn ofalus a dylid pwyso a mesur manteision gweithredu'r newid yn erbyn unrhyw gostau. Wrth ystyried y cais, rhaid i reolwyr llinell wneud yn siŵr nad ydynt yn gwahaniaethu'n uniongyrchol neu'n anuniongyrchol yn erbyn y gweithiwr. Os oes unrhyw amheuaeth ynghylch yr hyn y gallai hynny ei olygu, yna gellir gofyn am gyngor gan y tîm Cydraddoldeb, Amrywiaeth a Chynhwysiant neu Gwasanaethau Pobl / Adnoddau Dynol / Gweithlu a Datblygu Sefydliadol lleol.

Unwaith y gwneir penderfyniad, dylai'r rheolwr hysbysu'r gweithiwr yn ysgrifenedig gan ddefnyddio rhan 3 o'r ffurflen gais neu drwy ESR.

5.4.2 Os penderfynir cymeradwyo cais y gweithiwr, neu ei dderbyn gydag addasiadau, dylid cynnal trafodaeth i benderfynu sut a phryd y gellid gweithredu'r newidiadau orau. Gall hyn gynnwys cyfnod prawf. Mae'r rheolwr llinell yn gyfrifol am sicrhau bod PCGC yn cael ei hysbysu os oes unrhyw newidiadau i gyflog.

Rhaid i'r gweithiwr drafod a chytuno ar sut y bydd yn trefnu ei waith ac yn cyflawni terfynau amser ar y cyd â'i reolwr. Rhaid gwneud trefniadau rhwng y gweithiwr a'i reolwr i sicrhau eu bod yn cael gwybod am ddyletswyddau cyfredol y gweithiwr a ble/sut y bydd yn gweithio.

5.4.3 Rhaid gwneud pob ymdrech i ddiwallu ar gyfer y cais yn llawn neu'n rhannol, neu drwy ddarparu dewis arall. Os, ar ôl trafod gyda'r gweithiwr ac ystyried yr holl ddewisiadau amgen sydd ar gael, mae'r rheolwr yn teimlo nad yw'n gallu cefnogi gweithio hyblyg mewn swydd benodol, dylai drafod y cais gyda Gwasanaethau Pobl/Adnoddau Dynol. Yn dilyn y sgwrs hon, os yw'n dal i deimlo nad yw'n gallu cymeradwyo'r cais ac ni allant ddod o hyd i ddewis arall sy'n dderbyniol i'r ddwy ochr y mae'n rhaid iddo gwrdd â'r gweithiwr i egluro hyn iddo a darparu rhesymau ysgrifenedig, gyda chyfiawnhad gwrthrychol drosto a rhoi rheswm gweithredol clir pam nad yw hyn yn ymarferol. Rhaid i'r rheolwr ddarparu manylion am y rhesymau busnes dros wrthod y cais a sut maent yn berthnasol yn yr achos hwn.

Yr unig resymau derbyniol yw:

- Baich costau ychwanegol
- Effaith niweidiol ar y gallu i ateb galw cwsmeriaid
- Anallu i ad-drefnu'r gwaith ymhlith y gweithwyr presennol.
- Effaith niweidiol ar ansawdd
- Effaith niweidiol ar berfformiad.
- Effaith niweidiol ar y gallu i gwrdd â gofynion y gwasanaeth.
- Dim digon o waith ar gyfer y cyfnodau y mae'r gweithiwr yn bwriadu gweithio
- Newidiadau strwythurol arfaethedig i'r adran.

5.4.4 Efallai y bydd achlysuron pan fydd y rheolwr yn ansicr a yw trefniant gweithio hyblyg yn gynaliadwy, neu lle mae pryder am yr effaith bosibl ar eraill yn yr adran. Yn yr achosion hyn, gall y rheolwr gytuno i'r trefniadau gweithio hyblyg ar sail dros dro neu gyfnod prawf yn hytrach na gwrthod y cais. Dylid gofyn am gyngor gan y Gwasanaethau Pobl/Adnoddau Dynol / Gweithlu a Datblygu Sefydliadol.

5.5. Cyfnod Uwchgyfeirio

5.5.1 Dylid defnyddio'r cam hwn os nad yw rheolwr llinell wedi gallu dod i gytundeb ar ddatrysiad yn y cam archwilio. Y diben yw gwirio am ddatrysiadau posibl eraill gan gynnwys a ellid bodloni'r math o hyblygrwydd y mae'r unigolyn yn chwilio amdano mewn tîm, lleoliad neu rôl wahanol.

Os nad yw cais am weithio'n hyblyg wedi'i gymeradwyo, ac nad yw'n teimlo ei fod yn gallu parhau i weithio yn yr adran honno gan nad yw'n gallu cynnal cydbwysedd rhwng ei waith / cyfrifoldebau bywyd, disgwylir i reolwyr gefnogi'r unigolyn wrth nodi unrhyw rolau amgen o fewn y sefydliad a all fod yn fwy cefnogol i amgylchiadau'r unigolyn ac yn unol â'i gais.

5.5.2 Pan drefnir cyfarfod i drafod y cais, neu i ystyried apêl, a bod y gweithiwr yn methu â dod iddo neu un cyfarfod arall wedi'i aildrefnu heb reswm da, gall y rheolwr ystyried bod y cais yn cael ei dynnu'n ôl. Os yw'r rheolwr yn ystyried bod y cais yn cael ei dynnu'n ôl, rhaid iddo hysbysu'r gweithiwr am hyn.

5.6 Timescales

Pan fydd y rheolwr yn derbyn y cais ffurfiol am weithio'n hyblyg, rhaid ystyried a phenderfynu arno o fewn cyfnod o 2 fis ar ôl derbyn y cais am y tro cyntaf. Mae'r terfyn amser dau fis hwn yn ofyniad cyfreithiol ac ni ellir ei ymestyn oni chytunir gan y rheolwr a'r gweithiwr ar y cyd.

Rhaid i reolwyr fod yn ymwybodol o'r cyfnod amser 2 fis hwn wrth drefnu'r cyfarfod/sgwrs gychwynnol gyda'r cyflogai i sicrhau yr ymdrinnir â'r holl geisiadau o fewn yr amserlenni gofynnol.

Mae gan weithwyr GIG Cymru hefyd yr hawl i apelio os yw eu cais yn cael ei wrthod. Mae'r amserlenni ar gyfer gwneud apêl wedi'u nodi isod.

5.7 Derbyn mwy nag un cais tua'r un adeg.

Mae'n bwysig bod rheolwyr yn ystyried ceisiadau i weithio'n hyblyg mewn ffordd deg ond nid oes gofyniad statudol i'w hystyried yn llym yn y drefn y cânt eu derbyn.

Os bydd yn derbyn mwy nag un cais i weithio'n hyblyg tua'r un pryd, efallai na fydd yn bosibl cefnogi'r holl geisiadau a dderbynnir. Yna mae'n rhaid i'r rheolwr edrych yn fanwl ar yr effaith y byddai cefnogi'r ceisiadau yn ei chael ar y gwasanaeth a'r effaith bosibl y byddai gwrthod yn ei chael ar bob gweithiwr cyn dod i benderfyniad. Wrth benderfynu sut i ddelio â cheisiadau sy'n cystadlu â'i gilydd, dylai'r rheolwr gadw mewn cof y gwahanol rwymedigaethau cyfreithiol sy'n berthnasol a gall ofyn am gyngor gan y tîm Cydraddoldeb, Amrywiaeth a Chynhwysiant neu Gwasanaethau Pobl / Adnoddau Dynol / Gweithlu a Datblygu Sefydliadol lleol. Bydd yn ddefnyddiol cael trafodaeth unigol gyda'r ddau (neu bob un) o'r ymgeiswyr i ddeall union natur eu ceisiadau ac i weld a ellir dod o hyd i unrhyw drefniant y gellir ei gytuno ar y cyd.

5.8 Apeliadau

5.8.1 Os gwrthodir y cais gweithio hyblyg, gall y gweithiwr gyflwyno apêl o fewn 14 diwrnod o gael gwybod am wrthod ei gais drwy gysylltu â rheolwr llinell ei reolwr.

Rhaid i hyn fod yn ysgrifenedig a datgan yn glir y sail y maent yn apelio arni. Gallai'r rhain fod:

- Pan fo gwybodaeth newydd bellach ar gael mewn perthynas â'r cais
- Pan fo'r gweithiwr yn teimlo na chafodd y cais ei drin yn unol â'r polisi
- Pan fo gan y gweithiwr gynnig nad yw wedi'i ystyried yn llawn mewn perthynas â rheswm busnes dros wrthod.

5.8.2 Cynhelir cyfarfod apêl, fel arfer o fewn mis i dderbyn yr apêl ysgrifenedig. Bydd hyn yn cael ei drin yn ddiduedd gan uwch berson na'r rheolwr a wnaeth y penderfyniad gwreiddiol.

Dylai gweithwyr gael y cyfle i ddod â chynrychiolydd undeb llafur neu gydweithiwr i unrhyw gyfarfod apêl. Bydd canlyniad yr apeliadau'n cael ei gyfleu'n ysgrifenedig o fewn saith diwrnod i'r cyfarfod apêl. Dyma ddiwedd y weithdrefn ac nid oes apêl bellach, er y gellir cyflwyno ceisiadau pellach am weithio'n hyblyg.

5.9 Adolygiad o Drefniadau Gweithio Hyblyg

5.9.1 Cyn y gwneir penderfyniad terfynol ynghylch a ellir cefnogi trefniant gweithio hyblyg ai peidio, gallai fod yn fuddiol cael cyfnod prawf cychwynnol o 3 mis ac adolygu'r trefniant ar ôl y cyfnod hwn i sicrhau ei fod yn gweithio i'r gweithiwr a'r gwasanaeth.

5.9.2 Pan gytunir ar drefniant gweithio hyblyg dros dro, mae'n bwysig ei adolygu ar adegau y cytunir arnynt i benderfynu a ddylid ei ymestyn neu ddod ag ef i ben ar y dyddiad y'i cytunwyd.

5.9.3 Ym mhob achos, argymhellir bod y trefniant gweithio hyblyg yn cael ei drafod yn flynyddol (e.e. wrth werthuso) i sicrhau ei fod yn dal i weithio i'r ddau barti. Os cytunir ar y trefniadau fel rhai parhaol o'r cychwyn cyntaf neu yn dilyn y cyfnod prawf tri mis a argymhellir, efallai na fydd bob amser yn bosibl i'r gweithiwr ailgydio yn ei drefniadau gwaith blaenorol gan y gallai cydweithwyr eraill fod wedi'u penodi i gyflenwi'r bwlch a grëwyd gan y trefniant gweithio hyblyg neu ailgynllunio gwasanaethau a allai fod wedi digwydd. Rhaid egluro hyn i'r gweithiwr yn ystod y trafodaethau cychwynnol. Fodd bynnag, dylai'r rheolwr ystyried unrhyw gais i ddychwelyd i'r hen drefniadau gweithio a chytuno lle bo'n bosibl gwneud hynny.

5.9.4 Os yw'r rheolwr o'r farn nad yw'r trefniadau gweithio hyblyg bellach yn gynaliadwy a bod angen eu newid, gellir cytuno ar hyn yn anffurfiol rhwng y rheolwr a'r gweithiwr fel rhan o'r sgwrs barhaus rhyngddynt. Lle mae'r cytundeb i gael ei derfynu/ei newid, dylid rhoi rhybudd rhesymol i alluogi'r ddau barti i wneud y trefniadau trosiannol priodol. Fodd bynnag, lle bynnag y bo'n bosibl, dylid cynnal trafodaeth ystyrlon a chytuno ar drefniant sy'n dderbyniol i'r ddau barti.

06 & 07

Gohebiaeth a Ystyriaethau Telerau ac Amodau

06 & 07 Gohebiaeth a Ystyriaethau Telerau ac Amodau

6. Gohebiaeth

Dylid cadw copïau o'r holl ohebiaeth mewn perthynas â cheisiadau ar ffeil bersonol y cyflogai a dylid cofnodi manylion y trefniadau y cytunwyd arnynt ar ESR er mwyn gallu monitro'r trefniadau gweithio hyblyg sydd ar waith ar lefel sefydliadol.

7. Ystyriaethau Telerau ac Amodau

Isod mae'r telerau ac amodau cyffredinol sy'n berthnasol i drefniadau gweithio hyblyg. Dylai rheolwyr sicrhau eu bod yn eu trafod â gweithwyr sydd â diddordeb mewn gweithio'n hyblyg i sicrhau eu bod yn deall unrhyw oblygiadau posibl.
Yn ogystal, dylai gweithwyr sy'n ystyried gwneud cais am weithio'n hyblyg ystyried effaith y trefniant ar eu cyflogau a'u pensiynau a chael cyngor gan Adran Gyflogres/Pensiynau PCGC lle bo angen.

- **Oriau Dyletswydd**
  Lle bo trefniadau gweithio hyblyg yn cael eu rhoi ar waith, dylid trafod a chytuno ar yr union oriau a sut y cânt eu gweithio cyn i'r newid gael ei roi ar waith

- **Gwyliau Blynyddol**
  Cyfrifir gwyliau blynyddol ar sail pro rata, fel y bo'n briodol

- **Tâl Salwch**
  Mae hawl i dâl salwch yn pro rata ac yn dibynnu ar hyd y gwasanaeth. Rhaid i weithwyr sy'n gweithio ar unrhyw drefniadau hyblyg roi gwybod am eu salwch yn yr un modd â phe na baent yn gweithio'n hyblyg

- **Mamolaeth / Rhiant newydd / Mabwysiadu / Absenoldeb Rhiant a Rennir**
  Mae'r cyflog yn pro rata (fel y bo'n briodol) ac mae'n dibynnu ar hyd y gwasanaeth. Yn dilyn cyfnod mamolaeth/mabwysiadu neu absenoldeb rhiant a rennir, efallai y bydd gweithiwr yn dymuno dychwelyd i'r gwaith gyda threfniadau gweithio wedi'u haddasu i fodloni eu hamgylchiadau newydd.
  Mae'n ddyletswydd ar y Bwrdd Iechyd/ Ymddiriedolaeth i gytuno i hyn lle bynnag y bo hynny'n bosibl. Os cytunir y gall cyflogai ddychwelyd ar sail hyblyg, gan gynnwys newid neu leihau oriau, am gyfnod dros dro y cytunwyd arno, ni fydd hyn yn effeithio ar ei hawl i ddychwelyd i'w swydd o dan ei gontract gwreiddiol ar ddiwedd y cyfnod y cytunwyd arno

- **Pensiynau**
  Bydd cyfraniadau pensiwn yn pro rata i weithwyr sy'n gweithio llai nag oriau llawnamser

- **Treuliau**
  Bydd yr holl dreuliau a godir (e.e. cynhaliaeth, teithio) yn cael eu talu yn yr un ffordd ag ar gyfer gweithwyr llawnamser. Bydd pob gweithiwr yn cadw lleoliad Bwrdd Iechyd/ Ymddiriedolaeth at ddibenion hawlio costau teithio

- **Cyflogau**
  Bydd y cyflog yn pro rata i weithwyr ar gontractau llai na llawnamser.
  Bydd y rhai sy'n gweithio yn ystod y tymor ac yn dymhorol yn cael eu talu mewn 12 rhandaliad cyfartal bob blwyddyn

- **Oriau Ychwanegol**
  Os yw gweithwyr yn gweithio y tu hwnt i'w oriau arferol (ond nid y tu allan i oriau llawnamser arferol) rhaid i hyn fod drwy gytundeb gyda'r rheolwr llinell a bydd yn cael ei dalu ar gyfradd amser arferol neu ei gymryd fel amser i ffwrdd yn lle hynny

- **Polisïau a Gweithdrefnau**
  Mae gweithwyr sy'n gweithio'n hyblyg yn parhau i fod yn ddarostyngedig i holl bolisïau a gweithdrefnau'r Bwrdd Iechyd/Ymddiriedolaeth.

08 & 09

Dogfennau Cysylltiedig Eraill a Monitro ac Adolygu

8. Dogfennau Cysylltiedig Eraill

Dylid darllen y Polisi hwn ar y cyd â pholisïau eraill Cymru Gyfan a pholisïau lleol ar y canlynol:

- Rheoli Presenoldeb yn y Gwaith
- Ymddeol
- Absenoldeb Arbennig
- Mamolaeth/Mabwysiadu/Rhannu Absenoldeb Rhiant
- Gweithio Gartref
- Gweithio Ystwyth
- Seibiant Cyflogaeth.

Dylid ei ddarllen hefyd ar y cyd â'r canlynol:

- Cod Ymarfer ACAS ar Geisiadau Gweithio Hyblyg
- Gweithio Hyblyg GIG Cymru – briffio ac arweiniad.

9. Monitro ac Adolygu

Bydd pob Adran yn cadw cofnod o'r holl geisiadau ffurfiol am Weithio'n Hyblyg a chofnod o gymeradwyaeth/gwrthod ac apeliadau.

Dylai sefydliadau sicrhau bod data sy'n ymwneud â cheisiadau am weithio'n hyblyg a chanlyniadau penderfyniadau yn cael eu cofnodi a'u hadrodd yn rheolaidd drwy'r strwythurau cyd-bartneriaeth a llywodraethu arferol. Dylai'r wybodaeth hon gael ei chynnwys yn adroddiadau dyletswydd y sector cyhoeddus blynyddol a gyhoeddir gan sefydliad. Dylai'r wybodaeth a gyhoeddir ddangos canlyniadau ar gyfer ceisiadau gweithio hyblyg sydd wedi'u ddadgyfuno fesul nodwedd warchodedig o Ddeddf Cydraddoldeb 2010. Yn ogystal, dylai sefydliadau ystyried adrodd canlyniadau fesul grŵp galwedigaethol a hefyd yn ôl adran.

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Atodiad 1

Diffiniadau

Mae **gweithio hyblyg** yn disgrifio math o drefniant gweithio sy'n rhoi rhywfaint o hyblygrwydd ar ba hyd, ble, pryd ac ar ba adegau y mae gweithwyr yn gweithio. Nod gweithio hyblyg yw diwallu anghenion personol gweithiwr a bodloni ei ofynion unigryw.

Gweithio ystwyth yw'r gallu i weithio ble ac ar yr adeg fwyaf priodol ar gyfer y dasg dan sylw. Er y gall gweithio ystwyth a gweithio hyblyg fod yn debyg o ran sut y maent yn cyflawni eu nod, er enghraifft gall y ddau ddull ganiatáu i weithiwr weithio gartref, mae gweithio'n hyblyg yn canolbwyntio ar y gweithiwr, tra bod gweithio ystwyth yn canolbwyntio ar yr effeithiau ar y busnes gan gynnwys perfformiad a chynhyrchiant.

Gall fod yn offeryn a all ategu neu gefnogi trefniant Gweithio Hyblyg, ond nid yw'n newid cytundebol i delerau nac amodau cyflogai. Mae gweithio ystwyth yn cynnig hyblygrwydd i weithwyr sy'n caniatáu iddynt weithio mewn ffordd sy'n addas iddyn nhw, ar yr amod bod y gwaith yn cael ei gyflawni.

Gweithio o bell yw pan fydd cyflogeion yn gweithio rhan neu'r cyfan o'u hwythnos waith mewn lleoliad oddi wrth eu lleoliad gwaith arferol. Gall hyn fod gartref neu mewn mannau eraill.
Gall gweithio o bell fod yn drefniant gweithio hyblyg (e.e. os yw'r unigolyn yn gofyn amdano ac yn cael ei gytuno fel ffordd reolaidd, barhaus o weithio), ond gall hefyd fod yn fath o weithio ystwyth.

Mae gan y rhan fwyaf o sefydliadau'r GIG weithdrefnau lleol i alluogi gweithwyr i ofyn am weithio o bell. Os nad yw hyn yn wir, gellir cymhwyso'r prosesau a nodir yn y Polisi hwn.

Mae **gweithio hybrid** yn gymysgedd o weithio o bell ac o weithio o leoliad.

Mathau o weithio hyblyg a gwmpesir gan y polisi hwn

Mae llawer o fathau o weithio hyblyg y gall gweithwyr wneud cais amdanynt. Dylai rheolwyr ystyried sut mae'r opsiynau hyn yn cael eu cyfleu i'r holl weithwyr wrth recriwtio, ymsefydlu, ac mewn cyfarfodydd un-i-un rheolaidd. Nid yw'r rhestr hon yn gynhwysfawr, a bydd sefydliadau'n ystyried modelau eraill o weithio'n hyblyg yn ôl y gofyn i wneud hynny.

Gweithio'n rhan amser
Mae gweithio'n rhan-amser yn ffurf sefydledig o weithio hyblyg sy'n golygu bod y gweithiwr yn lleihau ei oriau gwaith dan gontract islaw llawnamser (37.5 awr) er mwyn gweithio llai o ddiwrnodau neu ddiwrnodau byrrach mewn patrwm rheolaidd a drefnwyd ymlaen llaw.
Mae cyflog, gwyliau blynyddol a gwyliau banc yn cael eu lleihau pro rata.

Rhannu Swydd
Dyma lle mae dau weithiwr yn rhannu cyfrifoldebau, dyletswyddau a buddion un swydd llawnamser rhyngddynt.
Mae cyflog ac amodau gwasanaeth cyfunol yn cyfateb i gyflog un swydd llawnamser ac fe'u rhennir yn unol â nifer yr oriau a weithir gan bob rhannwr swydd. Mae'r egwyddor o rannu swydd fel arfer yn adlewyrchu patrwm gweithio integredig, lle gellir rhannu rhywfaint o'r gwaith a dosberthir tasgau eraill yn gyfartal i bob rhannwr. Ni ddylai cyfanswm yr oriau fod yn fwy na rhai swydd llawnamser.

Yn achos rhannu swydd, os bydd un rhannwr yn gadael, dylai'r person arall sy'n rhannu'r swydd gael cynnig swydd lawnamser (os caiff ei derbyn, rhaid i'r rheolwr lenwi ffurflen newid). Os nad yw'r rhannwr presennol y swydd eisiau gweithio'n llawnamser, rhaid hysbysebu oriau gwag y swydd.

Gweithio yn Ystod y Tymor
Mae gweithio yn ystod y tymor yn fath o waith rhan-amser lle mae'r gweithiwr yn gweithio yn ystod tymor yr ysgol yn unig a'i fod i ffwrdd o'r gwaith yn ystod gwyliau'r ysgol. Mae'r amser i ffwrdd yn cynnwys cyfuniad o wyliau blynyddol ac absenoldeb di-dâl. Mae'r cyflog yn seiliedig ar nifer yr wythnosau yn y gwaith ac yn cael ei dalu mewn 12 rhandaliad cyfartal. Fe'i cyfrifir ar sail unigol i ystyried hawl gwyliau blynyddol yn seiliedig ar hyd y gwasanaeth ac unrhyw drefniadau diogelu. Mae cyflog, gwyliau blynyddol a buddion cysylltiedig yn cael eu lleihau pro rata, a thelir cyflog mewn 12 rhandaliad cyfartal.

Oriau Tymhorol
Mae gweithwyr yn gweithio eu horiau contract dros gyfnod y cytunwyd arno, yn hytrach na nifer penodol o ddiwrnodau. Mae'r rhain yn aml yn oriau blynyddol, ond gallant fod yn chwemisol, yn chwarterol neu'n fisol.

Oriau cywasgedig
Gall gweithwyr weithio eu horiau contract llawn dros gyfnod byrrach nag sy'n safonol. Mae oriau contract a thâl yn parhau heb eu newid, ond gall gweithwyr gael mwy o ddiwrnodau neu hanner diwrnodau i ffwrdd. Mae enghreifftiau'n cynnwys wythnos 4½ diwrnod neu bythefnos 9 diwrnod. Rhaid cytuno ar y diwrnod nad yw'n ddiwrnod gwaith ar y cyd a gall fod yn hyblyg i ddiwallu anghenion y gwasanaeth.

Gostyngiad Gwirfoddol Dros Dro mewn Oriau
Gall gweithwyr leihau eu horiau contract rhwng 5% a 50% am gyfnod o ddim llai na 3 mis, a dim mwy na blwyddyn. Ar ddiwedd yr amser a gytunwyd, byddant yn dychwelyd i'w horiau contract gwreiddiol. Bydd cyflog/gwyliau blynyddol ac ati yn cael eu lleihau pro-rata am gyfnod y cytundeb. Cynghorir gweithwyr i gysylltu â'r gyflogres i benderfynu a fydd newid mewn oriau yn effeithio ar eu hawliau pensiwn. Os yw'r gweithiwr yn dymuno ymestyn y trefniant hwn am fwy na 12 mis, mae'n ofynnol iddo gyflwyno cais gweithio hyblyg newydd.

Amser Fflecsi ("Flexitime")
Mae gweithio oriau hyblyg ("Flexitime") yn gynllun sy'n rhoi rhywfaint o ddisgresiwn i weithwyr o amgylch amser dechrau a diwedd y diwrnod gwaith, yn seiliedig ar amseroedd gwaith craidd. Er mwyn elwa o hyn, byddai angen i adran fod â threfniant Oriau Hyblyg ar waith (ni fyddai pob adran mewn sefyllfa i gynnig yr opsiwn hwn).

Gall gweithwyr gronni debyd neu gredyd o oriau a weithir o fewn cyfnod y cytunwyd arno (4 wythnos fel arfer) a throi'r oriau ychwanegol yn ddiwrnod neu'n hanner diwrnod i ffwrdd. Mae'r cynllun oriau hyblyg fel arfer yn seiliedig ar weithdrefnau manwl y cytunwyd arnynt yn lleol sy'n nodi:

- yr oriau craidd
- cyfyngiadau ar weithio'n gynnar ac yn hwyr
- yr isafswm egwyl ginio y gellid ei chymryd
- uchafswm nifer yr oriau credyd a debyd y gellir eu cronni
- cyfyngiadau ar nifer yr oriau y gellir eu cario drosodd i'r mis nesaf
- cyfyngiadau ar nifer y diwrnodau i ffwrdd a ganiateir mewn unrhyw un cyfnod
- cyfyngiadau ar nifer y gweithwyr a ganiateir i fod i ffwrdd ar unrhyw un adeg.

Ymddeoliad Hyblyg a Rhannol
Mae nifer o ffyrdd y gall gweithiwr gynefino i ymddeol mewn ffordd hyblyg. Nodir manylion y mathau o hyblygrwydd sydd ar gael a'r prosesau sydd i'w dilyn yn y Polisi Ymddeoliad.

Oriau Cyfnodol
Mae hyn yn caniatáu i weithwyr benderfynu ar eu patrymau gwaith yn wythnosol ac wedi'i gynllunio.
Gellir gwasgaru oriau drwy'r wythnos neu ar un neu ddau ddiwrnod yn unig, o fewn amseroedd cyrraedd a gadael penodol, yn barhaol neu dros dro.

Hollti Sifftiau
Mae hyn yn caniatáu i weithwyr gwblhau eu horiau gwaith mewn dau sifft neu fwy ar wahân, e.e. gweithio rhwng 7am ac 11am, ac yna dychwelyd i'r gwaith rhwng 4pm a 7pm.

Seibiant Cyflogaeth
Cyfle i adael y gweithle am gyfnod penodol o amser (rhwng un a phum mlynedd fel arfer) a dychwelyd i'r un swydd neu swydd debyg yn y sefydliad ar ddiwedd y cyfnod hwnnw. Am ragor o fanylion gweler Polisi Seibiant Cyflogaeth Cymru Gyfan.

Yn seiliedig ar Dîm / Hunan Restru
Mae'r gwaith rhestru yn seiliedig ar dîm yn dechrau ar y rhagdybiaeth bod gan bawb anghenion a dewisiadau cydbwysedd rhwng bywyd a gwaith, a bod angen trafod y rhain yn agored ac ar y cyd, ymhlith pawb ar bob rhestr ward, o fewn cyfyngiadau gwasanaeth ac anghenion ariannol. Mae hunan-restru yn gofyn i unigolion roi eu gofynion personol ar y rhestr bob mis, yn aml ar sail 'y cyntaf i'r felin'.

Mae Rhestru Tîm a Hunan Restru yn cael eu cyflwyno ar sail adran gyfan. Er ei bod yn mynd i'r afael ag anghenion cydbwysedd bywyd gwaith, ac egwyddorion gweithio hyblyg yn berthnasol, ni fydd y broses ymgeisio a nodir yn y Polisi hwn fel arfer yn briodol at y diben hwn.

11

Atodiad 2

Ffurflen Gais i Weithio'n Hyblyg

Rhan 1 - Gwybodaeth y gweithwyr	
Enw'r Gweithiwr:	
Swydd:	
Band:	
Rhif y gweithiwr:	
Cyfeiriad e-bost:	
Adran:	
Grŵp Gwasanaeth:	
Rheolwr llinell:	
Hoffwn wneud cais i weithio patrwm gwaith hyblyg sy'n wahanol i'm patrwm gwaith presennol.	
Dyddiad dechrau'r newid y gofynnwyd amdano:	
Hoffwn i'r newid hwn fod yn Barhaol/Dros Dro (dilëwch fel y bo'n briodol):	Parhaol/Dros Dro* *Am gyfnod o……
Disgrifiwch eich patrwm gwaith presennol e.e. lleoliad/diwrnodau/oriau a weithir ac ati:	
Disgrifiwch y patrwm gwaith yr hoffech weithio e.e. diwrnodau/oriau/amseroedd a weithir/gartref/yn y swyddfa ac ati:	
A yw eich cais am weithio'n hyblyg mewn perthynas â Deddf Cydraddoldeb 2010 e.e. (cyfrifoldebau anabledd, mamolaeth, gofalu)? *D.S. Nid oes rhaid i chi roi'r wybodaeth hon, ond bydd yn helpu'ch rheolwr i wneud penderfyniad ar eich cais.*	Ydy/Nac ydy
Os 'Ydy', rhowch fanylion:	
Llofnod y gweithiwr:	
Dyddiad y cais:	

NAWR, RHOWCH Y CAIS HWN I'CH RHEOLWR LLINELL

Ffurflen Gais i Weithio'n Hyblyg

Rhan 2 - Derbyn cais	
Dyddiad derbyn	
Enw'r Rheolwr Llinell (printiwch os gwelwch yn dda)	
Teitl y Rheolwr Llinell:	
Trefnwyd cyfarfod/ sgwrs ar gyfer:	

Rhan 3 - Ffurflen Derbyn neu Wrthod	
Naill ai: Yn dilyn y cyfarfod a gynhaliwyd ar (Date)……. Rwyf wedi ystyried eich cais am batrwm gweithio hyblyg newydd. ☐ Rwy'n falch o gadarnhau fy mod yn gallu cymeradwyo'ch cais. Yn weithredol o (date). Bydd hwn yn newid parhaol/dros dro (dilëir fel y bo'n briodol). Os yw'n newid dros dro, daw i ben ar (date). ☐ Gallaf gymeradwyo'ch cais ar gyfnod prawf i'w weithredu o (date) a'i adolygu ar date). ☐ Ni allaf gymeradwyo'ch cais gwreiddiol. Fodd bynnag, gallaf gynnig y patrwm amgen yr ydym wedi'i drafod a gytunoch y byddai'n addas i chi. Nodwch sut y bydd y gwasanaeth yn cael ei gynnal a sut y gellir lliniaru unrhyw effaith ar weithwyr eraill.	
Bydd eich patrwm gwaith newydd fel a ganlyn: Neu: Mae'n ddrwg gennyf ond ni allaf gymeradwyo'ch cais am y rheswm (rhesymau) busnes canlynol (ticiwch bob un sy'n berthnasol): ☐ Baich y costau ychwanegol ☐ Effaith niweidiol ar y gallu i ddiwallu anghenion defnyddwyr/cleifion y gwasanaeth ☐ Anallu i ad-drefnu'r gwaith ymhlith y staff presennol ☐ Effaith niweidiol ar ansawdd ☐ Effaith niweidiol ar berfformiad ☐ Effaith niweidiol ar y gallu i gwrdd â gofynion gwasanaeth ☐ Dim digon o waith ar gyfer y cyfnodau y mae'r gweithiwr yn bwriadu gweithio ☐ Newid strwythurol wedi'i gynllunio i'r adran Mae'r rhesymau hyn yn berthnasol o dan yr amgylchiadau oherwydd (eglurwch pam mae unrhyw batrymau gweithio y gallech fod wedi'u trafod yn y cyfarfod yn amhriodol. Parhewch ar daflen wag, os oes angen, **D.S. rhaid cwblhau'r adran hon i ddisgrifio sut mae'r rheswm a ddewiswyd uchod yn berthnasol yn yr achos hwn)**	
Dyddiad dechrau'r trefniadau gweithio newydd (os yn berthnasol):	
Llofnod y Rheolwr Llinell:	
Enw'r Rheolwr Llinell (yn Llawn):	
Dyddiad:	
Cadarnhewch pa un sy'n berthnasol: **Bydd y newid hwn mewn patrwm gwaith yn newid parhaol i'ch telerau ac amodau cyflogaeth oni nodir yn wahanol ac nid oes gennych hawl yn ôl y gyfraith i ddychwelyd yn ôl i'ch patrwm gwaith blaenorol oni chytunwyd yn flaenorol.** Neu: Bydd hwn yn newid dros dro i'ch trefniadau gweithio tan…… pan gaiff y trefniadau eu hadolygu.	
Os ydych yn anfodlon gyda'r penderfyniad, gallwch apelio yn ei erbyn. Nodir manylion y weithdrefn apelio isod.	
Llofnod y Rheolwr Llinell:	
Teitl y Rheolwr Llinell (yn llawn):	
Dyddiad:	
Os ydych yn derbyn y newid a amlinellir uchod, llofnodwch a chadarnhewch dderbyn y penderfyniad.	
Llofnod y Gweithiwr:	
Dyddiad:	

I'r Gweithiwr:

Os ydych yn anfodlon â'r penderfyniad, gallwch apelio yn ei erbyn. Nodir manylion y weithdrefn apelio isod.

Proses Gwneudd Apel

Os gwrthodir cais am weithio'n hyblyg, mae gan y gweithiwr yr hawl i apelio yn erbyn y penderfyniad. Dylid cyflwyno apeliadau'n ysgrifenedig, gan nodi'r rhesymau dros apelio, cyn gynted â phosibl ar ôl cael hysbysiad o'r penderfyniad i wrthod y cais (o fewn 14 diwrnod).

Dylid cyflwyno'r apêl i reolwr eich rheolwr llinell, a'i chlywed gan uwch reolwr yn hytrach na'r rheolwr a wrthododd y cais gwreiddiol.

Mae gan y gweithiwr yr hawl i gael cwmni yn y cyfarfod hwn, a dylid rhoi rhybudd ymlaen llaw o ba bryd y bydd yn digwydd.

Nodiadau:

Rhan 1 - i'w chwblhau gan y Gweithiwr a'i hanfon at ei Reolwr Llinell

Rhan 2 a 3 - i'w cwblhau gan y Rheolwr Llinell

Dylid dychwelyd y ffurflen at y gweithiwr pan fydd wedi'i chwblhau a chadw copi ar ei ffeil bersonol.

Rhaid cwblhau Ffurflen Gwybodaeth Bersonol a'i chyflwyno i PCGC lle mae newid i'r oriau.

Designed by the NWSSP Communications Team

Equality Impact Assessment (EQIA) Form		
Ref no:		
Name of the policy, service, scheme or project:	Scope:	
Flexible Working Policy	The policy applies to all employees of the Health Board/Trust from day one of their employment with Health Boards and Trusts in Wales with the exception of doctors in training for whom flexible working arrangements are arranged by and subject to the approval of the Wales Deanery.	
Preparation		
Aims and Brief Description	One of the defining features of the modern British labour market is its flexibility. In Britain the uptake of flexible working arrangements has increased slowly but steadily over the last decade (CIPD, 2019). This policy sets out the principles underpinning flexible working arrangements that allow people to balance work responsibilities with other aspects of their lives. Flexible working contributes to a positive work/life balance, which benefits both NHS employees through improved health and wellbeing, and employers because staff are more productive and satisfied at work. Offering flexible working opportunities is a way of attracting and retaining a diverse workforce and make the workplace more accommodating to diverse needs. According to the CIPD flexible working is a valuable tool in improving workplace equality and creating inclusive cultures. It can help parents return to work, reduce the gender pay gap, help people with fluctuating health conditions stay in work and help carers to balance their work and caring responsibilities There is a strong, unmet demand for more flexible jobs; 87% of people want to work flexibly, but only 11% of jobs are advertised as being flexible!2 • Advertising jobs as flexible can help organisations access a wider and more diverse talent pool – so you can get the best person for the job. Flexible working practices are a key reason for staff at all career stages being satisfied with their work and staying with their employer: flexibility can reduce staff turnover.14 Flexible working: the business case 2 • For senior and managerial staff, flexible working arrangements	

	are pivotal for being able to continue to work and develop as professionals,15 particularly if they become parents. • For entry-level employees, flexible working reduces job-life spillover which in turn improves retention and commitment.16 • Higher levels of engagement, experienced by working flexibly, can reduce staff turnover by 87%.17 both from flexible-working-business-case_tcm18-52768.pdf (cipd.org) (CIPD November 2018) Research by Timewise (2017) People are most likely to say their reason for wanting to work flexibly is work/life balance, or it being generally useful or convenient. Other key reasons include commuting issues, leisure or study interests, and caring responsibilities. The policy aims to: • • to support managers to make a cultural shift so that rather than "We can't do this because…" the question becomes "How can we make this happen"? This means that the default position will be that a request for flexible working will be approved, and every possible avenue explored to facilitate this, unless there are clear business reasons in policy and law to decline it. • Promoting flexible working practices across all levels throughout NHS Wales • Providing a framework for managers and their staff to hold a well-informed, confident and productive discussion around their request to work flexibly and the flexible working options that may be suitable for them. • Promoting the business benefits of flexible working and ensuring that managers are fully engaged and supported to enable flexible working opportunities in their areas • Ensuring that all managers/supervisors understand the principles of flexibility in the workplace and the procedure to be followed. • Ensuring that all applications for flexible working are welcomed from all and considered fairly and equitably The policy follows on from the work undertaken to develop a more agile working culture within the organisation. The policy sets out the process by which staff can apply to work flexibly in order to improve their work life balance and to improve

	recruitment and retention. The Policy takes account of the AFC Terms and Conditions (section 33) and the commitment made by NHS Wales to achieving the highest standards of health care services through recruiting and retaining highly skilled and motivated staff as set out in its **Flexible Working statement**. Managers must consider whether the request is in relation to a reasonable adjustment related to a disability or another protected characteristic and employees are encouraged to identify where this is the case. The Policy states that NHS Wales is committed to treating all people equally and with respect irrespective of their age, disability, gender, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, or sexual orientation.
Who is involved in undertaking the EQIA	Rachel Pressley, Head of People Assurance and Experience, Cardiff and Vale UHB Vicky Richards, RCM Mitchell Jones, Senior Equality and Inclusion Manager, Cardiff and Vale UHB All Wales Flexible Working Policy Working Group
Have you consulted with stakeholders in the development of this policy?	A working group was established to develop the NHS Wales Flexible Working Policy is working group consisted of NHS Employers, Employers (Workforce) and staff side representatives. The revised policy was then sent out for consultation through: • Workforce Directors • Trade unions
Does the policy assist services or staff in meeting their most basic needs such as; Improved Health, fair recruitment etc	Yes. NHS Wales is committed to an agile working culture, which means that wherever possible requests for flexible working arrangements will be supported unless there is a legitimate reason for refusing them based on business grounds. NHS Wales is also committed to developing and maintaining a flexible working culture to support the most effective and efficient provision of services for the benefit of staff, patients and the organisation. The aim of this approach, as set out in the Flexible Working Statement, is to support managers to make a cultural shift so that rather than “We can’t do this

	because…" the question becomes "How can we make this happen"? Flexibility in employment is a key factor in demonstrating NHS Wales commitment to fair and equal treatment in the workplace and in attracting the highest calibre of staff to work for the organisation. Flexible working opportunities should be considered for all staff and made available as far as practicable, regardless of role, shift pattern, team or pay band. Flexibility means giving people options and allowing them to work in ways that meet their needs while also meeting the needs of your clients and organisation. This kind of adaptability can improve inclusion, diversity, and efficiency while also increasing engagement and performance. According to NVCO (the membership community for charities, voluntary organisations and community groups in England) there is still a stigma surrounding flexible working which can make it hard for people to ask for the working patterns they need to thrive and do their best work. They state that negative attitudes toward flexibility are too often a barrier to people applying for new or more senior roles and that at its heart, flexibility is about inclusion for everyone. Flexible working should be a central part of conversations about social justice, social mobility and how charities become more inclusive, equitable and diverse. We might typically associate flexible working with parents and carers, but there is growing understanding of how flexibility in employment can be of benefit to individuals of all ages, and in many different circumstances, across the voluntary sector.
Who and how many (if known) may be affected by the policy?	The policy will apply to all staff. NHS Wales recognises that staff have different needs at different times in their working lives and flexibility in employment makes it possible for them to make choices about how and when they wish to work, taking into account the needs of the service. Any form of flexible working must meet the business needs of the Health Board/Trust and its commitment and ability to meet the required level and quality of services to our service users and their families. It may not be possible to

	agree to the exact request, but managers are expected to discuss with employees alternatives that might be possible. Flexible Working is now a day one qualification for all NHS staff. Within the NHS there is no limit on the number of applications that can be submitted by an individual each year. This means that it is possible to be more responsive to changes in individual's circumstances.
What guidance have you used in the development of this service, policy etc?	The policy is based on: • NHS Terms and Conditions of Service • NHS Wales Flexible Working Statement, • Existing policies/procedures from NHS Wales organisations • RCN Flexible Working Guide • RCM Flexible Working Guidance • All Wales Flexible Working Key Principles – agreed in partnership in 2014 • Draft All Wales Flexible Working Guidance – under development in partnership • Workforce Partnership Council Report on Flexible and Agile Working – published in December 2022

Equality Duties

The Policy/service/project or scheme Aims to meet the specific duties set out in equality legislation.	Protected Characteristics										
	Race	Sex/Gender	Disability	Sexual orientation	Religion and Belief	Age	Gender reassignment	Pregnancy and Maternity	Marriage & civil Partnerships	Welsh Language	Carers
To eliminate discrimination and harassment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote equality of opportunity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Promote good relations and positive attitudes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Encourage participation in public life	-	-	-	-	-	-	-	-	-	-	-
In relation to disability only, should the policy/service/project or scheme take account of difference, even if involves treating some individuals more favorably?			✓								

Key	
✓	Yes
x	No
-	Neutral

Human Rights Based Approach – Issues of Dignity & Respect

The Human Rights Act contains 15 rights, all of which NHS organisations have a duty. The 7 rights that are relevant to healthcare are listed below.

Consider is the policy/service/project or scheme relevant to:	Yes	No	N/A
Article 2: The Right to Life			✓
Article 3: the right not to be tortured or treated in a inhumane or degrading way			✓
Article 5: The right to liberty			✓
Article 6: the right to a fair trial			✓
Article 8: the right to respect for private and family life	✓		
Article 9: Freedom of thought, conscience and religion	✓		
Article 14: prohibition of discrimination	✓		

Measuring the Impact

What operational impact does this **policy, service, scheme or project**, have with regard to the Protected Characteristics. Please cross reference with equality duties	
	Impact
consider: **Race** **Sex/gender** **Disability** **Sexual orientation** **Religion belief and non belief** **Age** **Gender reassignment** **Pregnancy and maternity** **Marriage and civil partnership** **Other areas** **Welsh language** **Carers**	According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com) flexible work accounts for almost a quarter (23%) of the workforces across British nations (6.7 million workers in England, 650,000 workers in Scotland and 370,000 workers in Wales have flexible time arrangements). The national and regional distribution of workers on contracts with flexible time arrangements in Britain is almost identical to the national and regional distribution of all other workers. However, the availability of other types of flexible work varies across nations and regions: for example, Wales has relatively widespread flexibility in terms of the time of work arrangements, but flexibility in place of work and informal flexibility is rarer than in Scotland and England. They show that working flexible hours increased during the COVID-19 pandemic, eventually falling as the labour market started to recover. The number rose by 21% between October to December 2019 and October to December 2020 (from 6.3 million to 7.7 million), before falling to 7.1 million between April and June 2021. Since then, headline employment numbers have continued to improve. As of October to December 2021, the number of people on flexible contracts is 53% higher than it was in 2009 (rising from around 5.1 million to 7.7 million), making up almost a quarter (23%) of all workers, compared to 17% in 2009. The data shows that, since 2009, inflexible employment has declined slightly and flexible employment accounts for all growth. The Future Work report states that It is not clear how much of the increased move to flexible working during the COVID-19 pandemic – whether in terms of time or place – will be permanent. However, as more evidence is collected, it appears that the demand for increasing flexibility continues. Research by the Trades Union Congress (TUC) showed that, in Britain, more than nine out of ten people (91%) who worked remotely during the pandemic wanted to continue working from home at least some of the time after the pandemic (TUC, 2021b). According to the NHS Workforce data briefing September 2023 by Audit Wales NHS Wales is becoming a more flexible and equal employer but there is still more to do. • The participation rate of part time working in NHS Wales shows that generally fewer people are working part time up to the age of 30. Between the ages of 30 and 55 part time working is

increasing and beyond the age of 56, there is a clear movement to more staff working part time. The 'participation rate' is a measure of part-time working across an organisation's workforce. The higher the participation rate the more hours on average, an individual will work each week. 100% participation would mean that all staff are working full working weeks the briefing shows that female employees have a participation rate of 86% and male employees have a participation rate of 94%.

- NHS data on the ethnicity of the total workforce shows increasing employment of minority ethnic groups
- The percentage of staff identifying as disabled has increased over the last 5 years across Wales. The highest proportion of staff identifying as disabled are in Allied Health Professional (4.6%) and Admin and Clerical (4.3%) staff groups.
- Around third (30%) of NHS Wales staff have not stated their Welsh language competency in ESR. But of those who have, 59% of staff have indicated that they have no skills and only around 13% have identified that they have higher or proficient Welsh language skills

AGE:

According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com) In Britain between 2009 and 2019, workers aged 50 to 69 years old experienced the sharpest increase in flexible working (a 27% increase in the number of older workers in flexible work). This was followed by workers aged 25 to 49 years old (a 10% increase), with no increase for workers aged 16 to 24 years old. In 2009 approximately 5 million workers were employed in flexible work, 6% of people aged 16 to 24, 9% of those aged 25 to 49 and 9% of those aged 50 to 69. Flexible working arrangements increased throughout the COVID-19 pandemic for workers of all ages.
By 2021 those employed in flexible work had increased to 7.7 million workers. Of workers aged 16 to 24, 15% had flexible working arrangements, as did 25% of those aged 25 to 49 and 24% of people aged 50 to 69. Older workers were consistently employed more in flexible work. There are many reasons that could explain this difference, including individual needs and job requirements (CIPD, 2019). For example, older people are more likely to work flexibly to manage health conditions, caring responsibilities and / or to adjust towards retirement.

For many older workers, having access to flexible working opportunities is important for remaining active in the labour market. In particular, for people with additional needs or responsibilities, such as caring for a relative or managing a health condition, flexible working is imperative. (AGE UK)

According to the CIPD report 'Understanding Older Workers', older workers have higher rates of part-time working than younger workers. However, the finding that many would prefer shorter hours suggests there is still not enough flexibility to fully cater to older workers' preferences and employers should consider requests for reduced

hours. Older people are also much more likely to have caring responsibilities. This underlines the importance of ensuring employers take steps to increase the availability and range of flexibility as a means of both attracting and retaining workers as they get older.

The Equal Opportunities Commission says that discriminating against an employee or prospective employee because they are 'too old' or 'too young' is illegal and anyone who is subjected to unfair treatment or treated differently because of their age is considered to be a victim of age discrimination. All staff can apply for flexible working from day one of employment, and the Policy sets out the only reasons which can be given for rejecting an application. However, there may be differences in the ways different groups of staff want to work flexibly, for example, term-time working is designed specifically to assist employees with school age children, and is therefore more likely to be requested by younger workers.

One in eight older workers are forced out by ill health, and others are unable to fit work around caring responsibilities. Ethnically diverse communities and those in low-income jobs far more likely to have to stop work early for health reasons. Flexible working would benefit older workers managing long-term health conditions, needing to reduce their workload or with increased caring responsibilities by supporting them to stay in work longer if they want to. (https://www.tuc.org.uk/research-analysis/reports/extending-working-lives-how-support-older-workers 22 https://www.tuc.org.uk/research-analysis/reports/older-workers-after-pandemic-creating-inclusivelabour-market)

DISABILITY:

According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com) the number of disabled workers on flexible contracts rose 58% from 2013 to 2019 (19% to 21% of disabled workers), far more than the 8% increase for non-disabled workers (from 18% to 19% of non-disabled workers). This increase continued throughout the COVID-19 pandemic for both groups. The number of disabled workers on flexible contracts increased by 127% (from approximately 540,000 to 1.1 million) from 2013 to 2021, while for non-disabled workers the number rose by 43% (from 4.5 million to 6 million). In 2021, disabled and non-disabled workers were almost equally likely to work flexibly, with 26% of disabled workers and 25% of non-disabled workers having flexible working arrangements, an increase from 19% and 18% respectively in 2013. Many disabled people and representative organisations have advocated for greater availability of flexible and remote working. For some, remote working can be a way to gain and retain employment, as it helps to overcome some accessibility issues (EHRC, 2017). Under the Equality Act 2010, flexible working arrangements can also be a reasonable adjustment for disabled workers.

If an employee is disabled, it may be a reasonable adjustment to allow them to work flexibly if this removes a barrier to them being able to do the job (EHRC Guidance). Employers must make reasonable adjustments to make sure workers with disabilities, or physical or mental health conditions, are not substantially disadvantaged when

doing their jobs. Reasonable adjustments for workers with disabilities or health conditions - GOV.UK (www.gov.uk)

The Equality and Human Rights Commission states that equality law recognises that bringing about equality for disabled people may mean changing the way in which employment is structured, the removal of physical barriers and/or providing extra support for a disabled worker. This is the duty to make reasonable adjustments. The duty to make reasonable adjustments aims to make sure that, as far as is reasonable, a disabled worker has the same access to everything that is involved in doing and keeping a job as a non-disabled person

MATERNITY AND PREGNANCY:

- Employers are legally required to take reasonable steps to protect both the health and safety of pregnant employees and their baby. For example if they are finding it difficult to stand for long periods of time because of their advanced pregnancy, the employer must provide a suitable work space where they can sit down more frequently or take extra rest breaks. If sitting down or taking extra breaks are not feasible, the employer must provide suitable alternative work on similar conditions and terms. If there is no suitable work available, they would be entitled to have a suspension with full pay. (Equal Opportunities Commission)
- The Policy states that If at the end of their maternity leave an employee wishes to return to work on different hours, their manager has a duty to facilitate this wherever possible, with them returning to work on different hours in the same job. If this is not possible, the manager must provide written, objectively justifiable reasons for this and the employee should return to the same grade and work of a similar nature and status to that which they held prior to her maternity leave. These provisions are mirrored for staff on adoption leave and is also available to staff returning from Shared Parental Leave. Employees who return to work following Maternity Leave who are breastfeeding are entitled to frequent breaks, a private room etc. and do not need to access this Policy to achieve this

RELIGION & BELIEF:

- The ACAS guide for Religion or Belief discrimination: key points for the workplace (2018) states that an employer is under no obligation to automatically give staff time off for religious holidays or festivals, time to pray or a place to pray. However, it should consider requests carefully and sympathetically, be reasonable and flexible where possible, and discuss the request and explore any concerns with the employee. Refusing a request without a good business reason could amount to discrimination
- Some religions or beliefs may require their followers to pray at certain times of day, to have finished work by a particular time or to fast for extended periods (EHRC). This may have flexible working implications
- The Equality and Human Rights Commission website has a toolkit to support employers if staff request a change to their working conditions because of their religion, belief or lack or religion or belief. They advise that whether you say yes or no will depend on the circumstances of each case. You need to balance the effect of agreeing to the request on your business and other staff, against the effect on the individual of

not agreeing to the request.

GENDER

- According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com)Women are more likely to use flexible working arrangements than men in Britain, but since 2009 the use of flexible working arrangements has increased at a faster rate among men. Between 2009 and 2021 in Britain, on average 22% of women in work had flexible working arrangements compared to 16% of men. This is according to our analysis of data from the Labour Force Survey. Literature suggests that this contributes to some disadvantages for women, for example the gender pay gap (Costa Dias et al. 2018), and negative consequences for career progression (Chung, 2020). The COVID-19 pandemic, lockdowns, and widespread working from home for both men and women may have changed some of the negative perceptions around flexible work. Some evidence suggests that the appetite for continued remote working is equally high for men and women, and that the gender care gap narrowed during the pandemic between March and October 2020 (from 6.96 to 4.59 hours per week) (Nicks et al., 2021b). On the other hand, there is evidence to suggest that there were differences between how men and women experienced remote working during the pandemic, with women being more likely to report negative impacts on health, work–life balance and stress (Jones and Bano, 2021; Aviva, 2021). However, this requires further research to distinguish which patterns are long term and which are likely caused by unique circumstances during the pandemic. The number of women on flexible contracts rose 10% from 2009 to 2019, while the number of men on flexible contracts rose by 33% during the same period. This increase continued throughout the pandemic for both sets of workers. As of 2021, the number of women on flexible contracts is approximately 44% higher than in it was in 2009 (an increase from around 3.1 million to around 4.3 million), while the number of men on flexible contracts has risen by 65% (from around 2.1 million to around 3.5 million). The proportion of women on flexible contracts increased from 24% in 2009 to 29% in 2021, and the proportion for men increased from 15% in 2009 to 22% in 2021. Still, in November 2021, over 800,000 more women than men were working flexibly.
(Chung, H. (2020), 'Gender, Flexibility Stigma and the Perceived Negative Consequences of Flexible Working in the UK', Social Indicators Research, vol. 151, pp. 521–545.
Costa Dias, M., Joyce, R. and Parodi, F. (2018) 'IFS Working Paper: The gender pay gap in the UK: children and experience in work'. London: Institute for Fiscal Studies [accessed: 5 April 2022]
Nicks, L., Gesiarz, F. Likki, T., Baynham-Herd, Z. and Lohmann, J. (2021b), 'Impact of changes in flexible working during lockdown on gender equality in the workplace', London: The Behavioural Insights Team [accessed: 7 April 2022].
Jones, P. and Bano, N. (2021), 'The Right to Disconnect', Autonomy Website [accessed: 7 April 2022].

- Women are bearing the brunt of caring responsibilities, with almost six out of 10 avoiding applying for promotion because it was too hard to balance work and care. Research from Business in the Community carried out by Ipsos revealed that one in five women (19%) have left a job because of difficulties balancing work with caring responsibilities. Women account for 85% of sole carers for children, and 65% of sole carers for older adults.

- While women are more likely than men to use flexible working arrangements, since 2009 the uptake of flexible work has been increasing at a faster rate among men. (future of work report)

- Making flexible working available in all but the most exceptional of circumstances promotes greater gender equality. Research has shown that many of the underlying causes of the gender pay gap are connected to a lack of quality jobs offering flexible work. The unequal division of unpaid care and the lack of flexible working in jobs means that women often end up in part time work. (https://timewise.co.uk/article/article-real-reasons-behind-gender-pay-gap/, https://www.tuc.org.uk/sites/default/files/2019-10/BEISFlexibleworking.pdf)

GENDER REASSIGNMENT

- If a request to work flexibly is made because an employee proposes to undergo, is undergoing or has undergone gender reassignment, the employer should consider the request on the same basis as they would consider any similar request made under the right to request flexible working. Employers should not refuse a request or treat it less seriously because it is being made by a transsexual person (EHRC Guidance).

  A Government Equalities Office publication (2015) offering guidance for employers on the recruitment and retention of transgender staff states that "We know that trans people often leave their jobs before transitioning and often take lower paid jobs when they return to the workplace, often because of the possible discrimination they imagine they will face if they stay in their place of work. This can result in a loss of expertise and investment for their original employer."

- CIPD guidance on Transgender and non-binary inclusion at work advises that organisations should not remove someone from duties against their wishes while they're transitioning. However, transitioning employees may request temporary redeployment, flexible working or adjustments to their role. This must be led by the individual's preferences, and you should accommodate requests as far as is possible

SEXUAL ORIENTATION

- A Business in the Community report 'Working with Pride - issues affecting LGBTQ+ people in the

workplace' found that in relation to carers, gay/bi+ people are less likely to be accessing support from line managers, home working and flexible working policies, especially in the case of gay/bi+ male carers.

RACE

- Research commissioned by **Business in the Community**, The Prince's Responsible Business Network and Ipsos UK found that one in three (32%) Black, Asian, Mixed Race and other ethnically diverse people have left or considered leaving a job due to a lack of flexibility compared with one in five (21%) white people. The research also found that some groups were significantly more likely than others to have not applied for a job or promotion, or to have considered leaving or actually left a job, because of challenges combining paid work and care, including Black, Asian, Mixed Race and other ethnically diverse people; those on lower incomes; and shift worker

- According to the Future of Work Report | Equality and Human Rights Commission (equalityhumanrights.com) the number of workers from ethnic minorities on flexible contracts rose by 79% from 2009 to 2019, compared to 7% for White British workers. This saw the proportion of workers on flexible contracts increase from 18% of ethnic minority workers and 19% of White workers to 20% of both groups in 2019. This increase continued throughout the COVID-19 pandemic for all groups, with the number of workers from ethnic minorities on flexible contracts 171% higher in 2021 compared to 2009 (from approximately 700,000 to 1,740,000 workers), while the number of White British workers on flexible contracts only rose by 38% (from 4.5 million to 6 million). In 2021, this increased further, with 26% of workers from ethnic minorities and 25% of White British workers having flexible working arrangements.

OTHER FACTORS

- Flexible working supports a better work life balance, improved wellbeing, improving the experience of work for carers. It also improves productivity, increases staff retention and better recruitment (https://www.tuc.org.uk/research-analysis/reports/future-flexible-work?page=2#section_header)
- In some cases, the Equality Act can also protect carers from being treated unfairly because of their association with the person they care for; Associative discrimination or 'discrimination by association' comes about when someone is treated unfavourably on the basis of another person's protected characteristic. Discrimination by association doesn't apply to all protected characteristics. Marriage and civil partnership, and pregnancy and maternity are not covered by the legislation. Nor does it apply to instances of indirect discrimination by association - it has to be direct. This Policy will support staff in managing their work life balance more effectively (e.g. parents, those with caring responsibilities) Discrimination by Association should be considered when considering requests for flexible working,

- The ability to provide a service to Welsh Speaking patients should be considered when deploying our workforce (e.g. when considering requests for flexible working)
- Numerous studies have found that flexible working arrangements can have a significant positive impact on people's mental health with better sleep and lower stress levels as common outcomes. Equally, someone's mental health can have a significant impact on their ability to perform well in their job.
- CIPD 2018 quoted research which has shown that flexible working can reduce absence rates as it allows employees to manage disability and long-term health conditions, and caring responsibilities, as well as supporting their mental health and stress. Parents and carers (especially those on low incomes) benefit the most – they tend to have increased wellbeing and are less troubled by stress when given access to flexible work
- An ONS report from December 2018 showed that 25.8% of women were economically inactive (i.e. not employed or looking for/available for work, compared with 16.1% of men. The second biggest reason for being ecomically inactive is looking after family or home (the largest category is students)
- The Policy states that flexible working opportunities should be considered for all employees and made available as far as practicable, regardless of role, shift pattern, team or pay band and should also be considered for employees who work on rotation. It is not sufficient for departments who have a traditional way of working to reject an application for flexible working just because it has not been tried before or because 'this is how it has always been done'.
- The Policy states that Managers must consider whether the request is in relation to a reasonable adjustment related to a disability or another protected characteristic. Employees are encouraged to identify where this is the case. Managers should also consider any health and safety issues that might result from the change and identify ways to mitigate them (e.g., if the working arrangements will mean the employee or their colleagues would become lone workers). Advice can be sought from People Services/Human Resources, Health and Safety and Occupational Health as appropriate.

  Research by Timewise has shown that good flexible working can help households manage rising costs. The 2021 Flexible Jobs Index noted that only 1 in 4 jobs are advertised as flexible in any way. There are even fewer part-time jobs advertised (just 1 in 10), and they are clustered at the lowest-paid end of the scale, with very few higher-paid ones available. This is a particular problem for parents, carers or those with health issues or other responsibilities, who simply can't work full-time. Being able to find a quality part-time or flexible role can allow them to get into (or back into, or progress in) the workplace and increase their household income. And the availability of good flexible jobs also has a positive impact on society as a whole. Evidence shows that flexible working can play a part in tackling social inequality, reducing child poverty, supporting social mobility, and increasing workplace diversity.

	Monitoring Arrangements Each Department will keep a record of all formal applications for Flexible Working and a record of approvals/ rejections and appeals. Organisations should ensure that data relating to applications for flexible working and outcomes of decisions are recorded and regularly reported through the usual joint partnership and governance structures. This information should be included in an organisation's published annual statutory public sector duty reports. The published information should demonstrate outcomes for flexible working applications disaggregated by each protected characteristic of the Equality Act 2010. In addition, organisations should consider reporting outcomes by occupational group and also by department.

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	23rd May 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Vice Chair and Independent Member
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 9th May 2024.

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. Following its annual review in March 2024, the Committee continues to mature, actively seeking opportunities for continuous improvement, together with the ongoing development of reporting formats, additional assurance mechanisms and discussions to facilitate ongoing streamlining and triangulation of information.

3. HIGHLIGHTS FROM THE MEETING HELD ON 9TH MAY 2024

3.1 Triangulated themes

The following triangulated themes were identified:

- Continuing challenges within SACT,
- Ongoing issues with communications and booking across the divisions,
- Medicines management linked to patient experience.

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-09052024/

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	**Transforming Access to Medicine (TrAMs) Progress Update**
	
	The Committee received a general overview of the report which had not been available prior to the meeting. Key points to note were as follows:
	
	• Overall status of the programme is currently at a red rating. The three separate scoring statuses for the programme are as follows:
	  ○ Quality and scope - green
	  ○ Project timelines - red
	  ○ Cost status - currently amber but work currently underway to create both capital and revenue cases for the programme.
	• Programme Board are working on costing work for the Southeast hub and design work is underway for IP5. Funding has been secured to complete a detailed design of Radiopharmacy and the team are currently developing a BJC submission case to Welsh Government for the Radiopharmacy unit expected in July 2024, then an OBC for the remainder of the hub expected in September

	2024. The FBC for the programme is anticipated to be submitted in March 2025. • Space secured at IP5 for a TrAMs quality-controlled laboratory and office space which will come into use during 2024 to support bringing the facilities online as quickly as possible, as well as facilitating some work around product development that can support local delivery of medicines. • Work underway with Digital Health & Care Wales (DHCW) in respect of the TrAMs digital project. It was queried whether the delays in the project are impacting on the ability to manage the increasing SACT workload. However, the Committee were advised that no impact has been identified at this stage.
ASSURE	The Committee received the updated **Trust Risk Register** With regards to Risk 3247 *[lack of consultation rooms]* the Committee were advised that since this risk was identified a full accommodation review of the site has taken place and as a result, capacity has been released within outpatients and some additional clinical space created. Additionally, work is underway to develop a virtual hub to facilitate virtual consultations to take place where appropriate. In terms of the overbooking of appointments the Committee were advised that the team have been working through some of the issues but the situation has been exacerbated by an increased demand for the service. A multi-professional clinical event is currently being arranged for a date in June, during which the issue will be looked at further. The Committee discussed Risk 2515 *[Brachytherapy]* and were advised that significant improvement has been made in recruitment, resulting in a reduced risk score to 9. Risks 3094 and 3095 were also discussed, and the Committee were advised that, having been recently reviewed through the Radiation Protection Strategic Committee, these risks have now significantly reduced to 12. The Committee received the **Trust Assurance Framework**, noting that good progress has been made in terms of migrating the template onto Power BI, this is expected to take place by the end of June. In respect of the Committee's intention to conduct a deep dive into particular areas of the Trust Assurance Framework (TAF), TAF03 *[strategic workforce risk]* and TAF08 *[strategic financial stability risk]* were discussed in detail.

With regards to TAF08 the Committee noted the work currently underway to address the gaps in controls and assurance highlighted in the dashboard.

Quality, Safety & Performance Reports

Welsh Blood Service Quality & Safety Divisional Report

The Committee received the report which covered the period December 2023-March 2024. The following key points were highlighted:

- Difficulties with supply chain activity, in particular with raising alerts over protracted time periods - a review has identified that much of this is as a result of staffing and workforce-related issues. The Committee were advised that a review of the nursing establishment and collection assistants has been conducted and positive recruitment and training activity was noted.
- Four Serious Adverse Events were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) under the Serious Adverse Blood-Related Events (SABRE) scheme. Concerns have been raised around the manual processes for selection of donors which is a particularly difficult task and may be contributing to the challenges of nursing staff retention.
- All quality markers are within range.
- All complaints have been managed at local resolution and within the timeframe.
- Buccal swab recruitment campaign for stem cell donors is demonstrating extremely encouraging results, particularly in terms of ethnic minority groups.

Trust Performance Management Framework Report and Supporting Analysis for January 2023/24

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 March 2024.

With regards to the ***Velindre Cancer Centre*** the following key points were highlighted:

- Radiotherapy - continued sustained current performance level, with a scheduled target up from 93% to 94%. Slight drop from 88% to 85% in compliance with the 7-day time-to-treatment target for urgent symptom control radiotherapy. Emergency is retained at 100%. The Committee were advised that patients are prioritised and

offered the first available appointment in response to clinical urgency of their pathway and should demand exceed capacity all referrals are submitted to escalation and prioritised, a clinical harm assessment undertaken and the patient booked according to clinical priority. Implementation of new LINAC equipment continues and has had some impact on capacity, although this is being well managed through the service with staff running extended and weekend clinics.

- SACT - due to the lengthy manual processes required for the validation of data and the pressures of the day-to-day management of patients the Committee noted that the report does not provide the March 2024 position. However, an increase from 79% to 90% is anticipated for non-emergency patients treated within the required time, leading to a reduction in breaches from 95 to 35. A daily review of patients and daily escalation meetings are held and harm reviews are undertaken where required.
- Pressure ulcers - there were no avoidable or unavoidable pressure ulcers reported for the second month running.
- Health & safety incidents - there were three reported incidents for the second consecutive month, the lowest since May 2023.
- Delayed pathways of care - one individual was delayed for a period of 19 days due to the wait for a nursing home placement. The Trust is actively engaged with the regional work around delayed pathways of care.
- Sickness rate - reduction in sickness for the month of March, due to the hard work by the teams in conjunction with Workforce and Organisational Development colleagues.

The Committee then received a brief overview of the ***Workforce and Wellbeing*** performance data, noting in particular the following key points:

- Sickness - to 24th April the rolling absence level for the Trust as a whole shows a continuing improved trajectory of 5.11% and a positive move towards the 4.7% local target. Long term absence levels are reducing considerably. Some increases in short-term absences have been noted and are being monitored.
- Wellbeing - improvements around the management of employee investigations and specific employee-related issues are understood to be contributing to the improving figures in this area. It is anticipated that the recent appointment of a Wellbeing Co-ordinator will bring a focus to the outcomes of the interventions put in place.
- PADRs - staff appraisals are holding steady at around 72% (divisionally, WBS at 83%, VCC at 73% Corporate at 62%). A review of the PADR process is planned and local discussions are

taking place within the two main clinical divisions. The significant workforce pressures and large number of vacancies in some areas were cited as particular challenges in improving these figures and whilst this was acknowledged, the possible link between the appraisal process and staff retention was highlighted.

An overall encouraging report for ***Welsh Blood Service*** was received.

Finance Report for the Period Ended 31st March 2024

The Committee received the Finance Report which provided an overall positive review of the financial position and performance for the period to the end of March 2024. The following points were highlighted:

- A small underspend of £30K reported for the year.
- Public Sector Payment Policy target achieved.
- Capital Expenditure Limit met.
- Long Term Agreement (LTA) income achieved through growth in activity levels.
- Cost savings proposals of just over £2.5M identified to support the all-Wales financial position.

The Committee were advised that the Trust is on track to meet its statutory administrative duties for 2023-24 across all areas of finance.

Medicines Management Group (including Medical Gases & CDs) Assurance Report

The Committee received a brief overview of the report which outlined the work of the Medicines Management Group over the period October 2023 to March 2024. Three key points of particular interest were noted:

- Changing strategic context - following an independent review of clinical pharmacy services across NHS hospitals in Wales, an internal review has been carried out to sense check against the resulting recommendations. As a consequence of the associated work some external support has been secured to develop a strategy for the Pharmacy services which will be brought to the Committee in due course.
- Implementation of the electronic Prescribing and Medicines Administration (ePMA) across Wales
- Cancer and hospital acquired thrombosis - there were no potentially hospital acquired thrombosis events at VCC over the period, which is of particular significance given the nature of the service and patients receiving treatment.

INFORM	**Velindre Cancer Service – Patient Story** The Committee heard from Dr Helen Hughes, a current Velindre Cancer Service patient who had shared her experiences in relation to the intravenous access service provision at Velindre Cancer Centre and how this differs to the standard of provision offered routinely to patients receiving SACT treatment in England. Dr Hughes explained how she first became aware of subcutaneous port implantation as an alternative to PICC line insertion for patients receiving medium to long-term intravenous therapy. Dr Hughes highlighted some of the challenges encountered with long-term PICC line use and explained how the insertion of a port had been of significant personal benefit. The Committee were advised that, of the three Health Boards across South Wales served by Velindre - Aneurin Bevan (ABUHB), Cwm Taf Morgannwg (CTMUHB) and Cardiff & Vale (CAVUHB) - only patients of ABUHB and CTMUHB are eligible for port insertion, those in CAVUHB currently are not. Work is underway to develop a Service Level Agreement with CAVUHB to rectify this, and support is being provided by St Joseph's Private Hospital, Newport in the interim to ensure that port insertion can be offered to patients of CAVUHB. The Committee concluded that much work is to be done in order to explore the matter, to establish level of required resource, capacity, etc. and that this would be brought back through the Committee for discussion as the situation progresses. **Workforce Supply and Shape & Associated Finance Risks** The Committee received the report which outlines the key priorities in the People Plan, highlights the actions undertaken in 2023-24 and the planned actions for the current financial year. It was noted that the recent period of industrial action has had a significant impact on the team, certainly from a workforce planning perspective and although no periods of strike action are currently underway, further action is anticipated in the coming months. An improving trend in terms of vacancy rates and the related reduction in agency spend was highlighted, along with the clear reduction in sickness rates. Moving to the finance element of the paper, the Committee noted that the reduction in vacancies had led to an underspend in the pay budget

	of just under £1M for the full year outturn. In terms of the pay award, a recurrent risk was noted and, although a positive response is anticipated, Welsh Government are yet to confirm whether this will be funded on a recurrent basis. In relation to the aforementioned reduction in agency spend, it was highlighted that the costs in this regard have dropped by just over £500K year-on-year. The Committee applauded the significant reduction in vacancies, from 138 in April 2023, down to 50 in March 2024, resulting not only in positive reporting in terms of finance, but also from a workforce wellbeing perspective. **Quarter 4 Quality & Safety Report** The Committee received the paper which covered the period 1st January to 31st March. The following key points were noted: • Slight drop in concerns compliance for responses within 30 days, from 100% to 81%. This was due to the particular complexity of the issue and all parties had been kept fully informed of the delays. • Increase in incidents closed within 30 days. • Two reportable incidents met the threshold for moderate harm or above - both have been managed within Duty of Candour and one within Nationally Reportable Incident procedures accordingly. • There is a continuing key theme across the divisions with regards to communication and appointment issues. More information has been requested by the Integrated Quality and Safety Group due to the continuation of this theme. • Four applications for Deprivation of Liberty Safeguards have been made. The Committee highlighted the redress caseload, noting a 40% increase with eight new inquests opened and queried whether there were any recurring themes or clear areas of concern. The Committee were advised that there were no identified themes and this appears to be a national issue, but the significant impact this is having on medical teams was noted. The **Private Patient Service Improvement Group Highlight Report and Improvement Plan Update** was received and the two actions listed for alert to the Committee were highlighted:

- Delays in establishing a Medical Advisory Committee - following recent discussions this is now due to be taken forward.
- External support provider end of contract - the Committee understood that a request has been made for the contract to be extended.

Trust Clinical Audit Plan

The Clinical Audit Plan was presented to the Committee and the three key developments were highlighted, as follows:

- Setup and use of the AMaT centralised clinical audit registration and management tool which has been rolled out across the Trust.
- Improved triangulation of quality & safety and clinical audit through the divisional quality hubs and Integrated Quality & Safety Group to ensure identified themes influence potential audits.
- Plans to broaden the scope of clinical audit within the Welsh Blood Service.

Trust-wide Policies and Procedures Compliance Report

The Committee received the report which provided an update to the committee on the continuing progress in policy compliance status between March-April 2024.

Implementation of Duty of Quality Update

A comprehensive report was received by the Committee, giving an overview on progress of Duty of Quality implementation over the first year. The Committee heard that good progress has been made in terms of always on reporting, with four divisional videos now uploaded to the website, offering a clear view of how each division's quality management system works.

Fire Safety Policy

The Committee received the revised Fire Safety Policy which had been subject to some minor amendments in anticipation of the change in national legislation.

The Committee queried the statement around staff participating in evacuations every 12 months, noting the associated challenges around a full evacuation of the Trust sites, but were assured that smaller evacuations are carried out in particular functional areas of Velindre Cancer Centre and that clear evacuation plans are in place and regularly

	tested. In terms of the Welsh Blood Service the Committee were advised that the Talbot Green site does indeed carry out a full annual evacuation and that all donor community venues are fully risk and fire assessed in advance of utilising the site, although a review by the Trust's Fire Safety Advisor was suggested. The Committee subsequently **APPROVED** the Fire Safety Policy. The following papers were also received and **APPROVED**: **Trust Learning Framework** **Trust Incident Management Framework** **Trust Updated Inquest Guidance and Protocol** The following papers were **ENDORSED** for Trust Board approval: **Quality & Safety Framework Refresh** **Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act (2016)** **Quality, Safety & Performance Committee Chair's Urgent Action Report** The Committee **NOTED** the **All-Wales Drug Contracting** report.
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

AUDIT COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	23/05/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Gareth Jones, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance
REPORT PURPOSE	FOR NOTING

ACRONYMS	
~	~

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meetings held on the 12 January 2024 and 12 March 2024, and the joint Audit Committee and Quality, Safety and Performance Committee held on the 21 March 2024.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meetings of the Audit Committee held on the 12 January 2024 and 12 March 2024, and the joint Audit Committee and Quality Safety and Performance Committee held on the 21 March 2024:

ALERT / ESCALATE	There were no reports taken to the Committee on the Trust Risk Register and Trust Assurance Framework. The Committee acknowledged the capacity issues in the Governance Team but stressed that the key issues in the Trust Assurance Framework and Trust Risk Register do need oversight and detailed scrutiny on a regular basis. The Committee agreed the Trust Risk Register and TAF papers would be updated and considered at an Extraordinary Joint Audit & QSP Committee before Trust Board as both these aspects of risk need scrutiny.
ADVISE	**AUDIT ACTION TRACKER** The Committee **AGREED** the requested extension dates for audit actions subject to work to provide further updates and information being sought outside of Committee. The Committee requested further clarification of the outstanding action from the external audit report on Workforce Planning. The Committee **AGREED** to formally closing the 14 Internal Audit and 5 External Audit green/complete actions. **AUDIT ANNUAL REPORT** The Committee **NOTED** the pleasing report that showed an unqualified opinion on the Trust 2022-23 Financial Statements. The Committee acknowledged the point that some Committees are finding it difficult to run meetings to time and confirmed this is a perennial problem for the Trust and stressed the need to not lose sight of this and the need to agree how this problem is resolved. **AUDIT POSITION UPDATE:** **Audit Wales Update** The Committee were informed that the Velindre UNHST Charity Accounts Audit is largely complete but is on hold as waiting for a PwC Report to give assurance on the new client management system of the fund Investment Managers and were advised that there are three other NHS Charity accounts in a similar position across Wales. The PwC report is expected in April 2024 and Audit Wales can then move to certify the accounts, subject to a satisfactory report. The Committee were informed of proposals to stand down the Operational Governance piece of work and refund the fees to the Trust and the further proposals to make a change to the programme of work to move the Follow Up of Quality Governance recommendations into the 2024 Plan, with Financial Efficiencies and Wellbeing Objectives work being completed in the 2023 Plan. These proposed changes would be agreed with Trust management.

	The Committee were advised of another piece of work commissioned by Welsh Government to review the new VCC hospital project governance and management, which is to be funded from the Welsh Consolidated Fund. The Committee were provided with the outline of a Project Brief that is looking at the NHS Wales strategic approach to reviewing timeliness of cancer diagnosis and treatment and of the barriers of cancer diagnosis and treatment. This is a piece of work intended for 2025 on some aspect of cancer delivery which will occur in Velindre and the Health Boards. **2023/24 Internal Audit Progress Update** The Audit Committee **NOTED** the report and **RECEIVED** the progress report and **AGREED** the deferring of the Quality and Safety Audit into a future plan given the significant overlap with the scheduled work of Audit Wales, which would result in duplicate assurance. Internal Audit assured the committee the deferral will not impact on the delivery of the Annual Opinion. The Committee were advised there are sixteen audits on the plan, eight final, one draft, five in progress and two in planning stage, and from the five in progress most are coming to a close. Since the last update report from the 19 December '23 committee three reports have been issued which were presented to the Committee. The Committee advised that the Trust performance around audit report turnaround of management responses (15 working days) requires improvement as currently achieving 38%. The planning work in relation to the 2024/25 audit plan has commenced. **COUNTER FRAUD UPDATE:** <u>2023-24 Plan Progress Report</u> The Committee were advised of the continued maintenance and development of the counter fraud activity database which records work (Proactive and Reactive) and activity undertaken, which is used to inform future areas of work. The Committee were advised of the Counter Fraud digital platform and members of the committee were encouraged to visit the site at the following link: https://nhswales365.sharepoint.com/sites/CAV_Counter%20Fraud%20&%20Internal%20Audit <u>Education & Learning</u> The Committee were advised that 7 education & awareness sessions for Trust new staff had been undertaken in December and January as well as 1 bespoke awareness session for Health Technology Wales and that the e-Learning package is now live on the ESR system. The Committee reviewed and **APPROVED** the 2024/25 Counter Fraud Annual Plan.

ASSURE	**VELINDRE UNIVERSITY NHS TRUST STRUCTURED ASSESSMENT REPORT 2023** The Committee were informed that this was a positive report with a small number of recommendations. The Committee discussed in detail the requirement for minutes to be published on the Trust Website within a 15 working day timescale. The Committee was advised the management response had been accepted, had been reviewed as an Executive Management Board and the context has been discussed in detail with the Chief Executive and Trust Chair who provided the formal endorsement of the report. The Committee agreed a process needs to be agreed in terms of notifying the Independent Members on working day 15 when the draft minutes are published and what action will be undertaken to update the public minutes in terms of feedback / corrections. It was agreed this would be brought for discussion to the Independent Members Group. The Committee were uncomfortable with publishing the Committee recordings and felt the publishing earlier of unapproved minutes would be the preference, but agreed a process around this is needed and the Secretariat and the Corporate Governance Team will need to discuss and produce a draft process on how this would work. The Committee acknowledged that there needs to be better triangulation of the Integrated Medium Term Plan (IMTP), the Trust Assurance Framework (TAF) and the Trust Risk Register. Work is required in terms of cross referencing the IMTP into the TAF which then requires an action plan to mitigate those organisational corporate risks identified. There is a need to pick the point up with the Integrated Quality, Safety and Performance Group on delivered and non-delivered action areas to ensure reports clearly articulate where mitigating actions have not achieved expected outcomes and the further actions being taken to deliver. The Committee was assured that the recommendations are reflected in the refresh of the Governance Manual and the new minutes process reflects this, including the time requirement for Welsh translation. **Trust Risk Register** The Extraordinary Joint Meeting of the AUDIT Committee and the Quality, Safety and Performance Committee: • **NOTED** 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. • **NOTED** the on-going developments of the Trust's risk framework. The Committees were presented with the '*Key Matters Summary of actions taken / In Plan from Recent Governance Cycle*' which summarised the development actions that have been taken over the last two cycles. The Committees discussed the timing of risk review through the Divisional Senior Leadership Teams, and the Executive Management Board to Committees. There was an acknowledgement that there should be a balance between ensuring that most up to date information can be shared, alongside being able to demonstrate closure of matters raised through the process. It was agreed that this would be explored offline to ensure there was agreement on what the optimum process and timings were.

	Trust Assurance Framework The AUDIT Committee and Quality, Safety and Performance Committee were informed that the refreshed set of strategic risks were approved in January 2024 Trust Board and are now in the normal cycle going forward in terms of managing and updating the risks. The Extraordinary Joint Meeting of the AUDIT Committee and the Quality, Safety and Performance Committee **DISCUSSED** and **NOTED** the Trust Assurance Framework. The AUDIT Committee and Quality, Safety and Performance Committee **NOTED** there are further considerations to take back into the routine cycle of the Audit and Quality, Safety and Performance Committees.
INFORM	**INTERNAL AUDIT REPORTS** The Committee received the following internal audit reports, two of which reported a reasonable level of assurance and one a limited level of assurance: • Education Strategy Audit Report – Reasonable • Private Patients Audit Report – Reasonable Assurance • Estates Assurance: Estates Condition Audit Report – Limited Assurance **OTHER BUSINESS:** The Committee also received written reports under the following agenda items: • Counter Fraud Progress Report Quarter 4 23/24 • Counter Fraud Annual Plan • Private Patient Service Plan • Private Patient Service Debt Position • Losses and Special Payments Report • Receipt of Finance Technical Updates • Audit Committee Annual Report • Audit Committee Terms of Reference • Procurement Compliance Report
APPENDICES	**NONE**

3. RECOMMENDATION

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

AUDIT COMMITTEE

ANNUAL REPORT 2023/24

Audit Committee
Annual Report 2023/24

1. Foreword

I am pleased to present the Annual Report of the Velindre University NHS Trust Audit Committee. It outlines the coverage and results of the Committee's work for the year.

Martin Veale was appointed as an Independent Member of the Velindre University NHS Trust in April 2017 and has Chaired the Audit Committee since that time with great expertise, knowledge and diligence and provided the Board with assurance around the Trusts systems of governance, risk management and internal control. Martin was supported by Independent Members, Vicky Morris and myself. Since Martin's absence from October '23 and to the end of his tenure on the 31st January '24 I have been acting Chair of the Audit Committeee. I would like to take this opportunity to put on record my sincere thanks to Martin for his leadership as Chair of the Audit Committee and his and Vicky's significant contributions made during the year.

I would like to express my thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by Internal Audit at NHS Wales Shared Services Partnership, Local Counter Fraud Services and by Audit Wales.

Meetings have been well attended and have been a hybrid approach of face to face and online. The meetings have been characterised by constructive dialogue and challenge, and the willingness of all parties to raise issues, acknowledge shortcomings and put forward positive suggestions to help bring about meaningful improvements to services, systems, and day-to-day working practices. This approach is to be welcomed and is very much appreciated by the Committee.

Going forward, the Committee intends to continue to pursue a full programme of work as set out in the cycle of business, covering a wide range of topics and subject areas as part of its long-term aim to help further strengthen the governance arrangements of the Trust, in order to achieve better value for money and high quality, sustainable outcomes for NHS Wales.

Gareth Jones
Acting Chair of the Velindre University NHS Trust Audit Committee
12 March 2024

2. Introduction

This report summarises the key areas of business activity undertaken by the Committee between January 2023 and February 2024 and highlights some of the key issues which the Committee intends to give further consideration to over the next 12 months.

This report reflects the Committee's key role in the development and monitoring of the governance and assurance framework within which the Trust operates.

3. Role and Responsibilities

The primary purpose of the Audit Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Trust's system of assurance – to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how its system of assurance may be strengthened and developed further.

The Trust operates a separate Audit Committee to provide assurance on the work of the NHS Shared Services Partnership (NWSSP). Whilst the same Independent Members sit on both committees, they are entirely separate, and the NWSSP Audit Committee produces its own Annual Report.

4. Agenda Planning Process

The Chair of the Committee, in conjunction with the Trust's Executive Director of Finance and Director of Corporate Governance, draws up the agenda for Committee meetings, which is based upon an agreed annual programme of work and clearly linked to the Committee's Terms of Reference.

The Trust Governance team aim to disseminate the agenda and papers to Committee members at least five working days before the date of the meeting.

5. Operating Arrangements

The Committee's Terms of Reference are reviewed annually, with the next review being considered at the March 2024 Audit Committee. A copy of the Terms of Reference extant at the point of writing this report is attached at the end.

The Audit Committee Cycle of Business for July 2023 to July 2024 was noted in July 2023 and will next be updated and presented in July 2024. The agenda of each meeting, however, is sufficiently flexible to allow the committee to consider any emerging issues.

6. Membership, Frequency and Attendance

The Terms of Reference of the Committee state that the Committee should consist of a minimum of three Independent members of the Board. One of these members must also be a member of the Quality & Safety Committee.

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. During 2023/24 this option was not exercised.

During the year the Committee met on five occasions with attendance as follows:

Name	Audit Committee
Mr Martin Veale JP *(Independent Member) Chair*	3 out of 4
Mr Gareth Jones *(Independent Member)* *(Acting Chair 2 out of 5 Commmittees)*	5 out of 5
Mrs Vicky Morris *(Independent Member)*	5 out of 5

During the year, the meetings were supported by the following:

- Mr Matthew Bunce, Executive Director of Finance
- Ms Claire Bowden, Head of Financial Operations
- Mrs Tracy Hughes, Interim Head of Financial Operations
- Mr Chris Moreton, Deputy Director of Finance
- Mrs Lauren Fear, Director of Corporate Governance
- Mrs Emma Stephens, Head of Corporate Governance
- Mr David Osborne, Head of Finance Business partnering
- Mrs Zoe Gibson, Interim Head of Quality Safety and Assurance

- Mr Steve Wyndham, Audit Wales
- Mr Darren Griffiths, Audit Wales
- Mr Dave Burridge, Audit Wales
- Mrs Kate Febry, Audit Wales

- Mr Simon Cookson, Director of Audit & Assurance, Internal Audit
- Mrs Emma Rees, Deputy Head of Internal Audit, Internal Audit
- Stephen Chaney, Head of Internal Audit (Aneurin Bevan University Health Board, Digital Health & Care Wales), Internal Audit
- Melanie Goodman, Audit Manager, Internal Audit

- Mr Gareth Lavington, Lead Local Counter Fraud Specialist

7. Audit Committee Activity 2023/24

The Audit Committee fulfilled its planned work for 2023/24 covering a wide range of activity. This work can be summarised under the following headings:

7.1 External Audit

- The Committee approved the Audit Wales plan for 2023/24 in July 2023. Updates from representatives from Audit Wales were given at each meeting.
- Audit Wales documentation was provided to the Committee during the year in relation to the:
    - Annual Audit Plan 2023/24;
    - Financial Audit 2022/2023;
    - Structured Assessment 2022: Corporate Governance & Financial Management Arrangements.

- Review of Quality Governance Arrangements.
- Reviewing approach to Equality Impact Assessments.
- Audit of Accounts Addendum.
- Structured Assessment 2023.

- In October 2023, Audit Wales provided the Committee with a report entitled "Review of Workforce Planning Arrangements". Overall, it was 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.

7.2 Internal Audit

- The Committee received regular progress reports from the Internal Audit team during the calendar year following agreement of an Internal Audit Plan for 2023/2024 in April 2023.
- During the year the Committee considered 16 review and 1 advisory reports completed by Internal Audit: their assurance ratings are shown below, with a full list of the reports shown in appendix 1.

Rating	**Number**
Substantial	2
Reasonable	13
Limited	1
Advisory	1
Total Reports	**17**

- Internal Audit's annual assurance opinion for 2022/2023 was reported to the Committee in July 2023. It stated that "the Final Opinion provides the Board with **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact** on residual risk exposure until resolved".

7.3 Annual Accounts, Annual Governance Statement & Accountability Report

- The Committee meeting in July 2023 received the audited 2022/2023 Annual Accounts, Annual Governance Statement, Letter of Representation and the Trust's response to Audit Wales regarding governance arrangements.
    - The Committee endorsed and recommended the approval of the Trust's Annual Accounts and other documents to the Trust Board.

7.4 Counter Fraud

- The Committee received the Counter Fraud Annual Report for 2022/2023 in April 2023.
- The Committee received the Annual Workplan for 2023/2024 in April 2023, and updates from the Counter Fraud Specialist or Lead at each meeting.

7.5 Internal Assurance & Risk Management Monitoring

- The Committee received details of the changes to the Trust Board standing orders for the updated Terms of Reference and Operating arrangements for the Quality, Safety & Performance Committee, Research, Development & Innovation Sub-Committee and Charitable Funds Committee; and endorsed them for Trust Board approval.
- The Committee received regular updates in relation to the Private Patient Service Improvement Group including progress against the agreed Improvement Plan.
- The Committee were provided with an update following the review of the Trust Assurance Framework, including a refresh of the Strategic Risks. The Committee also included on Highlight report an escalation regarding the delay in the updated Trust Assurance

Framework being presented to the Trust Board which resulted in a six month gap in reporting.

- Procurement Compliance was reported regularly to the Committee.
- Declarations of Interests, Gifts, Sponsorship, Hospitality & Honoraria were presented in the April and October 2023 meetings.
- The Trust Risk Register was presented at the January, July, October and December 2023 meetings for review by the Committee, noting that more detailed reviews took place in the relevant Committee and Divisional meetings.
- The Audit Action Tracker which monitors the implementation of the management responses and actions to the audit recommendations, was reviewed by the Committee at each meeting.
- The Committee received and reviewed the legislative and regulatory compliance register at their January 2023 meeting.
- The Committee received and reviewed regular reports on Losses, Compensation and Special Payments.
- The Committee received and reviewed reports of Finance Technical Updates during 2023/24.

8. Reporting the Committee's Work

The Chair of the Audit Committee reports to the Board on the key issues discussed at each meeting by way of a written Highlight Report. These reports are supported by the more detailed Committee minutes. Committee papers and committee minutes are routinely published on the Trust's website.

9. Conclusions and Way Forward

The work of the Audit Committee in 2023/23 has been varied and wide-ranging. The Committee's programme of work will continue to be reviewed to ensure that its contribution to governance, risk management, financial management, counter fraud and internal control is maximised.

This report demonstrates that the Audit Committee has fulfilled its terms of reference and significantly contributed to improving internal control within the Trust.

The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of control in place and that where necessary has recommended improvements to controls.

Appendix 1

Levels of Assurance Assigned by Internal Audit

Substantial Assurance	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk exposure.**
Reasonable Assurance	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.
Limited Assurance	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

List of Internal Audits Undertaken and Assurance Ratings - Velindre University NHS Trust

Internal Audit Assignment	Assurance Rating 2023
Managing Attendance at Work	Reasonable
Patient & Donor Experience	Reasonable
Digital Health & Care Record	Substantial
Cyber Security	Substantial
Decarbonisation **Advisory**	N/A
Performance Management Framework	Reasonable
Clinical Audit	Reasonable
Information Governance	Reasonable
Capital Systems	Reasonable
Follow Up: Previous Recommendations	Reasonable
New Velindre Cancer Centre - Contract Management Report	Limited
Trust Priorities	Reasonable
Business Continuity	Reasonable
Recruitment & Retention	Reasonable
New Velindre Cancer Centre - Approvals	Reasonable
New Velindre Cancer Centre - Planning	Reasonable
Digital Strategy & Transformation	Reasonable

SUMMARY (excluding advisory reports)	No. Reports
Substantial	2
Reasonable	13
Limited	1
Total	**16**

Appendix 2



Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	January 2023
Approved:	January 2023
Next Review Due:	January 2024

1. INTRODUCTION

1.1 The Trust's standing orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 A separate Audit Committee is in operation for the NHS Wales Shared Services Partnership (NWSSP) which has its own Terms of Reference.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:

  - the organisation's ability to achieve its objectives,

  - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,

  - the reliability, integrity, safety and security of the information collected and used by the organisation,

- the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses and Compensation;

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

3.5 To achieve this, the Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual

Report to the Board.

Authority

3.6 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors) *[one member should be a member of the Quality, Safety & Performance Committee]*

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

4.2 In attendance:

Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.)*
Executive Director of Finance
Director of Corporate Governance and Chief of Staff
Chief Operating Officer
Head of Internal Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales

By invitation — The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.5 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.6 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Committee

members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Workforce & Organisational Development.

5 COMMITTEE MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the Committee.

Frequency of Meetings

5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business. The External Auditor or Head of Internal Audit may request a meeting with the Chair if they consider that one is necessary.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6 RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, the Board retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees to provide advice and assurance to the Board by taking into account:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7 REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum *[as per section on Committee meetings]*

Cross reference with the Trust Standing Orders.

9 REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10 CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Committee, after first consulting with two other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

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

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	23rd May 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, Vice - Chair and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee held on 21st March 2024.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Strategic Equality Plan** The Trust has worked in partnership with eleven other public bodies to develop a shared set of Strategic Equality Plan Objectives for the period between 2024 to 2028. Following the Trust's own Strategic Equality Plan consultation, it was found that people largely agreed with the chosen objectives, however some issues were raised about the specific language used in them. The implementation plan will be monitored and reviewed through the Healthy and Engaged Steering Group. The Strategic Equality Plan will benchmark against peer networks and feedback comments. The Strategic Development Committee **ENDORSED** the Strategic Equality Plan and objectives for Trust Board approval. **Integrated Medium Term Plan – Update** It was suggested the Integrated Medium Term Plan and the Trust Assurance Framework need to be triangulated. The Trust Assurance Framework needs to include the objectives within the Integrated Medium Term Plan. Assurance was provided to the Strategic Development Committee that action plans and delivery plans sit under each area of the Integrated Medium Term Plan. It was confirmed the Integrated Medium Terms Plan is a balanced plan based on income. The Director of Finance for NHS Wales has communicated to all NHS Wales organisations his intentions which is outlined in the allocation letter. Subject to the Quality Impact Assessments being circulated and being made available to the Trust Board, the Strategic Development **ENDORSED** 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

Quality Management System
There was an error within the Quality Management System cover paper, the updated paper will be circulated following the Strategic Development Committee. It was highlighted there is an anticipated delay with the Quality Management System.

The Strategic Development Committee **NOTED** the paper as being received but **NOTED** a revised paper will be circulated.

Digital Inclusion Plan
Digital Communities Wales is the Welsh Government's dedicated digital inclusion programme, managed by the Wales Co-operative Centre. Digital Communities Wales set out the Digital Inclusion Guide for Health and Care in Wales with an overview of the user of digital technology for health in Wales which highlights challenges and opportunities we will face as we move forward with our Digital Inclusion plan for the Trust.

The Trust's Digital Strategy 2033 includes Digital Inclusion as one of its six key themes, this in an important foundation for our service users accessing our services.

Subject to Quality Impact Assessment being completed and circulated to members the Strategic Development Committee:

- **ENDORSED** for Approval the Digital Inclusion plan for Trust Board.
- **NOTED** that the Trust is going to seek accreditation against the Digital Inclusion Charter and the commitment to the 6 pledges.

Trust's Food Mission
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 Trust's food mission will be co-ordinated through the Healthy and Engaged Steering Group with the goal of improving the overall experience for staff in all areas of the Trust.

In March 2023, the Trust were successful in being awarded grant funding of £30,000 from Welsh government to develop a mission for local food sourcing and an agroecological food supply chain.

	It is hoped by 2035, at least 70% of food sourced by Velindre University NHS Trust will be Welsh, environmentally friendly and globally responsible. Originally it was aimed by 2030 the Trust will source 80% of food environmentally friendly, globally responsible and locally but it was decided to make this target more realistic and achievable to reduce it to 70% and by 2035. It was confirmed the Quality Impact Assessment will need to be completed. Subject the Equality Impact Assessment being reviewed the Strategic Development Committee **ENDORSED FOR APPROVAL**.
ASSURE	**Trust Well Being Objectives** The Trust originally developed its Trust Well-Being Objectives in 2015. However, there is now a requirement for the Trust Well-Being Objectives to be reviewed and updated. This is a statutory obligation due to the amendment in the legislation. Under the Act, all named public bodies must review their current objectives to ensure they are still compliant, whenever an amendment is made. The Act has had a minor amendment, changing the word 'fair' to 'decent' under A Prosperous Wales. Following the approval of the Trust Destination 2033 Strategy and supporting strategies together with a slighted change in the Well-being of Future Generations (Wales) Act legislation, there is a requirement to review the Trust Well-Being of Future Generations Objectives. This presents an opportunity to refresh the objectives and ensure tight alignment with the Trust strategies. The Trust Wellbeing Objectives will be reviewed on an annual basis tracking progress. The Strategic Development Committee: • **NOTED** the current, Trust Board approved, Trust Well-Being Objectives (Appendix 4) • **NOTED** the engagement and consultation process which has been undertaken to receive feedback on the existing Trust Well-Being Objectives (Appendix 1- and 2) • **NOTED** the feedback received in relation to the Trust Well-Being (Appendix 3(a) and Appendix 3(b)) • **NOTED** the next steps in relation to the finalisation of our Trust Well-Being Objectives (Page 3)

	Talbot Green Infrastructure Programme: Progress Update The Supply Chain Partner and Healthcare Planner have been commissioned to complete the Outline Business Case. The Programme is currently considering the economic benefits of each option in order to reach a preferred solution to develop into a full Outline Business. The Programme Board will consider and approve the preferred option at the Programme Board meeting in April 2024. The final draft of the Outline Business Case is on track to be completed in August 2024 and, following a 12-week internal approval process, will be submitted to Welsh Government in November 2024. The Strategic Development Committee **NOTED** the Talbot Green Infrastructure Programme: Progress Update
INFORM	**Clinical and Scientific Strategy** A huge amount of content has been developed for the Clinical and Scientific Strategy. The aim is for the Clinical and Scientific Strategy to be published in September. The Clinical and Scientific Strategy will not be duplicating work within other strategies. Following discussions with Llais and the need to undertake further engagement with the public and some stakeholder groups, the actions required and timetable for completing this work has been revised. It was confirmed in due progress the strategic aims will become more focused and streamlined. The Strategic Development Committee: • **NOTED** the contents of the report • **REVIEWED** the emerging themes, draft strategic aims, objectives, means of achievement and core principles • **NOTED** the revised plan and timetable for completing the Clinical and Scientific Strategy The Strategic Development Committee **NOTED** the Velindre Oncology Academy Implementation Board Highlight report. The Strategic Development Committee **NOTED** the Value Based Healthcare progress update. The Strategic Development Committee **NOTED** the Research, Development & Innovation Sub-Committee Highlight Report.

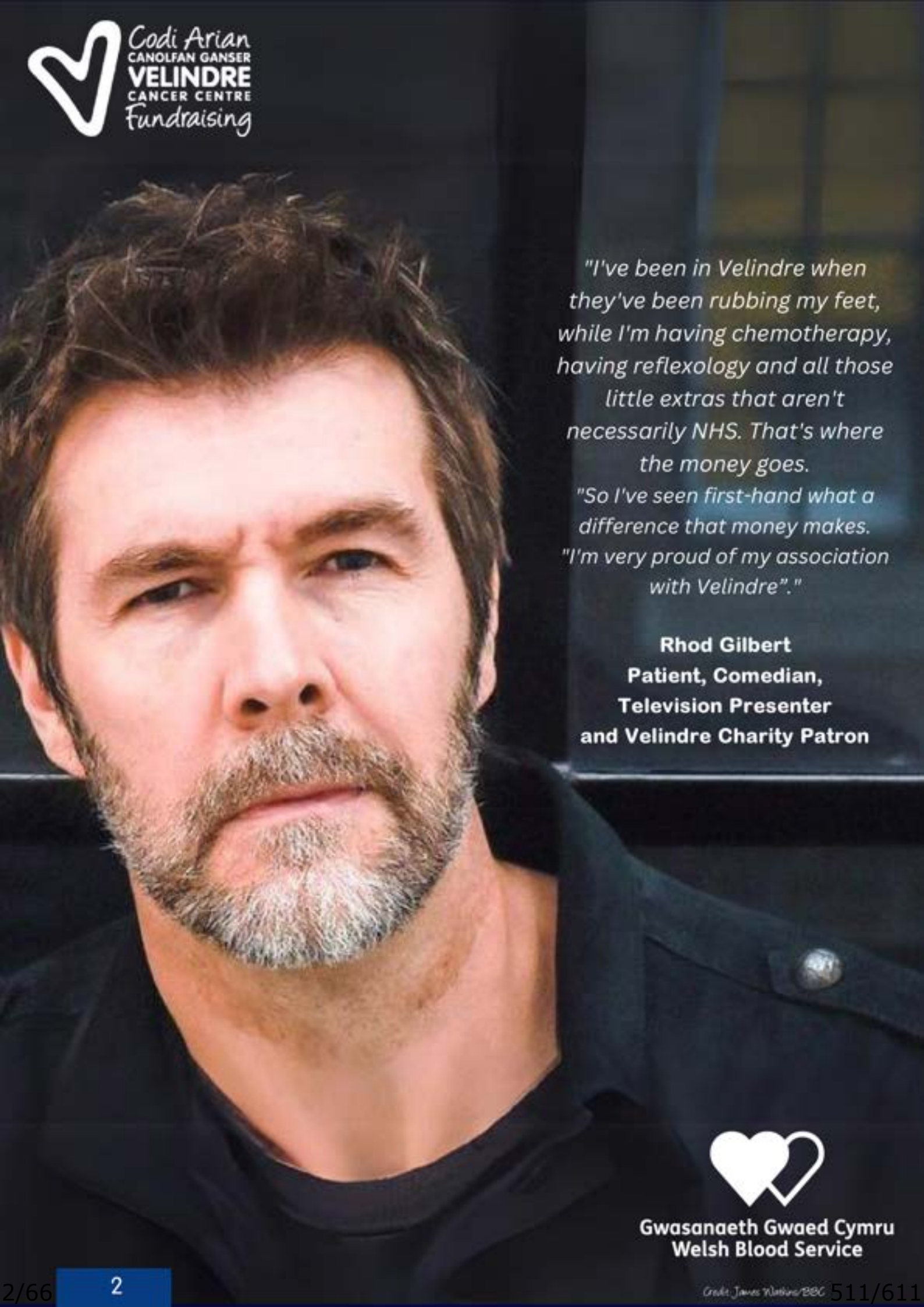
APPENDICES	**NOT APPLICABLE**

Velindre University NHS Trust Charity

Annual Report and Accounts 2022 - 2023



Codi Arian
CANOLFAN GANSER
VELINDRE
CANCER CENTRE
Fundraising



"I've been in Velindre when they've been rubbing my feet, while I'm having chemotherapy, having reflexology and all those little extras that aren't necessarily NHS. That's where the money goes.

"So I've seen first-hand what a difference that money makes.

"I'm very proud of my association with Velindre"."

Rhod Gilbert
Patient, Comedian,
Television Presenter
and Velindre Charity Patron

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Credit: James Waters/BBC

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Glossary of Abbreviations

AHPs
Allied Health Professionals

AHSC
Academic Health Science Centre

CFC
Charitable Funds Committee

CNS
Clinical Nurse Specialist

COVID 19
Coronavirus2019

CTU
Clinical Trial Unit

ESOL
English for Speakers of Other Languages

FR
Fundraising Regulator

FRS
Financial Reporting Standard

ISAs
International Standards on Auditing

NPHS
National Public Health Service

PARS
Physical Activity Rehabilitation Programme

PCH
Prince Charles Hospital

POC
Point of Care

R&D
Research & Development

RD&I
Research Development & Innovation

ROM
Range of Motion

RT
Radiotherapy

SABT
Stereotactic Ablative Body Radiotherapy

SACT
Systemic Anti-Cancer Therapy

SC
Supportive Care

SOFA
Statement of Financial Activities

SORP
Statement of Recommended Practice

UGI CNS
Upper Gastrointestinal Clinical Nurse Specialist

UK
United Kingdom

VAT
Value Added Tax

VCC
Velindre Cancer Centre

WBS
Welsh Blood Service

What our Annual Report will tell you

The Velindre University NHS Trust Charity Annual Report showcases how the funds raised through Charitable Funds in 2022-23 has made a difference and enhanced the services provided by the Trust. The report provides information about the Charity's performance this year, key activities and developments, and plans for 2023-24 and beyond.

The Charity's priorities are shaped by its Vision, Mission, Objectives, and Aims, which are set out on pages 12 and 13 of the report.

The report outlines the achievements, financial expenditure, and plans of the Velindre University NHS Trust. The Trust is committed to ensuring the delivery of safe, high-quality, and effective care to its patients and donors, and to continuous quality improvement to achieve this.

In accordance with our commitment to the Well-being of Future Generation (Wales) Act 2015, hard copies will be available on request, in addition to the digital copy of our Annual report available on our Trust website. As such, if you would like copies of our Annual Report in print form and/or alternative formats or languages, please contact us using the details below:

Velindre University NHS Trust, Corporate Headquarters,
Unit 2, Charnwood Court, Parc Nantgarw, Cardiff. CF15 7QZ

Tel: 029 2019 6161

Email: Corporate.Services2@wales.nhs.uk

Website: www.velindre-tr.wales.nhs.uk

On behalf of the Corporate Trustee of Velindre University NHS Trust Charity, we present the Velindre University NHS Trust Charity Annual Report together with the Audited Financial Statements for the year ended 31 March 2023.



Welcome

On behalf of the Corporate Trustee of Velindre University NHS Trust Charity, we present the Charitable Funds (Trustee) Annual Report together with the Audited Financial Statements for the year ended 31 March 2023.

Velindre University NHS Trust, which incorporates the Velindre Cancer Service and the Welsh Blood Service, is dedicated to providing quality, care and excellence in its treatment and engagement with patients, donors, their families and other people we come in contact with.

We are proud of our staff dedication in providing the very best possible services and the way, in turn, we are valued by our patients and donors. We believe we have a story to tell and, while we are required by the Charity Commission to produce an Annual Report detailing our accounts and activities over the past year, we are delighted that it also gives us a great opportunity to tell you more about the Charity and the services we have helped to enhance.

Presenting this report also provides an opportune time, for the Trustees to extend an important thank you to all our fundraisers supporters and Partners, the level of support the Charity receives is exceptional and for this we are extremely grateful.

Against the continuing backdrop of COVID, 2022–23 was another successful period. £5.020m was raised. On behalf of the Corporate Trustee we extend a huge vote of thanks for the continued generosity to all our patrons, ambassadors, fundraisers and supporters. We thank them also for their commitment and time in raising these funds to help support the Velindre University NHS Trust Charity.

To all our supporters, fundraisers, staff and volunteers with your help we continue to grow and support our Charity mission. Warmest thanks are also due to our Fundraising Team and Charity support staff, for their continued dedication in progressing the actions and activities that drive our Charity forward.

The Trustees would also like to thank the patient's and fundraisers who have attended the Charitable Funds Committee, providing a valuable patient and fundraiser voice throughout discussions on new projects, activities and initiatives. The patient's and fundraiser's commitment and support is extremely helpful and we look forward to continuing to work with them during 2022-23 and beyond.



Welcome from our Chair, Professor Donna Mead OBE



I'm pleased to introduce our Annual Report and Accounts and to share the Velindre story of this past year. One we can look back on being filled with achievement, innovation, creativity and collaboration to meet the needs of the communities we serve in Velindre University NHS Trust.

I know very well from my own personal experience and the experiences of so many others, that the services we provide across our fantastic organisation are life changing. From the expert cancer care, through the research and innovation we undertake, to the blood donations collected and distributed to hospitals across Wales. Every minute of every day, we are making a real difference.

With the vital help of the Charity, I've been impressed by the way that our services across Velindre Cancer Centre and the Welsh Blood Service have continued to grow and strengthen, having a meaningful impact on the tens of thousands of people who use them each year.

The charitable funds allow us to invest in to many areas such as research, service development, patient support or colleague wellbeing and you will read many examples throughout this report of how that has happened. However, looking to the year ahead, whilst the legacy of Covid-19 lives on for so many, we recognise that the cost of living crisis is affecting more and more families, each and every day.

For those who know us well, you will recall our determination to invest in our patient support services. For many, that support is aligned to understanding and dealing with cancer as an illness, but our very caring patient support team go so much further to work with and signpost those most in need of navigating the financial difficulties cancer can also bring. I am incredibly proud of how the investment of charitable funds has brought so much hope and support to so many people.

For this to be able to happen we are of course reliant upon the kind donations, generosity and hard work of our loyal supporters, our president, patrons, ambassadors, fundraisers, volunteers and fundraising staff who form a crucial part of 'Team Velindre'.



I have the envious privilege of being able to meet so many of them throughout the course of each year. Incredible, selfless people who never cease to amaze me with wonderfully inspiring stories. Their passion, enthusiasm, hard work, expertise and dedication to our work is infectious.

We are of course never complacent about success in Velindre and we know the year ahead will be challenging, but along with my colleagues we have a healthy appetite to continue to push the boundaries for improvement in all that we do. Our patients, their families, friends, carers and wider support groups deserve it, our incredible staff deserve it, the people of Wales deserve it. We will represent them well and drive forward our ambitions.

I look forward to sharing an exciting year ahead.

Thank you.

Professor Donna Mead, OBE
Chair

Welcome from our Chief Executive, Steve Ham

In what was an extremely challenging year, I am proud that our patients, donors and families have continued to benefit from the highest standards of care, innovation and professionalism across the range of services we deliver.

We successfully maintained the delivery of transplant services and the supply of blood and blood products to the whole of NHS Wales whilst also delivering essential tertiary cancer services to the South East Wales population. We believe the strong foundations and clinical operating models that we have established will stand us in good stead, as we enter 2023/2024.

The year ahead looks equally challenging but I remain confident that our talented and committed colleagues, supporters and volunteers will be instrumental in our achievements. With the help of charitable funds, donated with such generosity, we will put that to good use.

We will continue to develop the services we offer focussing on meeting the evolving requirements of the communities we serve making a significant difference for our patients, families, supporters and colleagues.

It's now time to focus on the future and an ambitious new strategy that marks the beginning of an exciting chapter for our Charity. I am eager to develop this strategy with the help of our supporters, with the ultimate goal of creating an environment of togetherness.

One of my main goals is to ensure that our staff are well-supported and that our charity is even more effective, ambitious, and inclusive. It is crucial that everyone feels heard, respected, and able to flourish and grow. Above all, I am committed to continuing to make a meaningful and positive impact on the lives of our service users, those who require us in their greatest time of need.



The seeds of our ability to keep growing are of course due to the generosity and dedication of our supporters. These supporters are comprised of many, many individuals who share our purpose and vision, and who graciously donate their time, expertise, and funds. Without their contributions, we simply could not achieve many of the successes we do.

I'd like to pay particular attention to our fundraising team. They have been instrumental in our achievements this past year. Without their tireless efforts and commitment, we would not have been able to accomplish what we did. Recognising and celebrating their success is something in which I know our supports will join me. We are so fortunate to have such great people in Velindre.

Finally, I would like to take this opportunity to express my sincere gratitude to my leadership team, our Chair, and Board for their unwavering support in ensuring the smooth operation of our esteemed Charity.

Thank you.
Steve Ham
Chief Executive

Our Purpose

Charity Vision

"Invest in promoting Quality, Care and Excellence in the services provided by Velindre University NHS Trust".

Mission

"To support the Trust's provision of world class research-led treatment, care and support for patients and families affected by cancer as well as other patients supported by the Trust and those who are involved in the donation of blood or stem cells".

Aims

"to improve the quality and quantity of research undertaken by the Trust"





Our Objectives

General

For charitable purposes relating to the general or specific use of Velindre University NHS Trust. Or to purposes relating to the health service and for any other health services for which specific monies have been donated for use within the UK or overseas.

Donors

For the promotion of blood and stem cell donation to grow the donor pool and to improve donor care and experience.

Staff

For the relief of sickness, improving or supporting welfare and promoting the efficient and effective performance of duties of Trust staff.

Patients

For the relief of illness of patients suffering from cancer or its effects as well as other patients who are or have been treated by Velindre University NHS Trust.

Research

For any charitable purpose or purposes principally (but not exclusively) at or in connection with Velindre University NHS Trust which will further our research goals overleaf.

Our Research Goals



- The investigation of the causes of cancer and the prevention, cure, treatment and defeat of cancer in all its forms.
- The advancement of scientific and medical education and research in topics related to cancer.
- The furtherance of any other charitable purpose for the relief of persons diagnosed with cancer.
- To support research and development in to new and novel uses of blood, blood components and cellular technology for the benefits of patients.
- Improve donor care through the development of research activity.
- Improve quality and safety of blood components and products; and support research to approve outcomes in transplantation.

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Canolfan Ganser Felindre
Velindre Cancer Centre

January



Dinas Powys Mini's FC started 2022 with a bang by climbing Pen y Fan.

"Our fantastic football family want to raise money to support Nadine whilst she undergoes her treatment at Velindre" The weather didn't stop 'Team Velindre'!

February



A record year for our annual WEAR RED FOR WALES' campaign with over 300 schools and organisations joining in the fun to help us paint Wales RED!

March



Our Young Ambassadors programme and commitment to youth engagement have allowed us to make lasting connections with the local community and teach them new skills to prepare them for the future.

Codi Arian
CANOLFAN GANSER
VELINDRE
CANCER CENTRE
Fundraising

Total Income Raised: £5.020m

Events, Fundraising and Donations: £2.081m

During 2022 to 2023, the total amount raised from general donations, grants, events and fundraising was over £2m, which is a testament to the immense generosity, passion, commitment and dedication of our staff and loyal supporters. We are grateful for their continued support, recognising that our future plans would not be possible without the support of our dedicated fundraisers. We remain extremely grateful for their efforts.

Legacies £2.795m

In the period of 2022 to 2023, the total amount of legacies received was in excess of £2.7m. The Charity continues to receive legacies, which are a crucial source of income, and we express our gratitude to those who have the generosity and foresight to remember Velindre by leaving a gift in their will.

Investments £0.144m

The charity has entrusted external investment advisors to manage its portfolio of investments in accordance with guidelines and responsible policies that have been agreed upon with the charity's Trustees. In the course of the year, the portfolio generated a dividend of £0.144m.

Codi Arian
CANOLFAN GANSER
VELINDRE
CANCER CENTRE
Fundraising

Total Expenditure: £2.188m

Research: £0.821m

Every year, the funds raised by the charity are utilised to support innovative research and clinical trials. These trials can aid in the development of advanced treatments that enhance patient and donor care, and improve the quality and safety of blood components and products..

Patients, Staff Wellbeing and Amenities: £0.246m

The funds raised through the charity has a significant impact on patients and staff welfare by funding support services, therapies, equipment, and more. These resources help improve the quality of patient care and contribute to employee well-being.

Fundraising: £0.898m

Our charity relies heavily on fundraising, which is not only a crucial source of income but also plays a vital role in raising awareness and gaining continued support from the public. The cost of raising funds is in line with other charities of similar size and nature.

Support Costs: £0.199m

Support costs and fees are kept to a minimum, however, to ensure that the charity can be run effectively it is essential that a clear management and governance structure is in place. Support costs are in line with other Charities of similar size and nature.

Investment Management Fees: £0.025m

The investment fees paid to the Charity's Investment Management Advisors account for a small proportion of expenditure. However, this expert advice is crucial in ensuring that the Charity's Investment Portfolio is managed effectively in line with agreed guidelines and policies.

Codi Arian
CANOLFAN GANSER VELINDRE CANCER CENTRE
Fundraising

Examples of activity that the monies raised supported during 2022-2023

Activity	Description
Cancer Clinical Nurse Specialists	The Charity provides support for the employment of Cancer Clinical Nurse Specialists who work in a specialised and intricate cancer environment. Due to the complex nature of their work, there are inherent demands and emotional implications involved in supporting patients. The service provided by these specialists is of immense value to our patients.
Complimentary Therapies	The Charity has provided support to offer complimentary therapies to patients at Velindre, which will complement the existing Therapy, Nursing, Consultants, and specialty Doctors. This presents an excellent opportunity to balance the wellbeing of patients with the medical and clinical teams that deliver high-quality patient care.
Early Phase Trials: Medical Sessions for the Future	To support the provision of world class research-led treatment, care and support for our patients and families affected by cancer, the Charity supported investment in early phase trials which will help support us to meet our aims of: • Investigating the causes of cancer and the prevention, cure, treatment and defeat of cancer in all its forms; • The advancement of scientific and medical education and research in topics related to cancer.

Advanced Practice Physiotherapist	All gynaecological cancer patients in Velindre Cancer Centre now have access to a dedicated, first of its kind in Velindre Therapies, Trainee Advanced Practice Physiotherapist, offering prehabilitation and specialist rehabilitation from the side effects of gynaecological cancer treatment. The service offers holistic, individualised physiotherapy input that previously patients had limited access to.
Children's Resources	All of the children's resources at Velindre Cancer Centre are funded by the charity. These resources include memory boxes, lion toys, worry monsters, and educational books that help support a child when experiencing a diagnosis or loss in the family
Equality and Inclusiveness	The charity has funded an initiative involving teachings the importance of health screening and blood donation to students taught through teaching English as a foreign language. The students then become ambassadors in diverse communities encouraging the uptake of health screening and blood donation.







Further information

The activities described above provide only an example of the activity that Velindre University NHS Trust Charity has agreed to support during the year. Further information and detail can be sought from the Charitable Funds Committee meeting papers, which are published on the Velindre University NHS Trust website: www.velindre-tr.wales.nhs.uk/charitable-funds-committee-cfc-

April



The Cardiff Half Marathon 2022 saw 46 fundraisers run in aid of Velindre, raising vital funds for the Charity. Many of these avid athletes have continued to run for us in 2023, and plan to do so in 2024.

May



Velindre remained the headline charity at the Brecon Carreg Cardiff Bay Run with 150 runners signed up to represent and support our #TeamVelindre

June





"I'm doing this for you Grancha, and I know you will be looking down on us and cheering us along the way"

July



Young ambassadors Seren and Morgan founded 'Veggies for Velindre', a fresh fruit and veg programme based in Tynewydd, RCT.

August



Established in memory of musician Andrew Nichols nicknamed Mega, the Megaday Music Festival returned to Caerphilly Rugby Club during the August Bank Holiday weekend. The event focusses on three key objectives which are to have fun, remember loved ones, and raise vital funds for Velindre.

September



September saw our valued ambassador Tracey Davies, joined by our Chair, lead an inspirational 'Walk for Hope' in Dare Valley Country Park. An inclusive event which attracted families young and old, walkers with disabilities and many others, all of whom were touched by cancer and wished to support Velindre.

Structure, Governance and Management of Charitable Funds



The Velindre University NHS Trust Board as a Corporate Trustee is ultimately accountable for charitable funds donated to Velindre University NHS Trust Charity, you can meet our Trustees on page (64) of this report.
The Chair and Independent Members of the Trust Board are appointed by the Welsh Government while the Chief Executive and Executive Directors are appointed by the Trust Board. Trustees of Velindre University NHS Trust Charity are responsible for controlling the management and administration of the Charity and have collective responsibility for the Charity.

The duties of a Trustee is to:

- Ensure the Charity is carrying out its purposes for the public benefit
- Comply with the Charity's Governing Document and the law
- Act in the Charity's best interests
- Manage the Charity's resources responsibly
- Act with reasonable care and skill
- Ensure the Charity is accountable

The Charity Commission has written guidance which sets out what is required of a Charity Trustee, including their responsibilities to the Charity. This guidance is available here.

In order to facilitate the administration and management of the charitable funds the Trust Board has established a Charitable Funds Committee to provide advice and recommendations to the Board. The Charitable Funds Committee manages, on behalf of the Trust Board, all aspects of control, investment and expenditure of the Trust's charitable funds. The Trustees have been appointed under s11 of the NHS and Community Care Act 1990.
The Charitable Funds Committee may delegate authority to commit expenditure but cannot delegate accountability.

The Executive Director of Finance is responsible for the day to day management and control of the administration of the charitable funds and reports to the Charitable Funds Committee. The Executive Director of Finance has particular responsibility to ensure that the spending is in accordance with the objectives and priorities agreed by the Charitable Funds Committee and the Board; that the criteria for spending charitable monies are fully met; that full accounting records are maintained and that devolved decision making or delegated arrangements are in accordance within the policies and procedures set out by the Board as the Corporate Trustees.

The Charitable Funds Committee is supported by a Sub-Committee, the Investment Performance Review Sub-Committee which has particular responsibility for managing the Charity's Investment Portfolio together with the Charity's Investment Management Organisation (Brewin Dolphin).

The Charitable Funds Committee is supported by a Sub-Committee, the Investment Performance Review Sub-Committee which has particular responsibility for managing the Charity's Investment Portfolio together with the Charity's Investment Management Organisation (Brewin Dolphin).



The main objectives of the Investment Performance Review Sub-Committee are to:

- Ensure that when investing charitable funds Trustees achieve an appropriate balance for the Charity between the two objectives of:
  - Providing an income to help the Charity carry out its purposes effectively in the short term; and;
  - Maintaining and, if possible, enhancing the value of the invested funds, to enable the Charity to carry out its purpose in the longer term.

- Ensure that the standards as defined in the Trustee Act are followed, whether they are using the investment powers in that Act or not:
  - That the Charity is discharging its general duty of care (as described in section 1 of the Trustee Act), which is the duty to exercise such care and skill as is reasonable in the circumstances. This applies both to the use of any power of investment and to the discharge of the specific duties which the Act attaches to the use of investment powers.

- Secondly, that the Charity is complying with the following specific duties:
  - Trustees must consider the suitability for the Charity of any investment. This duty exists at two levels. The Trustees must be satisfied that the type of any proposed investment (e.g. a common investment fund or a deposit account) is right for the Charity. They also have a duty to consider whether a particular investment of that type is a suitable one for the Charity to make, based on the overall investment policy set by the Charitable Funds Committee. Trustees should, at both levels, try to consider the whole range of investment options which are open to them; how far they should go here will, of course, depend on the amount of funds available for investment.

- Trustees must consider the need for diversification, i.e. having different types of investment, and different investments within each type. This will reduce the risk of losses resulting from concentrating on a particular investment or type of investment.

- Trustees must periodically review the investments of the Charity. The nature and frequency of these reviews is up to the Trustees to decide, but the reviews should be proportionate to the nature and size of the Charity's investment portfolio. To review too infrequently may result in losses or missed opportunities; chopping and changing investments too frequently may incur unnecessarily high levels of transaction charges. A review of the investments should be carried out at least once a year.

- Trustees must monitor the overall performance of the portfolio and, in so far as it is possible, compare the rate of return with returns achieved by other similar organisations. The rate of return will need to be reported annually to the Charitable Funds Committee as part of its annual report.

- Before exercising any power of investment, and when reviewing the Charity's investments, Trustees must obtain and consider proper advice from a suitably qualified adviser.

The Charitable Funds Committee is also supported by the Charity's Senior Leadership Group, to monitor the strategic delivery and operational application of all Charitable Funds held within the Velindre University NHS Trust.

Within the charity there are a number of designated funds relating to particular areas. The charity manages spending through the Individual Fund Holders who are allocated part of the total budget to spend in accordance with agreed authorisation limits.

Fund Holders for each of the designated funds manage these funds on a day-to-day basis within the Trust's Standing Orders and Standing Financial Instructions and powers of delegated authority set by the Corporate Trustee (The Velindre University NHS Trust Board).

The Trustee oversees the work of the Fund Holders and has the power to revoke a Fund Holders remit or, subject to any specific donor restriction, direct the use to which funds are put.



Charity Related Policies

The Charitable Funds Policies and Procedures are managed in accordance with the Velindre University NHS Trust Policy for the Management of Policies, Procedures and Written Control Documents; this provides the Trust Board with robust assurance that the charitable funds are handled with efficiency and effectiveness. The Charitable Funds policies are available here.

Management of Concerns

Concerns received in relation to the Charity are managed in accordance with the Velindre University NHS Trust Handling Concerns Policy. Any concerns received against the Charity would be captured and reported as required to the Charitable Funds Committee. In response to findings identified from any concerns raised against the Charity the Charitable Funds Committee would consider any lessons learned and identify areas where improvements could be made. There were no concerns received against the Charity in 2022-23.

The Trust Board as Corporate Trustee is responsible for the Charity's risk management and the effectiveness of internal control systems. The Trust Board and Charitable Fund Committee reviews major risks in accordance with the Trust Board appetite and the Audit Committee works to ensure that reasonable measures are taken to manage these risks.

The impact of the continuing economic uncertainty remains a major risk to the Charity. Therefore, plans, reserves and investment policies are frequently reviewed. The Trustees have considered the risks that the Charity faces and confirm that systems, procedures, and policies are in place to ensure that any risks are minimised.



The risk register is updated by the Charity's Senior Leadership Group as required and is subsequently reported to the Charitable Funds Committee via any escalated risks in line with the Trust's overarching Risk Management and Assurance Framework, to ensure actions are taken in the areas that have been identified as appropriate. This approach will continue to strengthen the position of the Charity and ensure the Trustees are indemnified in accordance with the Welsh Risk Pool (NHS Insurers) expectations.

These processes provide the Trust Board with the assurance that internal controls and risks are monitored and managed effectively. The Charitable Funds Committee continues to improve reporting procedures to ensure that it can foresee and react to changes in the economic environment.

The Charity's investment policy focuses on minimising the Charity's exposure to losses and this is explained in the Investment policy.

As the present economic situation continues the Charity needs to ensure that it is able to meet its liabilities as and when they fall due. The Charity has procedures in place to control its cash flow and commitment forecasts additionally, its reserves policy is continuously reviewed.



Relationships with Related Parties/External Bodies

During the year, none of the Trustees or members of the key management staff or parties related to them have undertaken any material transactions with the Velindre University NHS Trust Charitable Funds. Board Members (and other senior staff) take decisions both on Charity matters and endeavor to keep the interests of each discrete and do not seek to benefit personally from such decisions.

Most grants made are to Velindre University NHS Trust Charity to support the activities relating to the objectives of the charity. For example, The Charitable Funds do not directly employ the staff, working on different activities, grants are made to Velindre University NHS Trust to employ those staff.

Audit Requirements

The Velindre University NHS Trust Audit Committee reviews any Internal Audit and External Audit reports from audits undertaken across key operations of the Charity and its risks.

The Audit Committee meets with the external auditor on a regular basis to discuss findings and risks that the Charity could face.

Financial Risk Management

The Charity's activities expose the Charity to credit risk, market risk and liquidity risk. The Charity's financial activities are governed by policies approved by the Charitable Funds Committee and the Trust Board, and these activities are directly supported by the Charity's Senior Leadership Group, Executive Director of Finance and the Senior Finance and Procurement team.

The principal financial assets are bank balances, investments, and receivables. Credit risk is mainly attributable to bank balances, and these are well controlled. A number of the Charity's investments are subject to market activities and have recorded some limited realised and unrealised gains in the year.

Future Plans - Governance Activity

The following key priorities in respect of the Trust Charitable Funds governance arrangements have been identified for 2023-24 and beyond:

- Refresh the Charity's aims and objectives in line with the strategic vision and direction for the Charity, in accordance with the Trust's overarching Integrated Medium Term Plan governance cycle.
- Continuously review and improve the Business Case Expenditure and Evaluation Process to further embed and strengthen the quality and consistency of information provided to the Charitable Funds Committee.
- It is our intention to review our patron and ambassador model and attempt to become more inclusive.
- Undertake a review of the induction programme for new Executive Directors and Independent Members of Velindre University NHS Trust in regards to their responsibilities as Board members of Velindre University NHS Trust and as Corporate Trustees of the Velindre University NHS Trust Charity.
- Continually review the Charitable Funds Committee effectiveness and monitor its ongoing arrangements.



Codi Arian
CANOLFAN GANSER
VELINDRE
CANCER CENTRE
Fundraising

October



For yet another year, our Velindre runners took part in the London Marathon.
Go 'Team Velindre'!

November



In November, Jiffy's Golf Day went international! Hosted in Dubai, this event brought together many celebrities and sponsors to raise money and awareness of Velindre Cancer Centre.

December



A successful year of supporting

The Hospital of

Hope

Social Investment Activity

The Charities (Protection and Social Investment) Act 2016 ('the 2016 Act') provides a statutory power for charities to make social investments. This came into force on 31 July 2016. The Charity commission guidance states the following:

In the legislation, a 'social investment' means a 'relevant act' of a charity which is carried out 'with a view to both directly furthering the charity's purposes and achieving a financial return for the charity'. In this interim guidance, the term 'social investment' has the same meaning as it has in the 2016 Act.

A 'relevant act' means one of two things:

- an application or use of funds or other property by the charity; or
- taking on a commitment in relation to a liability of another person which puts the charity's funds or other property at risk of being applied or used, such as a guarantee.

In this context, an application or use of funds or other property achieves a 'financial return' if its outcome is better for the charity in financial terms than expending the whole of the funds or other property in question and this interim guidance generally uses the term in this way.

It is important to remember that whether a social investment is being made is determined by the motivation of the charity – if the reasons for applying funds in a particular way include both directly furthering the charity's purposes and making a financial return then the proposed action will be a social investment. In view of this, the Charity will continue to actively consider which (if any) activities of the charity fall within the definition of 'social investment'. This is because Trustees have specific legal duties which apply when making social investment decisions and they should be able to show that they have made these decisions in good faith.



Structure, Governance and Management of Charitable Funds

Financial Summary for the Year ended 31st March 2023

Thanks to the donations and legacies received we have achieved a total income of £5,020,000 (2022: £3,188,000). Expenditure from charitable activities for the year was £1,215,000 (2022: £2,301,000) which we used for patient and staff welfare, improvement of facilities and research.

Investment Policy and Performance

At the 31 March 2023, the market value of the investment portfolio is £5.8m (2022: £6.2m). The portfolio is managed by the Charity's investment brokers Brewin Dolphin. They work within the limits of the investment policy to achieve the charities financial objectives: generating growth, maximising returns, supporting the reserves policy and ensuring risks and liquidity are managed. The investment policy is to invest in low risk 'Wealth Builder Funds' and also funds must not be invested in tobacco, alcohol, gambling and armament related entities.

The value of the investments decreased by £376,000 over the financial year. The Charity has a long-term time horizon for its investments and is able to weather short-term volatility in order to meet its long-term objectives. The Trustees, with the aim of minimising the risk to Velindre NHS Charitable Funds, have agreed to operate within a lower risk investment strategy. The level of investment risk taken is reviewed regularly and has been appropriately mitigated by apportioning the funds into two well- diversified lower risk portfolios. Investment decisions are supported by the advice of the investment advisors.

The performance of Brewin Dolphin in their role as investment managers and advisors is monitored and regularly reviewed by the Trustees.

Unrestricted Funds Reserves Policy

Reserves are part of the charity's unrestricted funds that are available to spend on any of the charity's purposes. Reserves are maintained at a level, which enables the charity to ensure financial commitments are met, as they fall due and to manage any short-term volatility. This assessment of the required level of reserves excludes those funds that are designated or restricted as they are only available for a specified purpose.

The Trustees consider that reserves should be set at a level, which is equivalent to estimated planned commitments for the following four months at any given point. At this level, in the event of a significant reduction in charitable funding, it is anticipated that the Charity would be able to continue with the current programme of activity for such time as is necessary to allow for a properly planned and managed change in the activity programme and/or the generation of additional income streams.

In accordance with the above, the unrestricted reserve target for the general-purpose fund was set at £2,051,002 as at 31st March 2023 (2022: £816,040). The balance £6,121,694 (2022: £2,616,612) exceeds the target by £4,070,693 (2022: £1,800,572) and excludes an apportionment of dividends, management fees, realised and unrealised losses and transfers to/from unrestricted/designated Funds. Trustees will continue to monitor the Charity's future funding strategies and detailed budget plans to ensure these are of the highest standard and the unrestricted funds reserve policy is met.

Grant Making Policy

Grants are awarded for funding requests which meet the objectives of the charity in support of its mission to support the Trust's provision of world class research-led treatment, care and support for patients and families affected by cancer and those who are involved in the donation of blood products and stem cells. Grants are predominantly awarded to Velindre University NHS Trust; however, grants are also awarded to other institutions to support the overall objectives of the charity. A rigorous process of review and evaluation is carried out on all funding requests to ensure they are of the highest standard.

Funds held as Custodian Trustee on behalf of others

On 1st October 2009, Public Health Wales NHS Trust was established which incorporated the former Screening and National Public Health Service (NPHS) divisions of Velindre University NHS Trust. The Charitable Funds relating to the Screening and NPHS divisions have remained in Velindre University NHS Trust Charitable Funds. The total amount of these funds held is £65,000 (2022: £65,000).

Trustees

The Trustees are responsible for preparing the Trustees Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards.

The law applicable to Charities in England and Wales requires the trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period. In preparing these financial statements, the trustees are required to:

- Select suitable accounting policies and then apply them consistently;
- To establish and monitor a system of internal control;
- Observe the methods and principles of the Charities SORP FRS 102 and Charities Act 2022;
- Make judgments and estimates that are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any departures disclosed and explained in the financial statements.

Donna Mead OBE
Trust Chair

Matthew Bunce
Executive Director of Finance

Approved by the Board Trustees and authorised for issue on: 23rd April 2024

The independent auditor's report of the Auditor General for Wales to the Trustee of the Velindre University NHS Trust Charity

Opinion on Financial Statements

I have audited the financial statements of Velindre University NHS Trust Charitable Funds for the year ended 31 March 2023 under the Charities Act 2011. The financial statements comprise the Statement of Financial Activities, the Balance Sheet, the Statement of Cashflows and related notes, including the significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice). In my opinion the financial statements:

- give a true and fair view of the state of affairs of the charity as at 31 March 2023 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the Charities Act 2011.

Basis of Opinion

I conducted my audit in accordance with applicable law and International Standards on Auditing in the UK (ISAs (UK)) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of my report.

My staff and I are independent of the charity in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions Relating to Going Concern

In auditing the financial statements, I have concluded that the use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the body's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from when the financial statements are authorised for issue. My responsibilities and the responsibilities of the trustee[s] with respect to going concern are described in the relevant sections of this report.

Other Information

The other information comprises the information included in the annual report other than the financial statements and my auditor's report thereon. The trustee[s] [is/are] responsible for the other information contained within the annual report. My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my report, I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard

Matters On Which I Report by Exception

I have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require me to report to you if, in my opinion:

- I have not received all of the information and explanations I require for my audit;
- sufficient accounting records have not been kept, or returns adequate for my audit have not been received from branches not visited by my team;
- the financial statements are not in agreement with the accounting records and returns; or
- the information given in the financial statements is inconsistent in any material respect with the trustee's report.

Responsibilities of the Trustees for the Financial Statements

As explained more fully in the statement of trustee's responsibilities the trustee is responsible for:

- maintaining sufficient accounting records;
- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- internal controls as the trustee determine is necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error; assessing the Velindre University NHS Trust Charitable Funds ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going
- concern basis of accounting unless the trustee anticipates that the services provided by the charity will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

I have been appointed as auditor under section 150 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act. My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

My procedures included the following:

- Enquiring of management, the Head of Internal and those charged with governance, including obtaining and reviewing supporting documentation relating to Velindre University NHS Trust Charitable Funds policies and procedures concerned with:
- identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
- detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
- the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud.
- Obtaining an understanding of Velindre University NHS Trust Charitable Funds framework of authority as well as other legal and regulatory frameworks that it operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Velindre University NHS Trust Charitable Funds
- Obtaining an understanding of related party relationships.

In addition, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business
-

I also communicated relevant identified laws and regulations and potential fraud risks to all audit team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit. The extent to which my procedures are capable of detecting irregularities, including fraud, is affected by the inherent difficulty in detecting irregularities, the effectiveness of the Velindre University NHS Trust's controls, and the nature, timing and extent of the audit procedures performed. A further description of the auditor's responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website www.frc.org.uk/auditorsresponsibilities. This description forms part of my auditor's report.

Other auditor's responsibilities

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Adrian Crompton
Auditor General for Wales

1 Capital Quarter Tyndall Street Cardiff CF10 4BZ

Statement of Financial Activities for the year ended 31 March 2023

	Note	Unrestricted Funds	Restricted Funds	Total Funds 2022-2023	Total Funds 2021-2022
		£'000	£'000	£'000	£'000
Incoming resources from generated funds:					
Donation and Legacies	3	4,229	0	4,229	2,647
Charitable Activities		0	0	0	0
Other Trading Income	3	647	0	647	427
Investments	5	144	0	144	114
Other		0	0	0	0
Total incoming resources		**5,020**	**0**	**5,020**	**3,188**
Expenditure on:					
Raising Funds	6	973	0	973	363
Charitable Activities	7	1,207	8	1,215	2,301
Other		0	0	0	0
Total Expenditure		**2,180**	**8**	**2,188**	**2,664**
Net gains/ (losses) on investments	12	(486)	0	(486)	108
Net income/ (expenditure)		**2,354**	**(8)**	**2,346**	**632**
Transfer between Funds	17	0	0	0	0
Net Movement in Funds		**2,354**	**(8)**	**2,346**	**632**
Reconciliation of Funds:					
Fund balance brought forward	18	7,175	220	7,395	6,763
Fund Balance Carried Forward	**18**	**9,529**	**212**	**9,741**	**7,395**

Balance sheet as at 31 March 2023

	Note	Unrestricted Funds	Restricted Funds	Total 31st March 2023	Total 31st March 2022
		£'000	£'000	£'000	£'000
Fixed Assets:					
Investments	12	5,649	161	5,810	6,186
Total fixed assets		5,649	161	5,810	6,186
Current Assets:					
Debtors	13	1,670	0	1,670	24
Cash at bank and in hand	14	2,312	51	2,363	2,352
Total current assets		**3,982**	**51**	**4,033**	**2,376**
Liabilities:					
Creditors: amounts falling due within one year	15	(102)	0	(102)	(1,167)
Net Current assets/ (liabilities)		**3,880**	**51**	**3,931**	**1,209**
Total assets less current liabilities		**9,529**	**212**	**9,741**	**7,395**
Creditors amounts falling after more than 1 year	15	0	0	0	0
Total Net assets/(liabilities)		**9,529**	**212**	**9,741**	**7,395**
The Funds of the Charity					
Restricted funds	18	0	212	212	220
Unrestricted funds	18	9,529	0	9,529	7,175
Total funds		**9,529**	**212**	**9,741**	**7,395**

The notes on pages 39 to 63 form part of the accounts

Approved by the Board of Trustees and authorised for issue on 23rd April 2024

Donna Mead OBE
Trust Chair

Matthew Bunce
Executive Director of Finance

Statement of Cash Flows for the year ended 31 March 2023

	Note	Total Funds 2022-2023	Total Funds 2021-2022
		£'000	£'000
Cash Flows from operating activities:			
Net Cash provided by (used in) operating activities	16	(23)	1,167
Cash Flow from Investing Activities:			
Dividend, interest and rents from Investments	5	144	114
Proceeds from the sale of investments	12	783	1,900
Purchase of investments	12	(1,158)	(2,005)
(Increase)/ Decrease in Cash held in Investments	12	265	17
Net Cash provided by (used in) investing activities		**34**	**26**
Change in Cash and cash equivalents in the reporting period		11	1,193
Cash and Cash equivalents at the beginning of the reporting period	14	2,352	1,159
Cash and Cash equivalents at the end of the reporting period	14	2,363	2,352

Notes on the Accounts

1. Accounting Policies

(a) Basis Of Preparation

The financial statements have been prepared under the historic cost convention, with the exception of investments which are included at fair value.

The accounts (financial statements) have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it is effective and applies from 1 January 2015.

The accounts (financial statements) have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The Trustees consider that there are no material uncertainties about the Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

In future years, the key risks to the Charity are a fall in income from donations or investment income but the trustees have arrangements in place to mitigate those risks (see the risk management and reserves sections of the annual report for more information). The Charity meets the definition of a public benefit entity under FRS 102.

(b) Funds Structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- A restricted fund or
- An endowment fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. The Charity's restricted funds tend to result from appeals or legacies for specified purposes.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. These funds are sub analysed between those where the Trustees have the discretion to spend the capital (expendable endowment) and those where there is no discretion to expend the capital (permanent endowment).

The charity does not currently hold any endowment funds.

Those funds which are neither endowment nor restricted income funds, are unrestricted income funds which are sub analysed between designated (earmarked) funds where the Trustees have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the Trustees' discretion, including the general fund which represents the charity's reserves. The major funds held in each of these categories are disclosed in note 18.

(c) Incoming Resources

Income consists of donations, legacies, income from charitable activities and investment income.

Donations are accounted for when received by the charity. All other income is recognised once the charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received, and the monetary value of incoming resources can be measured with sufficient reliability.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met or uncertainty exists as to whether they can be met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable, whichever falls sooner.

Receipt is probable when:

- Confirmation has been received from the representatives of the estate(s) that probate has been granted
- The executors have established that there are sufficient assets in the estate to pay the legacy and
- All conditions attached to the legacy have been fulfilled or are within the charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

(e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(f) Investment Income

Income from investments is re-invested into the investment portfolio.

(g) Recognition of expenditure and associated liabilities as a result of grants

Grants payable are payments made to linked, related party or third party NHS bodies and non NHS bodies, in furtherance of the charitable objectives of the funds held on trust, primarily relief of those who are sick.

Grant payments are recognised as expenditure when the conditions for their payment have been met or where there is a constructive obligation to make a payment.

A constructive obligation arises when:

- We have communicated our intention to award a grant to a recipient who then has a reasonable expectation that they will receive a grant.
- We have made a public announcement about a commitment which is specific enough for the recipient to have a reasonable expectation that they will receive a grant
- There is an established pattern of practice which indicates to the recipient that we will honor our commitment.

The Trustees have control over the amount and timing of grant payments and consequently where approval has been given by the trustees and any of the above criteria have been met then a liability is recognised. Grants are not usually awarded with conditions attached. However, when they are then those conditions have to be met before the liability is recognised. Where an intention has not been communicated, then no expenditure is recognised, but an appropriate designation is made in the appropriate fund. If a grant has been offered but there is uncertainty as to whether it will be accepted or whether conditions will be met, then no liability is recognised, but a contingent liability is disclosed

(h) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include staff costs, costs of administration, internal and external audit costs. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 9.

(i) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objectives. The costs of generating funds represent fundraising costs together with investment management fees. Fundraising costs include expenses for fundraising activities and a fee paid to the related party for salaries and overhead costs of the NHS Trusts fundraising office.

(j) Charitable Activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objectives of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 7.

(k) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

(l) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90-day notice interest bearing savings accounts.

(m) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long term creditors.

(n) Investment Fixed Assets

Listed Investments are stated at market value. The SOFA includes realised gains and losses on investments sold in the year, and unrealised gains and losses on the revaluation of investments.

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

Investments are subject to review of impairment when there is an indication of a reduction in their carrying value. Any impairment is recognised in the year in which it occurs.

2. Related Party Transactions

During the year none of the trustees or members of the key management staff or parties related to them have undertaken any material transactions with Velindre University NHS Trust Charitable Trust. Board Members (and other senior staff) take decisions both on Charity and Exchequer matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions. Declarations of personal interest have been made in both capacities and are available to be inspected by the public.

None of the members of the Board received any expenses or remuneration during the year for their duties to the charitable trust.

Velindre University NHS Trust, the corporate trustee of the Charitable Trust, has received reimbursement from the Charitable Trust of £1,343,000 (2022: £2,157,000). Cardiff University has received reimbursement from the Charitable Trust of £120,000 (2022: £199,000). As at the 31st March 2023 £55,000 (2022: £1.087,000) was outstanding in respect to these transactions to Velindre University NHS Trust and £45,000 (2022: £62,000) to Cardiff University. As at the 31st March 2023 £1,511.000 (2022: £12,000) was owed and outstanding to the Charity from Velindre UNHS Trust.

3. Income from Donations, Legacies & Trading Activities

	Unrestricted Funds	Restricted Funds	Total Funds 2022-2023	Total Funds 2021-2022
	£'000	£'000	£'000	£'000
Donation	1,434	-	1,434	1,333
Legacies	2,795	-	2,795	1,314
Other Trading Activities:				
Trading	-	-	-	-
Fundraising Events	647	-	647	427
Total	4,876	-	4,876	3,074

4. Role of Volunteers

Like all charities, Velindre University NHS Trust Charitable funds is reliant on a team of volunteers for our smooth running. Our volunteers perform 2 roles:

Fund Advisors

There are about 37 Velindre staff who manage how the charity's designated funds should be spent. These funds are designated (or earmarked) by the trustees to be spent for a particular purpose or in a particular ward or department. Each fund advisor has delegated powers to spend the designated funds that they manage in accordance with the trustees wishes. Fund advisors who spend more than £5,000 are required to report to trustees setting out what they intend spending the money on, and the difference it will make to the patients / staff or research led by Velindre.

Fundraisers

There are hundreds of local volunteers who actively fundraise for Velindre University NHS Trust Charitable Funds by running a huge variety of events such as coffee mornings, open gardens, sports tournaments, sponsored walks, balls and dinners. Fundraisers also carry out a number of collections at supermarkets and events.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

5. Gross Investment Income

	Unrestricted Funds	Restricted Funds	Total Funds 2022-2023	Total Funds 2021-2022
	£'000	£'000	£'000	£'000
Income from investments	144	-	144	114
Total	**144**	**-**	**144**	**114**

6. Analysis of Expenditure on Raising Funds

	Unrestricted Funds	Restricted Funds	Total Funds 2022-2023	Total Funds 2021-2022
	£'000	£'000	£'000	£'000
Fundraising Office	262	-	262	205
Fundraising Costs, Donation Charges & Events	636	-	636	112
Investment Management	25	-	25	26
Support Costs	50	-	50	20
Total	**973**	**-**	**973**	**363**

7. Analysis of Charitable Activity

	Grant Funded Activity	Support Costs	Total Funds 2022-2023	Total Funds 2021-2022
	£'000	£'000	£'000	£'000
Patient Welfare and Amenities	194	86	280	886
Staff Welfare and Amenities	52	4	56	-
Research	821	58	879	1,415
Total	**1,067**	**148**	**1,215**	**2,301**

8. Analysis of Grants

The charity does not make grants to individuals. The majority of grants are made to Velindre University NHS Trust to provide for the care of NHS patients in furtherance of our charitable aims. The charity also awards grants to Cardiff University to undertake research in partnership with Velindre University NHS Trust. The total cost of making grants, including support costs, is disclosed on the face of the Statement of Financial Activities and the actual funds spent on each category of charitable activity, is disclosed in note 7.

The trustees operate a scheme of delegation for the majority of the charitable funds, under which fund advisors manage the day to day disbursements on their projects in accordance with the directions set out by the trustees in charity standing orders and financial instructions. Funds managed under the scheme of delegation represent ongoing activities and it is not possible to segment these activities into discrete individual grant awards.

The significant grants made to institutions are:

	Total 2022-2023	Total 2021-2022
	£'000	£'000
Velindre University NHS Trust	886	1,797
Other NHS Bodies	14	57
Cardiff University	120	199
Other	47	113
Total	**1,067**	**2,166**

9. Allocation of Support Costs

Support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic, and day to day management of a charity.

	Raising Funds	Charitable Activities	Total 2022-2023	Total 2021-2022
	£'000	£'000	£'000	£'000
Governance				
External Audit	5	16	21	21
Finance and Administration	21	64	85	52
Other Professional Fees	-	-	-	-
Total Governance	**26**	**80**	**106**	**73**
Finance and Administration	23	70	93	82
Other Professional fees	-	-	-	-
Other Costs	-	-	-	-
Total	**49**	**150**	**199**	**155**

	Raising Funds	Charitable Activities	Total 2022-2023	Total 2021-2022
	£'000	£'000	£'000	£'000
Raising Funds	49	-	49	20
Charitable Activities	150	-	150	135
Total	**199**	**-**	**199**	**155**

Support costs are allocated based on actual expenditure incurred across the various activities of the charity.

10. Staff Costs, Trustees' remuneration, benefits and expenses

The charity does not make any payments for remuneration nor to reimburse expenses to the charity trustees for their work undertaken as trustee.

The charity has no employees. Staff services are provided to the charity from Velindre University NHS Trust, the corporate Trustee of the charitable trust.

11. Auditors Remuneration

The auditors remuneration of £21,000 (2022: £21,000) related solely to the audit of the statutory annual report and accounts.

12. Fixed Asset Investments

Movement in fixed assets investments	Total 2022-23	Total 2021-22
	£'000	£'000
Market value brought forward	6,186	5,990
Add: additions to investments at cost	1,158	2,005
Less disposals at carrying value	(783)	(1,900)
Change in cash held within investment portfolio	(265)	(17)
Add net gain/(loss) on revaluation	(486)	108
Market Value as at 31st March	**5,810**	**6,186**

At Market Value	Total 2022-23	Total 2021-22
	£'000	£'000
Cash	236	360
Sovereign & Fixed Income	2,382	2,093
Developed Market Equity	1,529	1,978
Emerging Market Equity	-	-
Real Estate and Infrastructure	315	399
Absolute Return	823	818
Global Investments	-	-
Commodities	264	245
Other	261	293
Total Investments	**5,810**	**6,186**

All investments are carried at their fair value.

The valuations are provided by the investment managers Brewin Dolphin.

Risk

The Trustees recognise that all investments involve an element of risk. The level of risk that is appropriate for the Trust will be influenced by various factors, including the Trustees' attitude to risk, the Trust's capacity to afford potential investment losses and its investment objectives. The Trustees in order to mitigate the Capital Risk have agreed to request the investment advisor/ manager to maintain a diversified portfolio of assets in order to protect the charity's investments from sudden variations in the market. Additionally, the Trustees have considered investing only, or substantially in markets where financial services are closely regulated and compensation scheme are in place. he Trustees in order to attempt minimizing the risk to Velindre University NHS Charitable Funds, is only prepared to accept limited losses over any period of time. Therefore, it has been agreed to set the Investments Risk Tolerance Category as LOW, which means that investments will be skewed significantly to less volatile asset classes such as high quality investment grade corporate and sovereign bonds. Riskier assets such as equities, alternative investments and commodities may be selected but they are likely to play a less significant role. The Trustees have determined that the purpose of the Velindre University NHS Trust Charitable Funds investment has been categorised as GENERAL with no specific investment purpose. The time horizon for the trust general investment accounts between 5 to 7 years.

The Trustees have requested that the Assets allocation should be distributed following the best advice from the Investment Manager and its direct effect in having an Investment Risk Tolerance Category in Low. he Asset Classes allocation considered by the Trustees should include the following:

- Cash
- Sovereign Fixed Income
- Corporate Fixed Income
- Developed Market Equity
- Emerging Market Equity
- Real Estate & Infrastructure
- Commodities
- Absolute Return

13. Analysis of Current Debtors under 1 year

	Total 31 March 2023	Total 31 March 2022
	£'000	£'000
Amount due from fellow subsidiary*	1,511	12
Accrued Income	-	-
Other debtors	159	12
Total	**1,670**	**24**

*Velindre University NHS Trust

During 2022-23 Velindre UNHS Trust had accumulated £1,500,000 of non-recurrent income from several sources which reduced the requirement to draw down on Charitable funding to support these services. The £1,500,000 funding that was provided from the Charity to Velindre UNHS Trust during the period was reimbursed but outstanding as at 31st March 23.

14. Analysis of Cash and Cash Equivalents

	Total 31 March 2023	Total 31 March 2022
	£'000	£'000
Cash and Bank Balances	2,363	2,352
Total	**2,363**	**2,352**

The cash balances are held on interest bearing deposit within NatWest bank account and represent restricted appeals to fund specific equipment or funds held to facilitate cash flow and the fulfilment of obligations to make grant payments. The funds are held on a 90 day notice account and are therefore classified as cash and cash equivalents

No cash or cash equivalents or current asset investments were held in non-cash investments or outside of the UK.

All of the amounts held on interest bearing deposit are available to spend on charitable activities.

15. Analysis of Liabilities

	Total 31 March 2023	Total 31 March 2022
	£'000	£'000
Creditors under 1 year		
Trade Creditors	47	80
Amount due to fellow subsidiary*	55	1,087
Deferred Income	-	-
Subtotal	**102**	**1,167**
Creditors over 1 year		
Trade Creditors	-	-
Other Creditors	-	-
Accruals	-	-
Subtotal	-	-
Total	**102**	**1,167**

*Velindre University NHS Trust

16. Reconciliation of net income/expenditure to net cash flow from Operating activities

	Total 2022-23	Total 2021-22
	£'000	£'000
Net income/(expenditure) (per statement of financial activities)	2,346	632
Adjustment For: Depreciation Charges	-	-
Adjustment For: (Gains)/Losses on investments	486	(108)
Dividends, interest and rents from investments	(144)	(114)
Loss/(profit) on the sale of fixed assets	-	-
(Increase)/decrease in stocks	-	-
(Increase)/decrease in debtors	(1,646)	5
Increase/(decrease) in creditors	(1.065)	752
Net cash provided by (used in) operating activities	(23)	1,167

17. Transfer between funds

During the year there were no transfers between restricted funds and unrestricted funds (2022: £0). Following approval of funding requests by the trustees £49,000 was transferred from unrestricted funds to unrestricted designated funds (2022: £296,000).

18. Analysis of Funds

a) Analysis of restricted fund movements

	Balance 1 April 2022	Income	Expenditure	Transfers	Gains & Losses	Balance 31 March 2023
	£'000	£'000	£'000	£'000	£'000	£'000
Patient Welfare & Amenities	13	-	(1)	-	-	12
Staff Welfare & Amenities	63	-	(5)	-	-	58
Research	144	-	(2)	-	-	142
Subtotal	**220**	**-**	**(8)**	**-**	**-**	**212**

b) Analysis of unrestricted and material designated fund movements

	Balance 1 April 2022 (Restated)	Income	Expenditure	Transfers	Gains & Losses	Balance 31 March 2023
	£'000	£'000	£'000	£'000	£'000	£'000
Unrestricted Funds						
General 'Umbrella' Fund	3,006	4,850	(1,653)	(49)	(486)	5,668
Designated Funds						
Patient Welfare & Amenities	238	0	(49)	-	-	189
Staff Welfare & Amenities	52	6	-	-	-	58
Research	3,879	164	(478)	49	-	3,614
Subtotal	**7,175**	**5,020**	**(2,180)**	**-**	**(486)**	**9,529**
Total	**7,395**	**5,020**	**(2,188)**	**-**	**(486)**	**9,741**

The opening balances have been restated to account for a previous transfer of that was presented incorrectly between the Unrestricted general purpose fund and the designated funds of Patient Welfare & Amenities and Research. This has been corrected amending the opening balances by reversing the previous entries

£ 43,000- Unrestricted general purpose fund

£(241,000) - Patient Welfare & Amenities

£ 198,000 - Research

There are a number of commitments where bids have been made against the Charity which are provided in note 20.

19. Post Balance Sheet Events

The charity was notified about several legacies from the representatives to the estate prior to the year end. These have not been included in the accounts as there is uncertainty as to the amount, and it cannot be reliably estimated.

20. Commitments

	Items Relating to these projects included within the SOFA for year ended March 2023	Commitments					
		Commit-ents Relating to 2023/24	Commit-ments Relating to 2024/25	Commit-ments Relating to 2025/26	Commit-ments Relating to 2026/27	Total Outstanding Commitments as at 31/03/2023	Total Outstanding Commitments as at 31/03/2022
Project Name	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Advancing Radiotherapy Programme	287	290	67	-	-	357	705
Clinical Nurse Specialists	139	-	-	-	-	-	684
Research & Development Infrastructure	200	-	-	-	-	-	915
Spirtual Support	6	-	-	-	-	-	28
Patient Information Manager	10	-	-	-	-	-	48
Provision of Wigs for Cancer Patients	6	-	-	-	-	-	29

Project Name	£000	£000	£000	£000	£000	£000	£000
Welfare Rights Advisory Service	6	-	-	-	-	-	45
Clinical Psychology	49	-	-	-	-	-	90
Bio sample Collection Wales Cancer Bank (WCB)	21	-	-	-	-	-	-
Complimentary Therapies	13	-	-	-	-	-	87
Pelvic Health	32	-	-	-	-	-	39
Professor in Nursing & Clinical Research Fellow	57	59	20	-	-	79	136
Consultant Research Sessions (AHSC)	21	-	-	-	-	-	93
RD&I Enhanced Clinical Leadership	17	-	-	-	-	-	-
R&D Small Grants	-	-	-	-	-	-	50

Project Name	£000	£000	£000	£000	£000	£000	£000
Therapies Data Manager	17	8	26	-	-	34	93
Driving the Implementation of related R&D Programmes of Work	93	47	-	-	-	47	118
Early Phase Trial: Medical Session for the Future	39	49	46	-	-	95	134
ESOL learners in BAME Communities	16	-	-	-	-	-	-
Advanced International fellowship programme	-	50	46	-	-	96	96
Clinical Psychologist	8	-	-	-	-	-	203
Gynae logical Late Effects of Pelvic Radiotherapy	-	-	-	-	-	-	77
Pump Priming Velindre Innovation team	-	53	38	-	-	91	91
PEARL Clinical Trial: Consultant Sessions	15	2	-	-	-	2	-

Project Name	£000	£000	£000	£000	£000	£000	£000
Cardiff Cancer Research Hub	-	76	(13)	(13)	-	50	-
Pilot Patient Engagement Hub	3	112	98	-	-	-	210
Early Phase Trials: Medical Sessions	-	62	64	65	-	191	-
Clinical Psychology & Counselling Service and Complementary Therapies	-	320	326	332	-	978	-
Wigs for Patients	-	30	30	31	-	91	-
Spiritual & Pastoral Support	-	32	33	33	-	98	-
Patient & Carer Information & Support Services Manager	-	52	54	54	-	160	-
Lead Welfare Rights Advisor	-	30	31	32	-	93	-
Clinical Nurse Specialist CNS Team	-	696	724	753	-	2,173	-
Velindre Cancer R&D Ambitions	-	2,171	2,171	2,171	-	6,513	-
Scalp Cooling Machines	-	240	38	8	-	286	-

Project Name	£000	£000	£000	£000	£000	£000	£000
WBS Website Replacement	-	25	-	-	-	25	-
Arts Co-ordinator	-	22	28	28	5	83	-
Clinical Research Fellow	-	19	20	-	-	39	-
CNS Navigators	-	195	204	212	-	611	-
Total Commitments	**1,055**	**4,640**	**4,051**	**3,706**	**5**	**12,402**	**3,761**

The charity has not entered into any contractual arrangement for the approved expenditure, the funds remain the charities and are drawn down based on activity

The items have been recognised on the SOFA and/or Balance sheet to the extent to which the project has been delivered.
The trustees hold the charity funds on trust to apply the income at their discretion, so far as is permissible by the charity's purposes and objects, unless they are restricted funds which can only be spent within the terms of the restriction. As an NHS charity the objects are NHS wide and for the benefit of NHS patients and public benefit.

During 2022-23 Velindre UNHS Trust had accumulated £1.5m of non-recurrent income from several sources which reduced the requirement to draw down on Charitable funding to support these services during the period.

Meet our Trustees



Professor Donna Mead OBE, Chair

Professor Mead was appointed Chair of Velindre University NHS Trust in May 2018



Mr. Stephen Harries Vice Chair/Independent Member

Mr. Harries was appointed as an Independent Member of the Trust in April 2017. In November 2018, Mr. Harries was appointed as Interim Vice and in April 2022 Vice Chair.



Mrs. Vicky Morris Independent Member (Quality and Safety)

Mrs. Morris was appointed as an Independent Member of Velindre University NHS Trust in November 2021.



Mr. Martin Veale JP, Independent Member (Finance)

Mr. Veale was appointed as an Independent Member of the Trust in April 2017



Professor Andrew Westwell Independent Member (University)

Professor Westwell was appointed as an Independent Member of Velindre University NHS Trust in August 2021.



Mr. Gareth Jones Independent Member (Legal)

Mr. Jones was appointed as an Independent Member of the Trust in April 2019



Mrs. Hilary Jones
Independent Member (Planning and Estates)

Mrs. Hilary Jones was appointed as an Independent Member of the Trust in March 2020



Mr. Steve Ham
Chief Executive

Accountable Officer



Dr. Jacinta Abraham
Executive Medical Director



Mr. Matthew Bunce
Executive Director of Finance



Mrs. Nicola Williams
Executive Director of Nursing, Allied Health Professionals and Health Scientists



Ms. Sarah Morley
Executive Director of Organisational Development & Workforce

Legal & Administrative Details

This Trustee's report and its Financial Statements have been prepared in accordance with the Statement of Recommended Practice on Accounting and Reporting for Charities (SORP), Charity Commission's general guidance and with applicable United Kingdom accounting standards.

The Governing Document of the Charity has been registered with the Charity Commission. This document encompasses the main objectives of the charity for the provision of patient care, staff welfare, research and Welsh Blood Service at the Velindre University NHS Trust, with the Board of Directors acting as a Trustee. The Velindre University NHS Trust Charitable Funds is a registered charity with the Charity Commission.

Reference and administration details:
Registration Charity Number: 1052501

Contact Details

029 2031 6211
info@velindrefundraising.com Velindre Fundraising, Velindre Cancer
Centre, Velindre Road, Whitchurch, Cardiff, CF14 2TL

Electronic versions of this document can be accessed via the Trust website at; www. velindre-tr.wales.nhs.uk

If you require additional copies of this document or an alternative format, such as audio, large print or Braille, please contact;

Head of Corporate Governance
Velindre University NHS Trust Headquarters 2 Charnwood Court, Parc Nantgarw, Cardiff. CF15 7QZ

Emma.Stephens@wales.nhs.uk or Telephone: 029 2019 6161

Velindre University NHS Trust Charity is registered with the Fundraising Regulator.

We are a member of the Association of NHS Charities and the Institute of Fundraising

Codi Arian
CANOLFAN GANSER
VELINDRE
CANCER CENTRE
Fundraising

TRECHU CANSER
VICTORY OVER CANCER

TRUST BOARD

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

DATE OF MEETING	23rd May 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 18th April 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	**TCS Programme Finance Report** The overall outturn for the Programme is an underspend of £0.030m for the financial year 2023-2024 against a budget of £20.948m. Additional capital funding of £1.229m was allocated by Welsh Government to the ADDA Project for this financial year in March 2024. It was reported as being fully utilised. There are four new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding as part of the Enabling Works Full Business Case Addendum. There is a risk of a lack of funding for the Whitchurch Hospital Site, which is being mitigated by securing additional funding from Welsh Government. It was reported that the delay on s.278 works was offset by an element of nVCC overspend. It was confirmed Welsh Government were informed and aware of the slightly higher than expected National Grid costs. The TCS Programme Scrutiny Sub-Committee were assured the transfer of the Whitchurch Hospital Site is imminent. The first meeting regarding the Whitchurch Hospital site disposal which is being led by Shared Services will be brought back to the TCS Programme Scrutiny Sub-Committee when more information is known. The TCS Programme Scrutiny Sub-Committee will be made aware of the progress. Nick Wood confirmed recently the security costs and disposable fees will be covered by Welsh Government.

	The TCS Programme Scrutiny Sub-Committee **NOTED** the TCS Finance Meeting. **New Velindre Cancer Centre: Implementation of Arrangements for Next Phase** The TCS Programme Scrutiny Sub-Committee were made aware Financial Close was reached on 28th March 2024. The Project Board is overseeing and coordinating the transition from previous project arrangements into the revised set out within the Management Case. The Trust is transitioning between one set of arrangements into the new arrangements. Four new workstreams are being established which includes: construction, transition, digital and engagement. The TCS Programme Scrutiny Sub-Committee **NOTED** the New Velindre Cancer Centre: Implementation of Arrangements for Next Phase.
ASSURE	There were no items to assure Trust Board.
INFORM	**Communications & Engagement** Further narrative will be provided by Welsh Government as well as the Trust regarding the CAPEX monies. Providing more clarity regarding the financial figures relating to the Holybush bridge not being built. Ensuring we reply to all correspondences in a clear way. The TCS Programme Scrutiny Sub-Committee received and **NOTED** the Communications and Engagement report.
APPENDICES	None.

JOINT COMMISSIONING COMMITTEE (JCC)
EXTRAORDINRY MEETING BRIEFING – 9 APRIL 2024

The Joint Commissioning Committee (JCC) held an inaugural extraordinary public meeting on 9 April 2024. The next public meeting will take place on 23 April 2024. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the JCC.

The Chair welcomed members and the newly appointed Lay Members to the newly established JCC.

The papers for the meeting can be accessed using the link below: Meeting Dates and Papers - NHS Wales Joint Commissioning Committee.

1. Joint Commissioning Committee Standing Orders (inc Scheme of Delegation) & Standing Financial Instructions (inc Financial authorisation matrix)

Members received a report requesting that the JCC approve the JCC Standing Orders (including the scheme of delegation) & the Standing Financial Instructions (SFI's) (including the financial authorisation matrix.

Members noted that guidance on the handling of interests had been developed, that the memorandum of agreement between the 7 Health Boards (HBs) will be established; and that the hosting agreement between the host body CTMHB and the 6 HBs will be established to outline the accountability arrangements and resulting responsibilities of the Host Body, the JCC and its team.

Members (1) **Noted** the establishment of the NHS Wales Joint Commissioning Committee (JCC) from 1 April 2024, as directed by Welsh Ministers, (2) **Noted** that the JCC has superseded the Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) with effect from 1 April 2024, (3) **Noted** the development of the JCC's governance framework, as a key component of the Health Board's governance framework, (4) **Approved** the Standing Orders and Scheme of Delegation and Reservation of Powers for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 18 March 2024, (5) **Approved** the Standing Financial Instructions for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 19 March 2024, (6) **Approved** the financial authorisation matrix; and (7) **Noted** the JCCs accountability map for information.

2. Interim Operating Model Framework for the NHS Wales Joint Commissioning Committee (JCC)

Members received a report requesting that the JCC note the transitional plan for Quarter 1 to enable the JCC to transact business when it went live on 1 April 2024. The plan incorporates the transitional plan developed by Welsh Government and the actions required to ensure stability and business continuity of the functions to be delivered.

Members **noted** the report.

JOINT COMMISSIONING COMMITTEE (JCC)
MEETING BRIEFING – 23 APRIL 2024

The Joint Commissioning Committee (JCC) held its latest public meeting on 23 April 2024. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the JCC.

The papers for the meeting can be accessed using the link below:
Meeting Dates and Papers - NHS Wales Joint Commissioning Committee.

1. Minutes of Previous Meetings
The minutes of the Emergency Ambulance Services Committee (EASC) and the Welsh Health Specialised Services Committee (WHSSC) meetings held on the 19 March 2024 were **approved** as a true and accurate record of the meetings. The minutes of the Joint Commissioning Committee (JCC) meeting held on 9 April 2024 were **approved** as a true and accurate record of the meeting.

2. Chairs Report
Members received the Chair's Report and **noted**:

- **The update from the new Chair of the JCC -** the inaugural JCC meeting on 9 April 2024 received and approved the governance framework for the new JCC after it had been approved by the 7 x Health Boards (HBs) in March 2024, and the overwhelming first impression was of an organisation in good heart and in good shape, notwithstanding the significant challenges and complexities of combining the different organisations into one new national NHS sub committee,
- **JCC Induction Programme –** an update on introductory meetings with key personnel and partners and the local induction session attended and the forthcoming NHS Wales Induction programme for new Independent Members (IMs),
- **Chair's Action WHSSC – Approval of the WHSSC Legacy Statement** – the Chairs action taken by the Chair of WHSSC on 25 March 2024 to approve the WHSSC Legacy Statement as part of the work to support the establishment of the new NHS Wales Joint Commissioning Committee (JCC) from 1 April 2024 in accordance with the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024 was ratified; and
- **Key Meetings attended.**

Members (1) **noted** the report; and (2) **ratified** the WHSSC Chairs action taken on 25 march 2024 to approve the WHSSC legacy statement.

3. Interim Chief Commissioners Report
Members received the interim Chief Commissioners Report and **noted** the following updates:

- **New Interim Chief Commissioner** - an update on the interim 6 month appointment of Chief Commissioner, meetings held with key partners, staff and stakeholders to build relationships and the warm welcome received from everyone; and
- **NHS Wales Joint Commissioning Committee Implementation -** The programme of work to establish the new NHS Wales JCC came to fruition on 1 April 2024. The final Welsh Government Oversight Board meeting is being held on 30 April 2024 to complete the programme. JCC members received the transitional plan for Quarter 1 2024-2025 at its meeting on 9 April 2024 which incorporated the transitional plan developed by Welsh Government and the actions required to ensure the stability and business continuity of the functions to be delivered.

Members **noted** the report.

4. Emergency Medical Retrieval and Transfer Service (EMRTS Service Review
Members received a report presenting the Joint Commissioning Committee (JCC) with recommendations of the Emergency Medical Retrieval and Transfer Service (EMRTS) Service Review which has been ongoing since November 2022 and overseen by the Emergency Ambulance Services Committee (EASC) up until 31 March 2024 which had responsibility for commissioning these services prior to the establishment of the Joint Commissioning Committee (JCC) on 1 April 2024.

The Committee gave thanks to stakeholders for their patience during the time taken to ensure the work could be carried out robustly, and were especially grateful for the way in which the Charity and EMRTS had supported and contributed to the Review in what had been challenging circumstances for them given the uncertainty affecting their people and business planning.

The Committee expressed gratitude to Llais, the national citizens voice body for Wales, who advised on the engagement as well as NHS Wales colleagues to have helped deliver the all Wales engagement with citizens.

Members noted that since taking up appointment the Chair and the interim Chief Commissioner felt it was important to listen to a variety of concerns and had been proactive in meeting with key stakeholders and had been struck by the passion and high regard that is held for the Wales

Air Ambulance Charity and the clinical teams of EMRTS, which had been acknowledged throughout the Review.

Members noted that the report presenting the recommendations of the EMRTS Service Review had been considered individually by each of the 7 x Health Board (HBs) in Wales between 20 March and 11 April, and they gave consideration to the following recommendations:

Recommendation 1 – **EMRTS Service Model.** The Committee approves the recommended service model for EMRTS including the consolidation of the Emergency Medical Retrieval and Transfer Services currently operating at Welshpool and Caernarfon bases into a single site in North Wales (Option A) as it best meets the objectives of the EMRTS Service Review,

Recommendation 2 – **Implementation.** To enable delivery of the agreed service model, the Committee requests that the Charity secures an appropriately located operational base in line with the agreed service model (as per the final recommendations of the Review),

Recommendation 3 – Implementation. The Committee approves that a joint plan is developed by EMRTS and the Charity, that maintains service provision across Wales during the transition to a new base and develop a comprehensive implementation plan for the agreed service model. This plan will be reflected in the Committee's future commissioning arrangements with EMRTS and the Charity,

Recommendation 4 – Additional service provision. The Committee approves the development of a commissioning proposal for bespoke road based enhanced and / or critical care services in rural and remote areas to enhance the core service model. It is recommended that the Ambulance and 111 Commissioning Team establish a Task and Finish Group to further refine and develop the approach and to deliver a detailed implementation plan by the end of September 2024. The Group will work in partnership with HBs and Llais and other key stakeholders and report to the JCC in October 2024. Following conclusion of this work, and agreement of the way forward, the implementation plan will be updated,

Recommendation 5 – **Lessons Learned.** The Committee supports a Lessons Learned exercise of the review and engagement process to help inform the future work of the JCC; and

Recommendation 6 – Implementation. The Committee agrees to receive regular progress reports on achievement of the implementation plan milestones, and benefits realisation.

Members discussed the recommendations and through a majority of 5 of the 7 HBs supporting, along with the 3 Lay members and Chair the recommendations were approved. Members noted that Betsi Cadwaladr UHB and Powys tHB did not support the recommendations.

Members requested that additional detailed work be undertaken, aligned to key milestones for delivery and that there was a need to provide the public with confidence on the process and impact across Wales.

Members (1) **Noted** the risks outlined above, (2) **Noted** the risk to patients and under-utilisation levels across Wales, (3) **Noted** the national feedback provided by the Picker Institute, (4) **Noted** the localised feedback from communities surrounding Caernarfon and Welshpool bases, (5) **Noted** the representations raised by Llais and the other representations, (6) **Noted** the risks to the Charity, (7) **Noted** that communications and engagement strategies are needed from both the Charity and EMRTS to rebuild trust and confidence with rural communities specifically to ensure the future of this partnership service; and
(8) **Approved** recommendations 1 to 4 in line with the Review report and to approve recommendations 5 and 6 on implementation monitoring lessons learned on implementation monitoring lessons learned; and that a report to be brought back to May 2024 meeting outlining key milestones.

5. Legacy Statements
Members received a report presenting the legacy statements from the predecessor joint committees / teams that transitioned into the new NHS Wales Joint Commissioning Committee (JCC) on 1 April 2024 for assurance.

Members noted that JCC became operational on 1 April 2024 and in accordance with the Interim Operating Model Framework for the NHS Wales JCC for Quarter 2024-2025 received by the JCC on 9 April 2024, there was a requirement for the new JCC to receive the legacy statements from the predecessor joint committees/teams.

Members noted the legacy statements for the:

- Emergency Ambulance Services Committee (EASC)
- National Collaborative Commissioning Unit (NCCU)
- 111 Service
- Sexual Assault Referral Centre (SARC)
- Welsh Health Specialised Services Committee (WHSSC)

6. Other reports
Members also **noted** update reports from the following joint Sub-committees:

- Audit and Risk Committee (ARC),
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel,
- Integrated Governance Committee (IGC),
- Quality & Patient Safety Committee; and
- Welsh Kidney Network (WKN).

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	21 March 2024

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Chair's Report

The Chair updated the Committee on her activities since the last meeting. This includes attending the Chairs' Peer Group and meeting with the Minister. The Welsh Risk Pool Committee was held the previous week with a full agenda and the Staff Awards Ceremony at the end of February was a very positive experience. The Chair also advised Committee members that there may be a need for an urgent Chair's Action before the May Committee. This is in respect of Radiopharmacy Isolators where approval is likely to be required in April to progress this urgent procurement.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- Following the approval of the IMTP by the Committee in January, the two keeping in touch meetings, with the Finance Delivery Unit and the Planning Director at Welsh Government, produced no significant issues and the plan, has now been formally submitted;
- Work to finalise the Business Justification Case for the Radiopharmacy service to be located in IP5 is progressing well with all necessary appointments to relevant contractors having been made;
- The NWSSP People & OD Team have recently supported a further visit to Kerala in India which included attendance by the Minister for Health and Social Care from Welsh Government, who signed a formal agreement with the Kerala Government to continue the current co-operation arrangements which provides for a further 250 qualified healthcare professionals to be recruited into NHS Wales;

- The closure of the Laundry in Carmarthen is well underway and is on track for the end of March, with the new hub coming into operation in April. All affected staff have been given the opportunity to continue to work in the service at the Swansea Laundry or working in a suitable alternative role within Hywel Dda UHB;
- The recruitment process to replace the Director of Finance & Corporate Services has concluded and Alison Ramsey, the current Director of Planning, Performance, and Informatics was successful in being appointed to this post;
- Similarly, Nicola Phillips the current Deputy Director of Primary Care Services was successful in being appointed to the role of Director of Primary Care Services.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Decarbonisation Action Plan

The original Action Plan covered the period 2021-23 and there is now a need to update it. The plan is both externally and internally focused. External achievements to date include setting up a reporting template for all NHS Wales organisations to measure their progress against the 46 initiatives contained in the Welsh Government Plan and providing advice on achieving net zero in future construction projects. Internally we have invested in LED lighting across the estate, solar panels, and electric vehicles in our fleet. Going forward the plan continues to provide support to NHS Wales organisations and to take forward projects within NWSSP subject to the availability of capital. The plan is ambitious but is equally pragmatic, given the financial context to the years ahead. In the light of these challenges, a coordinated approach across NHS Wales is essential. Monitoring of progress against the plan at Committee is via the quarterly IMTP updates, albeit this is by exception, and it was agreed that a more detailed half-yearly report would be helpful.

The Committee **APPROVED** the Decarbonisation Action Plan.

NHS Building for Wales 2 Framework

The framework provides a number of specialist advisors to support major capital schemes across NHS Wales. The current framework expires in April and work has been undertaken over the last two years to prepare for a new framework, which will commence in May for a period of four years, with the option to extend for a further two years. There has been extensive consultation with Health Boards throughout the development of the new framework, and there has been proactive initiatives to support the Welsh economy wherever possible,

The Committee **ENDORSED** the Framework for formal approval by the Welsh Government.

Nantgarw 2 Lease

Due to low occupancy rates at both Companies House and the current Nantgarw HQ, NWSSP is taking the opportunity to consolidate staff into one new building on the Nantgarw estate. This will provide a better working environment and will release revenue savings The previous plan to move into Cathays Park was discounted due to increasing costs and restrictions on access, and it would also not have allowed the exit from the current HQ. The Committee was therefore asked to approve NWSSP entering into a 10-year lease for the new building.

The Committee **APPROVED** the signing of the lease for Nantgarw 2.

Items for Noting

All-Wales Energy Arrangements

The Committee were updated on developments with the implementation of new governance and contracting arrangements, and also the proposals for the supply of energy in the next few years.

The Welsh Energy Group, supported by the Welsh Energy Operating Group, were both established in March 2023, replacing the Energy Price Risk Management Group. Both of the new groups have performed well, with regular and well attended meetings, which has led to informed strategic decisions on energy supply. The governance arrangements were recently reviewed by Internal Audit and their report was rated as providing substantial assurance. NHS Trusts in England are considering the benefits of centralising their purchase of energy requirements and the Welsh Energy Group is similarly considering the benefit of joining this arrangement.

The Committee **NOTED** the update.

Flu Vaccination Proposal

The Central Procurement of Influenza project brief was approved by the Vaccination Programme Wales Transformation Board last July. The aim was to deploy centrally procured adult Influenza vaccine during the autumn of 2025. NWSSP have formed part of the Project Group to establish feasibility and design of a centrally procured Influenza model.

The next phase of implementation requires the Minister to direct General Practice to not purchase Influenza vaccine for Autumn 2025, which they would normally commence in September of this year. For this direction to be given, assurance needs to be provided that NHS Wales will be ready to provide GPs, Health Boards and Trusts with centrally procured adult Influenza vaccine. An Influenza vaccine tender process would run over the summer of 2024 to enable vaccine delivery commencing in September 2025.

NWSSP will procure the vaccines but there is the option of these being directly

delivered by the supplier or being held and distributed centrally via NWSSP. The paper provided to Committee focused in the latter option, but it is for Welsh Government to decide the preferred approach.

The Committee **NOTED** the proposal.

Staff Benefits Update

NWSSP currently provide administration services for several Staff Benefit Schemes for multiple NHS Wales organisations covering Salary Sacrifice Cars, Bicycles and Home Electronics. These services ensure that a fully procured supplier has been sourced, providing quality and value for money.

The Salary Sacrifice Car Scheme current fleet of vehicles stands at 3,736 at February 2024 which represents a 23% increase over the last 12 months. Additionally 94% of live fleet are electric/hybrid vehicles and 87% of cars on order are electric/hybrid vehicles. The car scheme deliver savings estimated at £750 per car per annum, resulting in a total annual saving of £2.8m across NHS Wales.

The Home Electronic scheme provides employees access to over 5000 items from Currys taken via salary sacrifice, allowing the employees to make savings through their salary.

The Cycle to Work scheme is supplied in conjunction with Halfords. The scheme provides employees access to bikes and accessories from Halfords and Tredz taken via salary sacrifice, allowing the employees to make savings on the cost of new bicycles.

The Committee **NOTED** the update.

Finance, Performance, People, Programme and Governance Updates

Finance – NWSSP reported a break-even Month 11 financial position with a year-to-date additional non-recurring savings of £2.277m. The 2023/24 distribution to NHS Wales is now finalised at £2m. In addition NWSSP anticipate being able to return £1m of funding to Welsh Government so that the total additional savings generated and distributed for 2023/24 is £3m.

People & OD Update – The sickness absence rate remains very low with the average for the last 12 months being 2.98%. Statutory and Mandatory training compliance is good at over 93% but PADR compliance needs to improve from the current level of 83%.

Performance – The in-month January performance was generally good with 38 KPIs achieving the target against the total of 41 KPIs. The three that missed the target were Recruitment, where performance has improved and the target was only marginally missed, and two for Audit & Assurance in respect of the issue of draft audit reports and the subsequent timeliness of management responses.

Project Management Office Update – Two projects are currently rated as red. These are the Primary Care Workforce Intelligence System and Transforming Access to Medicine (TrAMS). On the former there are issues with increasing costs and extremely tight implementation timescales and on the latter the lack of capital is the major issue although good progress is being made on the development of the Radiopharmacy Service.

Corporate Risk Register – There remain three red risks relating to the impact of industrial action and also of responding to the UK COVID Public Inquiry, and the development of the TrAMs project.

The Committee **NOTED** the above Reports.

Papers for Information

The following items were provided for information only:

- Finance Monitoring Returns (Months 10 and 11).
- Final Version of IMTP.
- PPE Dashboard
- Audit Committee Assurance Report.

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	16 May 2024

TRUST BOARD

TRUST SEAL REPORT: 26TH MARCH 2024 – 22ND MAY 2024

DATE OF MEETING	23rd May 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 and the Chief Executive Officer of the Trust at every Seal Request **(26th March 2024 to 22nd May 2024)**.

RECOMMENDATION / ACTIONS	The Trust Board is requested to **NOTE** the contents of the Trust Board Seal Register included below as **Appendix 1.**

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

7 LEVELS OF ASSURANCE – N/A

APPENDICES
Appendix 1 – Seal Register

1. SITUATION/ BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(26th March 2024 to 22nd May 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 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
26th March 2024	Funder's Direct Agreement, between (1) Velindre University NHS Trust, (2) Norddeutsche Landesbank Girozentrale (London Branch) and (3) Acorn Velindre Limited.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO

Date	Document Details	Signed
26th March 2024	Independent Tester Contract, between (1) Velindre University NHS Trust, (2) Acorn Velindre Limited, (3) Artelia Projects UK Limited, (4) Norddeutsche Landesbank Girozentrale (London Branch) and (5) SACYR UK Limited.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Insurance Proceeds Account Agreement, among (1) Velindre University NHS Trust, (2) Acorn Velindre Limited, (3) Lloyds Bank PLC, (4) Norddeutsche Landesbank Girozentrale (London Branch) as Intercreditor Agent and (5) Norddeutsche Landesbank as the Security Agent.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Construction Contractor Collateral Agreement relating to the provision of the works of a new Cancer Centre at Whitchurch in Cardiff, between (1) Velindre University NHS Trust, (2) SACYR UK Limited, (3) Acorn Velindre Limited and (4) Norddeutsche Landesbank Girozentrale (London Branch).	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Service Provider Collateral Agreement relating to the provision of certain of the services of a new Cancer Centre at Whitchurch in Cardiff, between (1) Velindre University NHS Trust, (2) Kier Facilities Services Limited, (3) Acorn Velindre Limited and (4) Norddeutsche Landesbank Girozentrale (London Branch).	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Deed of Collateral Warranty of Architect and Lead Designer, between White Arkitekter and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Deed of Collateral Warranty of Structures, Breeam, Sustainability (Embedded Carbon Assesment), Noise & Vibrations and Transportation Consultant, between BAC Engineering Consultancy SLU and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO

Date	Document Details	Signed
26th March 2024	Deed of Collateral Warranty of Mechanical and Electrical Engineer, between Ingho Facility Management SL and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Deed of Collateral Warranty of Electrical, Acoustic and Fire Engineer, between Hydrock Consultants Limited and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Deed of Collateral Warranty of Healthcare Consultant, between Martin James Medical Limited and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Sub-contractor's Deed of Warranty in respect of Master Planning Services relating to an updated Cancer Care Service in South East Wales, between (1) SML Group Limited, (2) Velindre University NHS Trust and (3) Mott MacDonald Limited.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Deed of Variation in relation to an Advanced Design Development Agreement, relating to the design of a new Cancer Centre at Whitchurch in Cardiff, between Velindre University NHS Trust and SACYR UK Limited.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
26th March 2024	Project Agreement between Velindre University NHS Trust and Acorn Velindre Ltd, relating to the new Velindre Cancer Centre MIM Project.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
10th April 2024	Deed of Rectification between Velindre University NHS Trust and Toast Mail Order Limited.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
10th April 2024	Lease relating to part of First Floor South Wing, Block B, Mamhilad House, Mamhilad Park Estate, Pontypool, Torfaen, NP4 0YP, between Johnsey Estates Ltd and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
10th April 2024	Deed of Surrender relating to part Ground Floor of Beta Matrix Business Park, Northern Boulevard Enterprise Park,	Prof Donna Mead OBE, Chair

Date	Document Details	Signed
	Swansea, SA1 5ED, between VUNHST and Sterling (EMEA) Ltd.	Mr Steve Ham, CEO

TRUST BOARD

TRUST WIDE POLICIES UPDATE

DATE OF MEETING	23 May 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 **April 2024 to May 2024.**
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the policies that have been approved during the period **April 2024 to May 2024.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29/04/2024
Quality, Safety and Performance Committee	09/05/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Executive Management Board **ENDORSED** the Fire Safety Policy for submission to the Quality, Safety and Performance Committee. The Quality, Safety and Performance Committee **APPROVED** the Fire Safety Policy following an additional requirement to make it explicit that all staff must complete the required training.	

7 LEVELS OF ASSURANCE
N/A

APPENDICES	
Appendix 1	Fire Safety 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 **April 2024 to May 2024.**

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Since the last Trust Board, the Quality, Safety and Performance Committee **APPROVED** the policy below, which has been uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
PP01 Fire Safety Policy	Executive Director of Strategic Transformation, Planning & Digital	Quality, Safety & Performance Committee	09/05/2024	**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: 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**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: PP01

FIRE SAFETY POLICY

Executive Sponsor & Function:	Executive Director of Strategic Transformation, Planning, and Digital
Document Author:	Trust Fire Safety Manager
Approved by:	Quality, Safety and Performance Committee
Approval Date:	9 May 2024
Date of Equality Impact Assessment:	January 2024
Equality Impact Assessment Outcome:	No negative impact
Review Date:	May 2025
Version:	05

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1. Policy Statement

1.1. To provide an unequivocal statement of fire safety policy applicable in any premises owned, managed or under the control of Velindre University NHS Trust (hereby referred to as "the Trust") or its hosted bodies excluding a single private dwelling.

2. Purpose

2.1. To ensure that the Trust and its hosted bodies comply with their Statutory duties under the *Regulatory Reform (Fire Safety) Order 2005 (the Order)* and their Mandatory duties under the Welsh Assembly Government's *NHS Wales Fire Safety Policy* (issued under cover of WHC (2006)74) and *(W)HTM 05 – Fire safety in the NHS (Firecode).*

3. Scope

3.1 This policy applies wherever The Trust or its hosted bodies have a duty of care to service users, staff or other individuals.

4. Aims and Objectives

4.1. This policy aims to minimise the incident of fire throughout all activities provided by or on behalf of The Trust or its hosted bodies.

4.2. Where fire occurs, this policy aims to minimise the impact of fire and unnecessary fire alarm activations on building users, the delivery of services, the environment and assets.

4.3. This policy also aims to, so far as reasonably practicable reduce the number of unnecessary fire alarm activations in premises owned, managed or under the control of the Trust or its hosted bodies.

5. Roles and Responsibilities

5.1. ***All staff, contract staff and volunteers***

5.1.1. Whilst on premises owned, managed or under the control of the Trust or its hosted organisations, all staff, contractors and volunteers should:

- take reasonable care for themselves and others who may be affected by their acts or omissions at work;
- comply with the Trust's fire safety protocols and fire procedures and those set by others such as landlords etc;
- participate in fire safety training and fire evacuation exercises in accordance with section 7;
- inform their manager of any work situation, defect or other failing that represents a serious or imminent danger;

  Where necessary, report deficiencies and/or shortcomings in fire safety arrangements to the appropriate person(s) such as line manager, Fire Wardens, estates/facilities etc;
- report fire incidents and false alarm signals in accordance with Trust's protocols and procedures;

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

- always ensure the promotion of fire safety to help reduce the occurrence of fire and unwanted fire alarm signals;
- set a high standard of fire safety by personal example so that members of the public, visitors and students when leaving Trust premises take with them an attitude of mind that accepts good fire safety practice as normal.

5.2. ***Trust Board***

5.2.1. The Trust Board holds overall accountability for fire safety and discharges the responsibility for fire safety through the Chief Executive.

5.2.2. The Board must assure itself that the requirements of current fire safety legislation, the Welsh Government's fire safety policy for the NHS in Wales and the objectives of relevant fire safety guidance including, where appropriate, Firecode ((W)HTM 05) are being met.

5.2.3. The Trust Board will:

- discharge its responsibilities as a provider of healthcare to ensure that suitable and sufficient governance arrangements are in place to manage fire-related matters;
- provide appropriate levels of investment in the estate and personnel to facilitate the implementation of suitable fire safety precautions;
- facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of fire safety where reasonably practicable.

5.3. ***Chief Executive***

5.3.1. On behalf of the Board, the Chief Executive is responsible for ensuring that current legislation relating to fire and/or general building safety is complied with and appropriate, fire safety guidance is implemented in all premises owned, occupied or under the control of the Trust.

5.3.2. The Chief Executive discharges the day-to-day operational responsibility for fire safety through the Board Level Director (FIRE).

5.4. *Board Level Director (FIRE) - Director of Strategic Transformation, Planning, and Digital*

5.4.1. The Board Level Director (FIRE) is responsible for ensuring that fire safety issues are highlighted at Board level; this responsibility extends to the proposal of programmes of work relating to fire safety for consideration as part of the business planning process and the management of the fire-related components of the capital programme and future allocation of funding.

5.4.2. At an operational level the Board Level Director (FIRE) will:

- ensure that the Trust has in place a clearly defined fire safety policy and relevant supporting protocols and procedures;
- seek assurance that all work that has implications for fire precautions in new and existing Trust buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety requirements (including Firecode);

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- seek assurance that all proposals for new buildings and alterations to existing buildings are referred to the Fire Safety Manager before building control approval is sought;
- seek assurance that all passive and active fire safety measures and equipment are maintained and tested in accordance with the latest relevant legislation/standards, and that comprehensive records are kept;
- seek assurance that suitable arrangements are in place regarding cooperation between other employers where two or more share Trust premises;
- seek assurance through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained;
- ensure that agreed programmes of investment in fire precautions are properly accounted for in the Trust's annual business plan;
- ensure that an annual audit of fire safety and fire safety management is undertaken, and the outcomes communicated to the Trust Board;
- fully support the Fire Safety Manager function.

5.4.3. In line with delegated authority, the Board Level Director (FIRE) devolves day-to-day fire safety duties to the Fire Safety Manager.

5.5. ***Fire Safety Manager***

5.5.1. The Trust Fire Safety Manager is responsible for developing and implementing an effective fire safety management system on behalf of the Trust and acting as the focus for all fire safety matters across the Trust.

5.5.2. At an operational level the Fire Safety Manager is responsible for:

- the development, implementation, monitoring and review of the organisation's fire safety management system;
- the development, implementation and review of the organisation's fire safety policy and protocols;
- reporting of non-compliance with legislation, policies and procedures to the Board Level Director (FIRE);
- raising awareness of all fire safety features and their purpose throughout the Trust;
- providing expert advice on fire legislation;
- providing expert technical advice on the application and interpretation of fire safety guidance, including Firecode;
- the assessment of fire risks within premises owned, occupied or under the control of the Trust including the undertaking and recording and of fire risk assessments and development of action plans;
- ensuring that risks identified in the fire risk assessments are included in the Trust's risk register as appropriate;
- the operational management of fire safety risks identified by the risk assessments;

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- the development, implementation and review of the organisation's fire emergency action plan including the preparation of fire prevention and emergency action plans where appropriate and integration with Major Incident Plan(s) developed by divisions;
- ensuring that requirements related to fire procedures for less-able staff, patients and visitors are in place;
- the development, delivery and audit of an effective fire safety training programme;
- the investigation and reporting of all fire-related incidents and fire alarm actuations in accordance with Trust policy and external requirements;
- monitoring, reporting and initiating measures to reduce false alarms and unwanted fire signals;
- liaison with the enforcing authorities on technical issues;
- liaison with managers and staff on fire safety issues;
- liaison with NWSSP – Specialist Estates Service – the Trust's Authorising Engineer (Fire);
- monitoring the inspection and maintenance of fire safety systems to ensure it is carried out;
- ensuring that suitable fire safety audits are undertaken, recorded and the outcomes suitably reported;
- providing a link to the relevant Trust committees;
- ensuring an appropriate level of management is always available by the establishment of Fire Response Teams for Trust sites or premises.

5.6. ***Local Management***

5.6.1. Heads of service and departmental managers have responsibility for:

- monitoring fire safety within their respective workplaces and ensuring that contraventions of fire safety precautions do not take place;
- ensuring local fire risk assessments are undertaken and maintained up to date;

  Where necessary, ensuring that risks identified in the fire risk assessments are included in Divisional and/or Departmental risk registers as appropriate.
- notifying the Fire Safety Manager and others of any proposals for "change of use", including temporary works that may impact on the risk assessment, within their area;
- reporting any defects in the fire precautions and equipment in their area and ensuring that appropriate remedial action is taken;
- ensuring that local fire emergency action plans are developed, brought to the attention of staff and adequately rehearsed to ensure sufficient emergency preparedness;

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- ensuring that local fire emergency action plan is revised in response to changes, including temporary works, which may affect response procedures;
- ensuring the availability of a sufficient number of appropriately trained staff at all times to implement the local fire emergency action plan;
- ensuring that the duties outlined in this document and relevant fire safety instructions are brought to the attention of staff through local induction and ongoing staff briefings;
- ensuring that every member of their staff attends fire safety training and the opportunity to participate in emergency drills and exercises as set out in the Trust's fire safety training matrix;
- ensuring that all new staff, on their first day in the ward/department, are given basic familiarisation training within their workplace, to include:
  - local fire procedures and evacuation plan
  - means of escape
  - location of fire alarm manual call points
  - fire-fighting equipment
  - any fire risks identified;
- keeping a record of staff induction and attendance at fire safety training;
- ensuring staff at all levels understand the need to report all fire alarm actuations and fire incidents as detailed in the fire safety protocols;
- ensuring that the staff record is completed and returned denoting how this document has been brought to the attention of staff;
- where appropriate, ensuring that sufficient Fire Wardens are identified and appointed for their specific areas of responsibility.

5.7. ***Fire Wardens***

5.7.1. Based on the size and complexity of the building, an appropriate number of Fire / Evacuation Wardens should be appointed. Although they do not have an enforcing role, the Wardens will report issues or concerns regarding local fire safety to their head of service or departmental managers and if necessary, to the Fire Safety Manager.

5.7.2. Wardens will:

- act as the focal point on fire safety issues for the local staff;
- organise and assist in the fire safety regime within local areas;
- raise issues regarding local fire safety with their line management;
- support line managers in their fire safety issues.

6. Equality

6.1. The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against protected characteristics [age, disability, sex/gender, sexual orientation, gender

reassignment, marriage/civil partnership, pregnancy/maternity, race, religion, socio-economic and Welsh language].

6.2. The Trust has undertaken an Equality Impact Assessment [EQIA] and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any protected characteristics identified within the Equality Act 2010.

6.3. The assessment found that there was ***no impact*** to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

With regard to fire safety, the Trust recognises that during some religious festivals, there is a use of candles and lights, therefore naked flames, i.e. Advent/Christmas and Diwali, the Trust would recommend that staff, patients, donors and visitors, that wish to celebrate use electronic (battery powered) candles; additionally, any electronic main adapter lights are subject to PAT testing.

7. Training – (*Full guidance is provided in the fire safety training protocol*)

7.1. All staff must receive fire safety training appropriate to their role and responsibilities. The Trust has undertaken a Training Needs Analysis for fire safety which requires:

- All new starters receive essential fire safety information as part of their local induction.
- All new starters undertake essential fire safety training within 1 month of their start date
- Staff undertake the appropriate refresher training as follows:
  - Clinical staff and WBS Blood Collection Team staff - *Annually*
  - Non-clinical staff – *3-yearly*
  - Fire Wardens and Fire Response Team members - *Annually*

7.2. In support of fire safety training, all staff should participate in a fire evacuation drill/exercise once every *12 months as a minimum*.

8. Resources

8.1. The implementation and management arrangements associated with this policy do not present any significant resource implications to the Trust.

9. Implementation

9.1. The Trust Board expects those tasked with managing aspects of fire safety to:

- diligently discharge their fire safety responsibilities as benefits their position;
- have in place a clearly defined management structure for the delivery, control and monitoring of fire safety measures;
- have in place a programme for the assessment and review of fire risks;

- develop and implement appropriate protocols, procedures, action plans and control measures to mitigate fire risks, comply with relevant legislation and, where practicable, codes of practice and guidance;
- develop and disseminate appropriate fire emergency 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;
- develop and implement a programme of appropriate fire safety training for all relevant staff.
- Require all staff to complete their fire safety training (including participation in emergency drills and exercises) as outlined under section 7; and
- develop and implement monitoring and reporting mechanisms appropriate to the management of fire safety.

10. Audit and Monitoring

10.1. The Trust Board will monitor the implementation of this policy through:

- periodic review of fire and Unwanted Fire Signal (UwFS) reports;
- periodic reviews of fire safety training records;
- periodic review of fire service notices and communications;
- receipt of annual fire safety audit report;
- periodic independent reviews of fire safety by NWSSP – Specialist Estates Services.

11. Policy Conformance / Non-Compliance

11.1. If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

12. Distribution

12.1. The policy will be available via the Trust Intranet site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

13. Review

13.1. The Fire Safety Manager and Trust Fire Safety Management Group will review the operation of the policy as necessary; at least once every ***12 months***.

14. Legislation

14.1. The main Acts and Regulations, which relate to premises owned, managed or under the control of the Trust or its hosted organisations are:

- The Regulatory Reform (Fire Safety) Order 2005
- The Health and Safety at Work etc Act 1974
- The Building Act 1984

- The Housing Act 2004
- The Equality Act 2005
- The Fire and Rescue Services Act 2004
- The Construction (Design and Management) Regulations 2015
- The Smoke-Free Premises etc. (Wales) Regulations 2007
- The Management of Health and Safety at Work Regulations 1999 (as amended)
- The Dangerous Substances and Explosive Atmospheres Regulations 2002

15. Further Information

15.1. ***Contact***

Further information and support is available from the Trust Fire Safety Manager on 029 2061 5888 (ext. 4156) / WHTN 01875 4156.

15.2. ***Key guidance***

The Firecode suite of documents (Health Technical Memorandum 05 - fire safety in the NHS) builds upon the Welsh Assembly Government's Fire Safety Policy statement. Firecode comprises:

- 05-01: Managing healthcare fire safety (Welsh Edition).
- 05-02: Guidance in support of functional provisions for healthcare premises
- 05-03: Operational provisions (Parts A to L)

The Trust will also implement:

- Other Health Technical Memorandums
- Relevant Department of Health and NWSSP - Facilities Services Health Building Notes

(W)HTM 05 (Firecode) relates mainly to premises classified as 'healthcare' buildings (such as premises where patients are provided with medical care by a clinician.) and a majority of the premises that the Trust manage, occupy or use fall outside this definition. Therefore, the Trust will also adopt the relevant HM Government Fire Risk Assessment Guidance document relevant for the property type, including:

- Offices & Shops
- Places of Assembly (small)
- Places of Assembly (large)
- Sleeping Accommodation

Additionally, the Trust will also adopt the necessary Health and Safety Executive Approved Codes of Practice and Guidance Documents and other Approved Codes of Practice (i.e. British Standards).

15.3. ***Supporting Documents***

In support of this policy, a number of fire safety protocols have been developed that support implementation of this policy, including:

- Fire Safety and Risk Management System

- Fire prevention including the management of arson
- Fire risk assessment/audit strategy
- Emergency planning and procedures
- Fire safety training including training needs analysis and strategy for delivery
- Development of local fire safety information including fire strategies, fire manuals, fire drawings and information for attending fire crews
- Fire safety during construction and refurbishment projects
- Unnecessary fire alarm activations
- Passive fire protection
- Maintenance of fire safety systems and equipment.

16. References

16.1. HEALTH TECHNICAL MEMORANDUM 05-01 FIRECODE: Guidance in support of functional provisions for healthcare premises (Various publication dates) - Wales edition.

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