Public Trust Board

Tue 30 January 2024, 10:00 - 14:00

Velindre University Trust Headquarters, Nantgarw

Agenda

10:00 - 10:10 10 min	**1.** **STANDARD BUSINESS**

1.1.
Welcome and Apologies

> *Prof. Donna Mead OBE, Chair*

1.2.
In Attendance

> *Prof. Donna Mead OBE, Chair*

1.3.
Declarations of Interest

> *Prof. Donna Mead OBE, Chair*

1.4.
Minutes from the Public Trust Board meeting held on 30/11/2024

> *Prof. Donna Mead OBE, Chair*

📄 1.4.0 Public Trust Board Minutes 30.11.2023(V3).pdf (13 pages)

1.5.
Action Log

> *Prof. Donna Mead OBE, Chair*

📄 1.5.0 PUBLIC ACTION LOG.pdf (1 pages)

1.6.
Matters Arising

> *Prof. Donna Mead OBE, Chair*

10:10 - 10:30 20 min	**2.** **KEY REPORTS**

2.1.
Chair's Report

> *Prof. Donna Mead OBE, Chair*

📄 2.1.0 Chair's update Trust Board 30.01.24 DM.pdf (5 pages)

2.2.

Vice Chair's Report

Stephen Harries, Vice Chair

📄 2.2.0 Vice Chair's update Trust Board 30.01.24.pdf (5 pages)

2.3.
Chief Executive's Report

Carl James, Acting CEO

📄 2.3.0 Chief Executive's Report Jan 24- final 2.pdf (4 pages)

2.4.
Board Champion Report

Stephen Harries, Board Champion for Digital / Mental Health

📄 2.4.0 HWB Board Champion report11.1.24.pdf (7 pages)
📄 2.4.0a HWB Board Champion report Appendix 1.docx.pdf (1 pages)

10:30 - 11:00
30 min

3.
INTEGRATED GOVERNANCE

3.1.
Audit Wales Structured Assessment Report 2023

Katrina Febry, Audit Lead (Performance), Audit Wales

📄 3.1.0 3982A2023_VUNHST SA Report 2023 Final.pdf (40 pages)

11:00 - 13:00
120 min

4.
QUALITY, SAFETY & PERFORMANCE

4.1.
VUNHST Risk Register

Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 4.1.0 TRUST RISK REGISTER - Trust Board Jan 24- final.pdf (14 pages)
📄 4.1.0a Trust Risk Report - Datix - Jan 24.pdf (3 pages)

4.2.
Trust Assurance Framework (final version for approval)

Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 4.2.0 TAF Paper - Trust Board - Jan 24.pdf (8 pages)
📄 4.2.0a V35- TAF DASHBOARD 2.0 - 24.01.2024.pdf (24 pages)

4.3.
Performance Management Framework (November 2023)

Cath O'Brien, Chief Operating Officer

📄 4.3.0 Trust Board 30.01.23 NOV PMF Performance Report FINAL version 019.pdf (69 pages)

4.4.
Financial Report (November 2023)

Matthew Bunce, Executive Director of Finance

- 4.4.0 Month 8 Finance Report Cover Paper TRUST BOARD 30.01.2024.pdf (11 pages)
- 4.4.0a M8 VELINDRE NHS TRUST FINANCIAL POSITION TO NOVEMBER 2023 Trust Board 30th Jan.pdf (26 pages)
- 4.4.0b Appendix 2 - TCS Programme Board Finance Report (November 2023) - Main Report.pdf (17 pages)

13:00 - 13:10
10 min

5.
PLANNING AND STRATEGIC DEVELOPMENT

5.1.
Trust Values

Sarah Morley, Executive Director of Organisational Development & Workforce

- 5.1.0 Board Values 30.1.24.pdf (8 pages)

13:10 - 13:40
30 min

6.
CONSENT ITEMS

6.1.
CONSENT FOR APPROVAL

Prof. Donna Mead OBE, Chair

6.1.1.
Commitment of Expenditure exceeding Chief Executive's Limit

Matthew Bunce, Executive Director of Finance

- 6.1.1 PUBLIC Trust Board_Commitment of Expenditure_January 2024.pdf (6 pages)
- APPENDIX 1A - Commitment of Expenditure Over Chief Exec Limit - Wig Vouchers (RH EL Signed).pdf (8 pages)
- APPENDIX 1B CLI-OJEU-52728 Wigs Ratification Paper FINAL.pdf (7 pages)
- APPENDIX 2A - 3rd Linac Replacement.pdf (7 pages)
- APPENDIX 2B Commitment of Expenditure Over Chief Exec Limit 3rd Linac HOP approval.pdf (8 pages)
- APPENDIX 2C Halcyon Capacity Analysis.pdf (4 pages)
- APPENDIX 3 NWSSP Clean Room - Commitment of Expenditure Over Chief Exec Limit.pdf (7 pages)
- APPENDIX 4 NWSSP Commercial Storage - Commitment of Expenditure Over Chief Exec Limit.pdf (8 pages)
- APPENDIX 5 NWSSP Mamhilad House - Commitment of Expenditure Over Chief Exec Limit.pdf (7 pages)

6.1.2.
Chair's Urgent Actions Report

Prof. Donna Mead OBE, Chair

- 6.1.2 PUBLIC Chairs Urgent Action Report January 2024.pdf (7 pages)

6.1.3.
Trust Policies for Approval

Lauren Fear, Director of Corporate Governance and Chief of Staff

- **6.1.3.1** - Policy on the Use of Small Animals in Research
- **6.1.3.2** - People Policies

- 6.1.3.1 TrustBoard_Cover_PolicyOnTheUseOfSmallAnimalsInResearch_30Jan2024Mtg.pdf (8 pages)
- 6.1.3.1a Policy_UseOfSmallAnimalsInResearch.pdf (7 pages)
- 6.1.3.1b IntegratedImpactAssessmentForPolicyOnUseSmallAnimalsInResearch.pdf (33 pages)
- 6.1.3.2 People Policies Update Paper Trust Board.pdf (5 pages)
- 6.1.3.2a All Wales NHS Dress Code 2020.pdf (9 pages)
- 6.1.3.2b Draft - Annual Leave Policy (Agenda for Change).pdf (16 pages)
- 6.1.3.2c Draft - Redundancy and Security of Employment.pdf (20 pages)
- 6.1.3.2d Draft - Recrutiment and Selection Policy.pdf (8 pages)

6.1.4.
NHS Wales Shared Services Partnership - Renewal of Lease

Matthew Bunce, Executive Director of Finance

📄 6.1.4 NWSSP Mamhilad Lease Approval .pdf (6 pages)

6.2.
CONSENT FOR NOTING

Prof. Donna Mead OBE, Chair

6.2.1.
Trust-wide Policies Update

Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 6.2.1 TRUST WIDE POLICIES UPDATE January 2024.pdf (6 pages)
📄 APPENDIX 1 QS15 Management of Violence and Aggression Policy_v8.pdf (25 pages)
📄 APPENDIX 2 QS26 Safe Use of DSE Policy_v6.pdf (11 pages)
📄 APPENDIX 3 QS14 Safer Manual Handling Policy_v8.pdf (14 pages)
📄 APPENDIX 4 QS33 Control of Substances Hazardous to Health (COSHH)_v5.pdf (16 pages)
📄 APPENDIX 5 QS09 Policy for the Management of Latex and Latex Allergy_v7.pdf (16 pages)

6.2.2.
Public Quality, Safety & Performance Committee Highlight Report (16/01/2024)

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

📄 6.2.2 QSP January Committee- version 3 (final) approved by Committee chair.pdf (10 pages)

6.2.3.
Public Audit Committee Highlight Report (19/12/2023)

Gareth Jones, Independent Member and Acting Chair of Audit Committee

📄 6.2.3 Audit Committee Part A Public Highlight Report 19 December 2023 cm(GJ).pdf (3 pages)

6.2.4.
Public Strategic Development Committee Highlight Report (18/01/2024)

Stephen Harries, Vice Chair and Chair of Strategic Development Committee

📄 6.2.4 PUBLIC - Highlight Report SDC 18.01.2024 LF - SH.pdf (3 pages)

6.2.5.
Public Charitable Funds Committee Highlight Report (12/12/2023)

Prof. Donna Mead OBE, Chair of Charitable Funds Committee

📄 6.2.5 Charitable Funds Committee Public Highlight Report Draft 12 December 2023 MB DM.pdf (5 pages)

6.2.6.
Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report (23/11/2023)

📄 6.2.6 TRUST BOARD Highlight Report Public 23.11.2023.pdf (3 pages)

6.2.7.
Local Partnership Forum Highlight Report (19/12/2023)

Sarah Morley, Executive Director of Organisational Development & Workforce

📄 6.2.7 19.12.2023 LPF highlight report vfinal.pdf (4 pages)

6.2.8.

Public Welsh Health Specialised Services (WHSSC) Committee Briefing (21/11/2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 6.2.8 JC Briefing (Public) 21 November 2023.pdf (5 pages)

6.2.9.
Emergency Ambulance Services Joint Committee (EASC) Briefing (21/11/2023 & 21/12/2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 6.2.9a Chair's EASC Summary from 21 November 2023.pdf (9 pages)
📄 6.2.9b Chair's EASC Summary from 21 December 2023.pdf (8 pages)

6.2.10.
NHS Wales Shared Services Partnership (NWSSP) Committee Assurance Report (23/11/2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 6.2.10 SSPC Assurance Report 23 November 2023.pdf (6 pages)

6.2.11.
Trust Seal Approval Report (23/11/2023-30/01/2024)

Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 6.2.11 Trust Seal Report 24.11.23-30.01.24.pdf (4 pages)

6.2.12.
Nurse Staffing Level (Wales) Act Update (6 month report)

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

📄 6.2.12 NSA Trust Board paper (003).pdf (12 pages)

6.2.13.
Integrated Medium Term Plan (IMTP)

Carl James, Acting CEO

*Verbal update

13:40 - 13:40
0 min

7.
ANY OTHER BUSINESS

Prof. Donna Mead OBE, Chair

13:40 - 13:40
0 min

8.
DATE OF NEXT MEETING

The next meeting of the public Trust Board will be held on Tuesday 26th March 2024.

13:40 - 13:40
0 min

9.
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).

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

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

1.0.0	PRESENTATIONS	ACTION LEAD
1.1.0	**NHS Wales Shared Services (NWSSP) Integrated Medium Term Plan (IMTP)** The Chair welcomed Neil Frow, Managing Director, NHS Wales Shared Services Partnership (NWSSP) and Tracy Myhill, Chair of Partnership Committee to the meeting. Neil Frow provided an overview of the NHS Wales Shared Services Integrated Medium Term Plan (IMTP) 2023-2026, highlighting the following: • A refresh of their vision, values and strategic objectives, framed around people, services and value. • Key deliverables and key organisational priorities for 2023-2024 and associated core functions and activity to support this. • Key deliverables for years 2 and 3, further work planned and anticipated progress, in addition to an outline of opportunities to explore new programmes of work and innovations. • Current position and financial risks. Year 1 currently includes a balanced financial plan with the majority of planned objectives on track to deliver within the year. • Continued support for the COVID-19 public inquiry, vaccination campaigns and PPE equipment requirements. Work on international recruitment and plans for disruption caused by Industrial Action. • Customer Service Excellence Award (CSE).	

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	• Digital Priorities (examples of which include replacement of ESR, migration of Oracle Finance to Oracle Cloud, Electronic Prescription Services, Patient Registration replacement). • Challenges within the environment (financial sustainability, workforce). • Key areas of focus (time to hire, medicines and pharmacy, procurement, payroll modernisation and accommodation strategy). • Continued implementation of the Duty of Quality. The Chair requested an annual meeting with both attendees in addition to their attendance at a Board Development Session, given the direct impact of a number of initiatives shaped by the Shared Services Partnership on the Trust. Both parties were keen to maintain a positive relationship and it was recognised that NWSSP's recent further involvement with the Trust's Quality, Safety & Performance Committee and Audit Committee had provided additional effective triangulation. This was commended. Neil Frow indicated that further work is required in relation to the Transforming Access to Medicines (TrAMS) model and the Trust's requirements going forward. Donna Mead noted the dependency of the Velindre Cancer Service on the timing of this programme. In terms of international recruitment, Andrew Westwell queried how particular areas are identified to recruit from. Neil Frow advised that there is a direct link through Welsh Government. Nicola Williams confirmed that a national ethical recruitment framework is in place which the Trust adheres to. Retention of such staff relies on the support of local organisations and it was noted that Registrants are often clear where in Wales they wish to work and where their connections are. Alan Prosser wished to make the Board aware of the level of granularity provided to the Welsh Blood Service by NWSSP (for example the Scan4Safety Project), noting their key role in providing urgent time critical cross matching for blood from England into North Wales. It was acknowledged that the NWSSP Medicines Unit will also be invaluable to supporting the Service's wholesale. The Trust Board **NOTED** the content of the NWSSP Integrated Medium Term Plan and continuing positive working relationship.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies noted:** • Cath O'Brien, Chief Operating Officer • David Cogan, Patient Representative • Martin Veale, Independent Member	
2.2.0	**In Attendance** The Chair extended a warm welcome to the following additional attendees: • Neil Frow, Managing Director, NHS Wales Shared Services Partnership • Tracy Myhill, Chair of the Partnership Committee • Katrina Febry, Audit Lead, Audit Wales *(observing)* • Alan Prosser, Director, Welsh Blood Service *(in part) (attending remotely)* • Rachel Hennessy, Interim Director of Velindre Cancer Service *(attending remotely)*	

	• Peter Richardson, Head of Quality Assurance and Regulatory Compliance *(deputising in Alan Prosser's absence)*		
2.3.0	**Declarations of Interest** There were no declarations of interest to **note** in respect of today's agenda.		
2.4.0	**Minutes from the Public Trust Board meeting held on 28ᵗʰ September 2023** Vicky Morris also noted that the Chief Executive's report (item 2.3.0) stated that the Trust's intervention status in relation to the NHS Wales financial position is minimal, however this required amending to 'routine arrangements'. No further amendments were noted.	**Secretariat**	
2.5.0	**Action Log** There were no open actions for discussion on the action log. The Board was requested to confirm that it was content to close action ***3.1.0 – Identify a method of informing Trust Board that risks with an impact rating of 5 are being monitored and managed via SLT meetings.*** It was agreed to discuss this during the Risk item on today's agenda before closing the action. Gareth Jones suggested that action 3.2.0 should be worded "Seek approval of Trust Assurance Framework (TAF) via Chair's Urgent Action or via meeting / discussion with Board." Additionally, this was also on today's agenda for discussion prior to closure. It was agreed to amend the action updated to ensure that it was clear that Audit Committee view was that the Trust Assurance Framework should be brought to a full Board discussion for agreement. The Board was content that remaining actions were closed.	**Secretariat** **Secretariat**	
2.6.0	**Matters Arising** Vicky Morris noted that the VUNHST Risk Register (item 3.1.0) had stated that a 'deep dive' across all digital risks had been requested and would be presented to the November 2023 Quality, Safety & Performance Committee. This will, however, now be presented at the January 2024 Committee.		
3.0.0	**KEY REPORTS**		
3.1.0	**Chair's Report** In presenting the update, the Chair advised of her attendance at a number of events, the purpose of which were to connect with staff, charity, patients and donors alike. The Chair had also attended a Safe Care Collaborative event earlier in the week, led by the Executive Director of Nursing and her team. The session included a number of informative presentations in relation to the Trust's participation in this national initiative and it was suggested that Independent Members may wish to attend future sessions. The Trust Board **NOTED** the content of the Chair's Update Report.		

3.2.0	**Vice Chair's Report**	
	The content of the Vice Chair's report was presented. No questions were raised.	
	The Trust Board **NOTED** the content of the Vice Chair's Update Report.	
3.3.0	**Chief Executive's Report**	
	In presenting the update, the Chief Executive highlighted the following:	
	• The Joint Executive Team (JET) meeting had taken place on the 17th November 2023, with formal notes of the meeting still awaited. The successes summary were included for Board Members' information. • An update on the new Velindre Cancer Centre (nVCC) had been shared with Board members on the 22nd November 2023. • Continued progress of 'working together' staff sessions, providing opportunities to discuss the direction of building our futures together, in addition to engaging and connecting with staff across the organisation regarding how this will be achieved. • The first meeting of the Clinical & Scientific Board had recently taken place; the development of the Clinical & Scientific Strategy is a significant step for the organisation, setting the strategic, clinical and scientific direction for the Trust over the next 5 years.	
	No questions were raised and the Trust Board **NOTED** the content of the Chief Executive's Update Report.	
3.4.0	**Board Champion Report – Infection Prevention, Vulnerabilities and Violence & Aggression Champion**	
	Vicky Morris provided an overview of her approach to undertaking a number of Quality & Safety Champion roles, highlighting how information is triangulated and presented to the Board for assurance and / or escalation purposes. This is achieved by attendance at relevant Corporate meetings and Committees to ascertain processes currently in place, enabling triangulation of information received in performance reports presented to the Quality, Safety & Performance Committee.	
	Additionally, actively engaging with the '15 step' process enables a wider understanding of safety within clinical areas, in addition to identification of risks and issues, followed by recommendations for improvements and development of action plans should these be required.	
	Nicola Williams remarked that the 15 step process had now been extended to involve the wider Executive Team and all Independent Members. The Chair also commended the Business Support Team for their input. The Chair requested a comprehensive report, providing an overview of progress to date and potential emerging themes from 15 step visits; this will be presented at a future Executive Management Board meeting, followed by Quality, Safety & Performance Committee.	
	The Trust Board **NOTED** the content of the Board Champion report and subsequent discussion.	
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. Lauren Fear highlighted the following:

- The inclusion of a summary of actions taken in relation to the approach to management of risks as discussed during the last governance cycle of Quality, Safety & Performance Committee and Audit Committee.
- A discussion had been undertaken at the October 2023 Audit Committee as to whether the current Assurance Rating of Level 2 was still considered appropriate. As a number of risk scores remain high, it was agreed that the Rating would remain under review and reassessed at the December 2023 Committee.

Gareth Jones queried whether the data extract presented at today's meeting (or a refresh) would be reported at December's Audit Committee, as there had been no apparent reduction in risk scores. Lauren Fear advised that November's data would be submitted to both Executive Management Board and Audit Committee and that any decrease in scores not currently reported at Trust Board level would be summarised and reported, in addition to any reduction in scores reported at Board.

Hilary Jones indicated that the action column remains unclear, with a number of risks out of date or missing a responsible owner, in particular Risk 2515 (Brachytherapy) – Rachel Hennessy advised that this (inaccurately) reflects a national picture and the difficulties recruiting into specialist posts, as opposed to the work that is currently being undertaken in the Trust in relation to how the service is maintained. Hilary Jones noted that visibility of activity undertaken would be enable additional assurance due to the public facing nature of the document.

It was also suggested that the appearance of a number of closed actions in the extract may be the result of a glitch in Datix.

The chair requested that in future such matters are identified and corrected prior to the publication of papers.

Gareth Jones queried whether the risk rating is routinely updated in Datix following closure of a number of associated actions. It was advised that changes in broader risks such as Health and Wellbeing would not be sufficient to justify a reduction in the score. It was therefore suggested to improve the narrative qualifying why the risk remains at the reported rating, despite closure of actions.

The Trust Board:
- **NOTED** the risks level 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper.
- **NOTED** the on-going developments of the Trust's risk framework.

4.2.0	**Trust Assurance Framework (TAF)**	
	Following a review of the Trust Assurance Framework and refresh of the Trust's Strategic Risks, the report provided an update following September's Trust Board and October's Audit Committee.	
	Six of eight of the refreshed Trust Assurance Framework risks had been included on the new format and it was noted that the remaining two had been amended later in the review cycle and are currently being worked on at pace by Executive Leads. It is anticipated that these will be included for approval January 2024 Trust Board meeting.	
	The approach in terms of development and governance had been captured in section 3.2 of the report and continued discussion in this regard is anticipated. Vicky Morris suggested that it would be of benefit for the Board to focus on alignment with strategic objectives, providing assurance that the Trust's risk mitigations are enabling progress of these objectives. It was suggested to address this at a future Board Development Session.	
	The Trust Board **DISCUSSED** and **NOTED** the Trust Assurance Framework.	
4.3.0	**Public Audit Committee Highlight Report (19/10/2023)**	
	Gareth Jones suggested that the alert / escalate items contained within the report pertaining to the Trust Risk Register and Trust Assurance Framework (TAF) did not require further discussion than had already occurred during the meeting. It was noted that the cover paper should read 'Acting Chair' as Gareth Jones had chaired the meeting on behalf of Martin Veale.	
	Matthew Bunce remarked that the paper stated "without a TAF, it was difficult to be confident about our delivery of strategic objectives." It had been raised at the October Audit Committee that the Trust has never been without a TAF; however this had not been reflected in the highlight report. Notwithstanding the development of a new TAF in the interim, monitoring of the risks noted in the extant TAF had been maintained and that this had been utilised by Internal Audit to develop the Audit Plan, which will be linked to the new TAF once established. Hilary Jones suggested that the Board should have retained visibility of the extant TAF until signoff of the new iteration. Lauren Fear indicated that a note of this had been included in the TAF cover paper.	
	The Board noted that a change to Delegated Financial Limits of the Chief Executive Officer and Executive Director of Finance in reference to applications for spend against Charitable Funds had increased from £5,000 to £25,000 with appropriate reporting mechanisms also developed.	
	The Trust Board **NOTED** the content of the report.	
4.4.0	**Public Quality, Safety & Performance Committee Highlight Report (16/11/2023)**	
	Vicky Morris drew the Board's attention to issues for escalation within the report:	
	• Referral mechanisms into the Cancer Service – An emerging theme in relation to the referral / booking process had been identified via an increase in patient concerns and feedback. The Board was assured that	

	the Cancer Service had taken immediate action and a high level longer term plan would be brought to the next Committee.	
	• Policy Management Review and Compliance Status – it had been identified that 50% of Trust policies are past their review date. Although it was noted that the policies still apply, the Trust is to maintain the governance process and as such, the newly appointed Compliance Officer will assume responsibility for this.	
	Stephen Harries indicated ambiguity in relation to patient feedback received via the CIVICA system, which had signalled that patients were dissatisfied with waiting times. Due to the public nature of the document, it is important to clarify that this relates to a sample of patient waiting times within Outpatients (due to extra patients being seen at clinics resulting in overrunning) and it would therefore not be accurate to state that the majority of patients are dissatisfied with the time taken to be seen by the Cancer Service. Nicola Williams indicated that the questions asked by the patient survey are somewhat vague and work is to be undertaken to refine detail around specific areas of delay. A proportion of responses are obtained via national survey questions; although it is not possible to amend national questions within the survey, the Trust is permitted to reword its own questions as appropriate.

The Trust Board **NOTED** the clarification provided by the Vice chair and the content of the report. | |
| **4.5.0** | **Performance Management Framework (September 2023)**

The paper provided an update on the performance of the Trust for the month of September 2023 against a number of national targets. Rachel Hennessy provided the following highlights in relation to the Velindre Cancer Service:

• Significant improvement in Radiotherapy timescales for Quarter 2, which has been sustained throughout the year to date and introduction of new reporting metrics.
• Continued compliance (over 90%) with the 21 day time-to-treatment target for new Systemic Anti-Cancer Therapy (SACT) patients.
• Significant challenges in relation to workforce capacity across SACT Nursing and Pharmacy; a recruitment / resource plan is currently under development to address this.
• Formal multi-disciplinary reviews are in place to review performance outside compliance in relation to Infection Prevention Control and patient falls; however, no patient harm has been reported as a result.
• Delayed Transfers of Care (DToC) numbers remain low (3 during September 2023), as a result of bed capacity issues and repatriation back to patients' local Health Boards and links with Social Services. This is reflective of wider NHS challenges in this area. A regular submission of Trust data is made to the national dataset.
• Ongoing data quality issues related to the implementation of Digital Health & Care Records (DH&CR) continue to cause significant administrative challenges across the Cancer Service. The Board was informed that fundamental changes in ways of working, resolution of quality issues and continued progress by the Medical Records Team has increased the burden on the administrative system. However, a revised training plan for staff has been implemented, with some evidence of improvement to date. | |

The Chair queried whether patient harm for Radiotherapy patients waiting in excess of 7 days for a referral and transfer to the cancer centre is captured. Nicola Williams advised that regular reports are received via the Datix system in relation to delays (followed by a harm review) and any patient harm would be reported by the relevant clinician.

It was suggested that the Trust's performance management system (from Service Level through to Board) does not yet have the ability to identify key measures that would indicate levels of harm and therefore an Emergency Radiotherapy measure had been discussed, with service delivery for 85% of such patients within 24 hours and 95% within 48 hours. Further work is required in relation to enable specific capture of wider associated issues, including how the patient is received by the Trust and lack of 7 day availability of a number of procedures across the NHS as a whole.

Vicky Morris indicated that the patient and donor experience information in relation to the two patient satisfaction surveys was not indicative of activity and assurances reported to the Quality, Safety & Performance Committee, noting the following numbers against the 95% target ('Would you recommend us?' at 95% / 'Your Velindre Experience' at 63%.) Nicola Williams advised that the 'Your Velindre Experience' survey involves a far more comprehensive questionnaire. It was also noted that as the minimal number of patients completing the survey had responded with high scores, a data transfer issue may be responsible. Rachel Hennessy agreed to check this. Nicola Williams also agreed to reword the measure more appropriately.

RH
NW

The following points were raised by Gareth Jones:
- Inconsistency in the Capital Expenditure Limit within the Finance Section. This is to be amended to be consistent.
- Whether the Trust expenditure on agency and bank staff was meeting the target. Matthew Bunce advised that a correction to the figure following November's Quality, Safety & Performance Committee had not been actioned and that this would be rectified.
- The number of Health and Safety incidents recorded was 14 against a target of 0 and it was queried why the number was significantly in excess of the target. Carl James explained that although the intention is to reach 0, this is not likely to be achieved and will therefore be subject to review. The Board was assured, however, that the number remains reasonably small and it was confirmed that only one claim had arisen as a result.

Peter Richardson provided the following highlights in relation to the Welsh Blood Service:

- All Clinical demand (inc. platelets) was met during September 2023, however a 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) had been issued due to O negative demand; this was recovered internally and no mutual aid was required. The Board acknowledged the efforts made by teams within the Service to resolve the issue, including daily meetings to maintain the blood supply.
- Challenges remain around prediction and variation in demand, requiring use of resource to enable calling of donors to meet known demand. This has resulted in a reduction in recruitment of new donors.
- Stem cell collections continue to increase, however further work is required to further revise and develop the existing collection model.
- Donor feedback remains positive.

	• There was one reported incident where a Malaria risk had not been detected during the screening process. The product was withdrawn from the supply chain and subsequent testing of donor samples confirmed no donor risk. Sarah Morley provided the following Organisational Development and Workforce update: • A sickness absence rate of 5.61% to the 20th November 2023. Sarah Morley advised that this is in part due to a rise in COVID-19 cases and other respiratory infections due to the winter season. However, focus continues to be on the general wider wellbeing of staff. The Trust Board **NOTED:** • The contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Appendices 1 to 3. • The new style PMF Performance reports continue to be developed by the PMF Project Group, with a number of potential new measures currently under consideration. • The Chair requested that authors include a glossary of acronyms and abbreviations in cover papers.	
4.6.0	**Financial Report (September 2023)** In presenting the report outlining the financial position for the period ended (month 6) September 2023, Matthew Bunce highlighted the following in relation to the standard performance indicators: • A balanced revenue position, with an anticipated outturn forecast of breakeven (including an underspend of £0.007m). • The Public Sector Payment Performance (PPP) Target had been met, at upwards of 95%. • It is anticipated that the Capital target will be met, pending formal receipt of Welsh Government funding for the nVCC project management resource and extension to works until March 2024; Welsh Government has confirmed that this funding has been earmarked. • Communication had been received by all Health Boards and Trusts across Wales during July 2023, requesting identification of a number of options to support a reduction in the overall NHS Wales deficit. A response with a number of options was submitted during August 2023 and these have been delivered against to date. Matthew Bunce confirmed that a future follow up meeting would be held with Welsh Government in this regard. • Financial Risks – Although two financial risks had been highlighted in the paper, it was advised that these were no longer significant and could be supported via several opportunities should the need arise. Gareth Jones questioned whether an analysis had been undertaken of the potential saving if staff employed via agency were instead substantively employed by the Trust. Matthew Bunce advised that this could potentially be between £400k and £500k; it was also noted that a reduction in agency / bank staff spend is expected as international recruitment increases. The Trust Board **NOTED** the content of the September 2023 financial report and in particular the yearend financial performance which at this stage is reporting a **breakeven** position, together with above target compliance on PPP.	

5.0.0	**PLANNING AND STRATEGIC DEVELOPMENT**	
5.1.0	**Integrated Medium Term Plan Quarter 2 Report** Carl James provided the Board with an overview of the report, noting the current position and progress against IMTP actions to support the delivery of the Trust's Strategic Aims (as at Quarter 2). It was acknowledged that the majority of key deliverables will be achieved by the end of the quarter, however two remain delayed due to external factors outside of the Trust's control (implementation of the national Transforming Access to Medicines (TrAMS) model and implementation of the approved Full Business Case for the development of the new Velindre Cancer Centre (nVCC)). A review is currently underway to identify the Trust's anticipated position at the end of March 2024. The Chair queried the significance of the risk of the TrAMS model potentially not being up and running in time for the move to the nVCC, requesting the addition of this to the risk register and development of a potential alternative plan. Vicky Morris queried whether the actions within the plan where issues with delivery had been identified would be delivered in Quarter 3 and Carl James advised that it is expected that these would be delivered by the end of March 2024. It was also confirmed that this work would be reported within the Trust Assurance Framework (TAF). The Trust Board **NOTED** the progress made in the delivery of the agreed IMTP (2023-2026) actions as at Quarter 2 for both the Velindre Cancer Service and the Welsh Blood Service.	
5.2.0	**Integrated Medium Term Plan Accountability Conditions – Process for Delivery** Following approval of the Integrated Medium Term Plan (IMTP) during September 2023, the Trust had received an accountability conditions letter on the 2nd October 2023 from the NHS Wales Chief Executive. 4 key accountabilities and their corresponding leads were identified and it was recognised that the Trust will be required to demonstrate delivery of these by the end of March 2024. It was advised that although the Chief Operating Officer had been noted as responsible for 3 of the 4 listed, support would be provided by the relevant Executive Lead and Divisional Director. Gareth Jones reiterated that the report recommended that a quarterly progress report should be submitted to Executive Management Board, Quality, Safety & Performance Committee and Trust Board. Vicky Morris questioned whether tracking / monitoring of the accountability conditions set out in the previous year's letter had been undertaken in addition to this year's more operational conditions, querying where this information is reported. Carl James advised that this had been undertaken and the outcomes included in the JET slide deck for discussion with Welsh Government. The slides had been circulated to Independent Members.	

	As there is no indication that the conditions are cumulative or as some are noted as 'one year' issues, it was agreed that reporting would be on a cumulative basis. The Trust Board **NOTED:** • The Welsh Government accountabilities conditions; • The approach for reporting against the Welsh Government conditions.	
5.3.0	**Blood Establishment Computer System (BECS)** Carl James provided an overview of the Blood Establishment Computer System, noting the requirement for the procurement and implementation of a replacement system as it approaches the end of its current contractual arrangements. The system is fundamental for blood safety, providing a means of tracking blood from donor to patient. A number of regulatory requirements are enforced through regular inspections by national regulators. The Board acknowledged the challenge in replacing the system while still meeting current requirements and that the Trust is currently working through a number of options, seeking to identify the most appropriate route forward. This item will be explored in further detail during today's private meeting. The Trust Board **NOTED** this update on the project, the challenges and strategic context and that options for the future provision are being explored.	
6.0.0	**CONSENT ITEMS**	
6.1.0	**CONSENT FOR APPROVAL**	
6.1.1	**Commitment of Expenditure exceeding Chief Executive's Limit** Gareth Jones indicated that the outline of the procurement strategy within Appendix 1 (Provision of Oncotype Testing) was ambiguous; stating that this would be via a <u>direct award</u> by an NHS framework implies a new agreement, whereas later in the document it is indicated that 'renewal of this contract poses no cost pressures to the Trust'. Matthew Bunce understood this to be a new contract as opposed to an extension of an existing one. The Trust Board **AUTHORISED** the Chief Executive to **APPROVE** the award of contracts summarised within this paper and supporting appendices **and AUTHORISED** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement, subject to the note above.	
6.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chair's Urgent Actions taken between 20/09/2023 and 22/11/2023.	
6.1.3	**Revisions to the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts; and Model Standing Financial Instructions** The Trust Board **APPROVED** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Model Standing Financial Instructions.	
6.1.4	**Trust Policies for Approval** The Trust Board **APPROVED** the following policies:	

	• Trust Claims Policy (QS04a) • Handling Concerns Policy (QS03) The Trust Board was **not** in a position to approve the following policy as it had been identified that further work on this is required: • NHS Wales Shared Services Partnership – Registration Authority Policy	
6.1.5	**NHS Wales Red Cell Shortage Plan** The Trust Board **APPROVED** the NHS Wales Red Cell Shortage Plan	
6.1.6	**NHS Wales Shared Services Partnership (NWSSP) – Renewal of Lease** The Trust Board **APPROVED** the renewal of the lease between NWSSP and the Treforest Trustee (Jersey) Limited.	
6.2.0	**CONSENT FOR NOTING**	
6.2.1	**Trust-wide Approved Policies Update** The report provided the Board with an update regarding the status of Trust wide policies, advising of those that had been approved during October and November 2023. Gareth Jones reiterated that a significant proportion (50%) of policies are currently past their review date and queried whether there may be legal consequences as a result. Lauren Fear confirmed that existing policies remain extant. The Trust Board **NOTED** the content of the report.	
6.2.2	**Public Strategic Development Committee Highlight Report 07/11/2023)** The Trust Board **NOTED** the content of the report.	
6.2.3	**Public Charitable Funds Committee Highlight Report (07/09/2023)** The Trust Board **NOTED** the content of the report.	
6.2.4	**Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports (12/10/2023 & 26/10/2023)** The Trust Board **NOTED** the content of the reports.	
6.2.5	**Remuneration Committee Highlight Report (16/11/2023)** The Trust Board **NOTED** the content of the report.	
6.2.6	**Local Partnership Forum Highlight Report (07/09/2023)** The Trust Board **NOTED** the content of the report.	
6.2.7	**Public Welsh Health Specialised Services (WHSSC) Committee Briefing (19/09/2023)** The Trust Board **NOTED** the content of the report.	
6.2.8	**Emergency Ambulance Services Joint Committee (EASC) Briefing (19/09/2023)** The Trust Board **NOTED** the content of the report.	

6.2.9	**NHS Wales Shared Services Partnership Committee Assurance Report (21/09/2023)** The Trust Board **NOTED** the content of the report.	
6.2.10	**Trust Seal Approval Report – (September-November 2023)** The Trust Board **NOTED** the content of the report.	
7.0.0	**ANY OTHER BUSINESS** The Chair had not received prior notice of any other business.	
8.0.0	**DATE of the next meeting** The next meeting of the Public Trust Board will take place on Tuesday 30th January 2024.	
9.0.0	**CLOSE**	

No.	Action	Owner	Target Date	Progress to date	Status (Open / Closed)
				ACTIONS ARISING FROM 28/09/2023	
3.1.0	Identify a method of informing Trust Board that risks with an impact rating of 5 are being monitored and managed via SLT meetings	Director of Corporate Governance & Chief of Staff	28/09/2023	**Update 06/11/2023** – Included in paper for November 2023 Trust Board. Trust Board agreed to close following the paper, rather than at the start of the meeting.	**CLOSED**
3.2.0	Confirm approach to approval of Trust Assurance Framework (TAF) via Chair's urgent action or via discussion with Board.	Director of Corporate Governance & Chief of Staff	28/09/2023	**Update 23/01/2024** – Propose to close depending on Trust Assurance refreshed risks being approved in 30/01/2024 meeting. **Update 06/11/2023** – Approach agreed at Audit Committee to be via consideration during a full Board meeting – to be in January 2024.	**OPEN** (PROPOSE TO CLOSE DEPENDING ON TAF RISKS BEING APPROVED DURING MEETING)
				ACTIONS ARISING FROM 30/11/2023	
4.5.0	(Performance Management Framework) – check potential data transfer issue resulting in 63% score for 'Your Velindre Experience' patient survey.	Interim Director of Velindre Cancer Service	30/01/2024	**Update 22/01/2024** – There are two surveys, both which collate information differently. It was decided to capture scores of only 9 or 10 out of 10 for the 'Your Velindre Experience' patient survey, therefore resulting in a score of 63%. The score would be in the 90%s if scores of 8 were also captured. This also means that there was a different score to the 'would you recommend us', which consistently scores around 95%. A discussion on 22/01/2024 will ensure that the scores for both surveys make sense and are clearly articulated.	**CLOSED**
4.5.0	(Performance Management Framework) – reword measure in relation to patient surveys.	Executive Director of Nursing, Allied Health Professionals & Health Science	30/01/2024	**Update 08/01/2024** – Work undertaken with performance team to reword the measure.	**OPEN**

<table>
<tr><td colspan="2" align="center">**TRUST BOARD**</td></tr>
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<tr><td colspan="2" align="center">**CHAIR'S UPDATE REPORT**</td></tr>
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DATE OF MEETING	30th January 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
*   Cheque Presentation – 27th November 2023
*   Youth Engagement nVCC Workshop – 13th December 2023
*   WBS Service Improvement Spotlight Event – 11th January 2024
*   WBS Donor Awards – 17th January 2024

3. **ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION**

3.1 **Board Development Sessions**

    A Board Development Session was held on the 14th December 2023. Topics discussed were:

*   **Organisational Values** – to achieve a consensus on the words to be used as the Trust's core values and how these can be embedded in day to day business and working life.
*   **Strategic Equality Plan** – to obtain responses from the Board relating to consultation questions.
*   **Building Our Future Together** – Development of the Trust's Clinical & Scientific Infrastructure and Strategy.
*   **Welsh Language** – providing updated information in relation to the Trust's current position in line with Welsh Language Standards.
*   **Integrated Medium Term Plan (IMTP) Development** – to provide a view of the overall current position and emerging issues.

3.2 **Presentation of cheque to the Charity**
    During November, the Chair and Chief Executive attended the presentation of a cheque to the Trust's Charity, which took place at Velindre Cancer Centre's Charity Offices. Following the extremely kind gesture of an individual to make Velindre Cancer Centre their residuary beneficiary, a personal visit by the Executors of their Estate was made to the Cancer Centre to hand over the notable sum of £551k.

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3.3 Youth Engagement nVCC Workshop

In December, Velindre Voices were heard and celebrated across a number of schools and organisations in a bid to help design family rooms and children's spaces at the new Velindre Cancer Centre.

The Trust collaborated with students of several comprehensive schools in addition to our Velindre Young Ambassadors and

service users. The Trust has also explored the existing facilities of LATCH Wales and the Teenage Cancer Trust.

These sessions are set to continue over the coming months as part of a wider partnership with young people.

3.4 WBS Service Improvement Spotlight Event

5 Minute Improvements

The Chair attended a Spotlight on Service Improvement event hosted by the WBS QA team. The event was a great success, with all areas and teams

sharing examples of their outstanding improvement work. 67 people attended the hybrid event in total, including a number of the Executive Team and Independent Members. All directorates were represented, demonstrating the spread of Service Improvement culture across the organisation.

3.5 WBS Donor Awards

The Abergavenny Donor Awards ceremony, attended by the Chair, welcomed 54 milestone donors to the second of the Autumn/Winter ceremonies to celebrate their commitment to the Welsh Blood Service.

The event, held at the Manor Hotel, Crickhowell, showcased local donors who were being celebrated for their 50, 75 and 100 blood

donation milestones. The donations made by the donors at the ceremony had potentially provided enough blood and blood products to save the lives of some 10,725 patients in need.

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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	Not required

4

For more information: *https://nhswales365.sharepoint.com/sites/VEL_I* *ntranet/SitePages/E.aspx*	5
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

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TRUST BOARD

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VICE CHAIR'S UPDATE REPORT

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DATE OF MEETING	30th January 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**):

- Extraordinary Private Trust Board Meetings
- Board Development/Briefing Sessions
- Trust Committee Meetings
- Attendance at Internal / External Meetings

3 IMPACT ASSESSMENT

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

2

	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 January 2024

This Report provides an update from the Vice Chair.

Trust Board & Committees

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

- Extraordinary Private Trust Board – 5 Dec 2023
- Extraordinary Private Trust Board – 12 Dec 2023
- Board Development Session – 14 Dec 2023
- Board Briefing Session – 21 Dec 2023
- Extraordinary Private Trust Board – 4 Jan 2024
- Board Development Session – 11 Jan 2024

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

- Strategic Development Committee, Public and Private Meetings – 18 January 2024

I have attended the following Committee meetings:

- QSP Committee, Public and Private Meetings – 16 January 2024

External Meetings

On 13 December 2023 and on 10 January 2024 I attended Meetings of Vice-Chairs of Health Boards and Trusts.

On 3 January 2024 I met with the Chief Executive of City Hospice, at the Hospice, to discuss ongoing collaboration and partnership arrangements[1].

On 9 January 2024 I attended a Meeting of Chairs of Health Boards and Trusts, on behalf of the Trust Chair.

On 11 January 2024 I attended a Meeting of Vice-Chairs of Health Boards and Trusts with the Health Minister.

On 15 January 2024 I attended a Meeting of Chairs, Vice-Chairs and Chief Executives of Health Boards and Trusts, with the Chair and Chief Officer of Llais.

On 16 January 2024 I attended an Information/Training Session involving Chairs and some Independent Members of Welsh Public Bodies, arranged and led by Welsh Government.

On 23 Jan 2024 I attended a Meeting of Vice-Chairs of Health Boards and Trusts with the Chief Executive of NHS Wales.

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, and have agreed the Annual Report to the Board in that latter role.

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[1] As per my previous Declarations of Interest, I am a former Trustee and former Chair of Trustees of City Hospice, from which roles I stepped down in 2018.

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	30/1/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Carl James, Acting Chief Executive Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Acting Chief Executive Officer

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1

1. SITUATION/BACKGROUND

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

Matters addressed in this report cover the following:

- Joint Escalation and Intervention Arrangements
- Industrial Action
- Mid Year JET Meeting 2023-24
- NHS Wales Planning Framework

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Joint Escalation and Intervention Arrangements

Under the Joint Escalation and Intervention Arrangements, the Welsh Government meets with Audit Wales and Healthcare Inspectorate Wales twice a year to discuss issues, concerns and other related information concerning each organisation in NHS Wales. This information and other insights are considered alongside a detailed analysis of the health body by Welsh Government and decisions are then taken about the escalation status. On 23rd January 2024, the Director General Health and Social Services/ NHS Wales Chief Executive wrote to the Chief Executive to confirm that following a recent meeting there has been no change in the escalation status of the Trust and it remains in "routine arrangements." The full letter has been circulated separately to Trust Board members.

2.2 Industrial Action

Junior Doctors balloted to take part in industrial action from 15th-18th January 2023 across NHS Wales. As the Board has been informed informally over recent weeks, the Trust set up its incident management command structure to

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prepare for and manage the period, in line with the Trust's response in previous examples of Industrial Action. The Chief Executive/Acting Chief Executive chaired Gold command.

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

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

The command structure has now been stood down and will be re-established if there is confirmation of further action.

2.3 Joint Executive Team Meeting Feedback

The Trust's Executive Team met with the Executive Team of Health & Social Care in Welsh Government on 17th November 2023 for a mid-year 2023/24 meeting. The feedback letter was received in 20th December 2023. A full copy has been shared with Trust Board members and summarises the discussion across the agenda topics (as reported on in CEO report for November Trust Board). There were no specific actions to record and monitor at Trust Board.

2.4   NHS Wales Planning Framework

On 18th December 2023, the Director General Health and Social Services/ NHS Wales Chief Executive wrote to the Chief Executives to confirm the process and governance arrangements for NHS organisations in the context of the NHS Planning Framework 2024-7.The letter has been shared with Trust Board

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members. It sets the context of the Planning Framework in collectively progressing our sustainability agenda and the delivery of 'A Healthier Wales.' It explains the requirements for: financial planning; integrated arrangements; 2024 developments; and sets out the timetable for submission.

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.

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TRUST BOARD

Board Champion (Health and Wellbeing) Report

DATE OF MEETING	30 January 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	Claire Budgen, Head of Organisational Development
PRESENTED BY	Stephen Harries, Independent Member and Health and Wellbeing Champion
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

APPENDICES	
Appendix 1	Health and Wellbeing Annual Workplan

1. INTRODUCTION

1.1 Wellbeing of staff is central to the vision for the Trust. The People Strategy has as part of its vision: **Healthy and Engaged People: of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and cultural identity.** This is followed by Wellbeing and Engagement being spelled out as the first of six priorities for action.

1.2 Health and Wellbeing is a broad concept and it is applied in a wide range of ways within the Trust. At one end of the spectrum, there is a focus on individual health and wellbeing, both physical and psychological. At the other end, we are working to create conditions at an organisational level that will enable individuals, teams and the whole service to develop healthy work practices and to thrive.

1.3 In 2023 the role of Health and Wellbeing Champion was introduced in the Trust. Board Champions are designed to engender board level commitment and focus around key areas of service development or delivery. For Independent Members, it provides an opportunity to gain a deeper level of insight and knowledge around key areas with the aim of better equipping them and the whole Board to fulfil its role. The Champion works in conjunction with the Executive Director in order to promote, celebrate and question progress with Wellbeing.

2. ARRANGEMENTS FOR HEALTH AND WELLBEING

2.1 There are well established governance processes around Health and Wellbeing. The Trust holds a Quarterly Healthy and Engaged Steering Group which is constituted of representatives of all Divisions, professions and functions within the Trust. This group develops, oversees and monitors the impact of Wellbeing

interventions that are put into place. These are captured in a Health and Wellbeing Action Plan (Appendix 1) which is reviewed at each meeting. This group submits Highlight Reports to the Executive Management Board to complete the governance loop.

2.2 Health and Wellbeing is embedded into the work roles of all managers and each member of the People function. Wellbeing is specifically resourced in three roles:

- Head of Organisational Development
- Clinical Psychologist for Staff and Teams
- Wellbeing Project Coordinator

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3. ACTIVITY IN 2023

3.1 The schedule below highlights some of the key milestones over the past 12 months. Further detail on the more complex examples is given below the table.

Date	Milestone
19.1.23	Disability Confident Level 2 renewed
25.1.23	Gold Level of Corporate Health Standard renewed
7.3.23	Champion visit to Velindre Cancer Centre
13.3.23	Champion attended the Healthy and Engaged Steering Group
20.4.23	Platinum Level of Corporate Health Standard renewed
7.8.23	Champion visit to Welsh Blood Service Headquarters
9.9.23	Fatigue and Facilities Charter for Medical Staff introduced
18.9.23	Mindful Employer renewed
30.9.23	VUNHST Employee Excellence Awards
19.10.23	Speaking Up Safely Task and Finish Group launched

1.11.23	NHS Charities Together funding awarded
27.11.23	NHS Wales Staff Survey closes
30.1.24	Trust Values refreshed

a. Corporate Health Standards provide a rigorous assessment of organisational arrangements and performance in relation to staff wellbeing and sustainability. The Trust was successful in securing re-accreditation in both Gold and Platinum levels. This work ensured different departments within the Trust worked together to achieve positive outcomes for staff, services users and the community. National developments, however, have seen the withdrawal of these Corporate Health Standards for future use and consequently we will not be re-assessed in 2024.

b. As the Trust Wellbeing Champion, I have been present in many arenas across the Trust during 2023. This included tours of Velindre Cancer Centre and Welsh Blood Service Headquarters to see first-hand the environment in which staff work. I have also attended one of the Healthy and Engaged Steering Group meetings and been co-host of the 2023 Employee Excellence Awards, thus giving visibility to the role of Wellbeing Champion.

c. The Fatigue and Facilities Charter has been established nationally as a benchmark for the quality of the working environment for Medical Staff. A Task and Finish Group of Medical staff and workforce colleagues oversaw the implementation of this standard. The final step to be achieved is to monitor continued observance of the standards through the Joint Local Negotiating Committee.

d. The Employee Excellence Awards was brought back after a hiatus of four years due to COVID. The process and communications were refreshed which led to a over 180 nominations being submitted. The Awards Event took place over two

separate sties with Velindre Cancer Centre linking up electronically with Welsh Blood Service Headquarters where a truly joint ceremony took place.

e.   The NHS Wales Speaking Up Safely Framework was issued in September 2023. The Trust swiftly developed and action plan and convened a Task and Finish Group to ensure all arrangements are in place by the end of March 2024. However, it is clear that the culture change that leads to Speaking Up Safely will take longer to achieve.

f.   The Trust submitted a bid to NHS Charities Together and in November 2023 was successful in securing funding for a two-year project worker who will develop methods for evaluating the impact of wellbeing interventions and also grow staff networks for wellbeing. Recruitment is taking place in January 2024. In addition, the Trust received an allocation for furniture for the Noddfa Wellbeing hub at Velindre.

g.   The NHS Wales Staff Survey returned for the first time since 2020. Throughout the year, the survey had been positioned in a positive light and once it opened in September, the approach to communications was sophisticated. Through a mixture of formal communications and line manager encouragement the Trust achieved a response rate of 34%, compared with 25% in 2020. For reference, NHS Wales achieved a response rate of 20%.

h.   And finally, 2023 saw the completion of a broad programme of engagement and development in reviewing the Trust values. This succeeded in capturing over 500 items of feedback. A highlight of this process was the two externally-facilitated focus groups, one for staff and the other for patients and donors. These proved to powerful forums where the needs and wants of stakeholders were heard. The conclusions from this work have led to the formulation of a refreshed set of values.

4. LEARNING AND NEXT STEPS

4.1 Wellbeing falls within the ambit of organisational development and naturally provides a rich environment for organisational learning. Some learning points from the year include:

- We have found more effective ways to engage staff from all working areas in the Trust by using a mixture of on-line and in person events, and involving Divisional and Departmental Managers in the communications, alongside the Trust wide messages
- We have recognised the difficulties of there being a lack of proven methods and availability of data to evaluate the effectiveness of our well-being initiatives and we will explore ways to produce relevant information to provide assurance to the board about what appears to be working.
- More time was required between the close of nominations for the Employee Excellence Awards and the event to allow greater period of review and planning.

4.2 In terms of 2024, the annual workplan will be reviewed and built upon in line with the implementation of the People Strategy. Some key themes for the coming year will be:

- Creating opportunities to embed the refreshed values in everything we do
- Receiving the results of the NHS Staff Survey and involving staff in creating improvements
- Following through the with Speaking Up Safely Action Plan and building a culture of psychological safety
- Using data and feedback to evaluate the impact of wellbeing interventions and to provide assurance to the Board

- Developing the Psychology Service for Staff and building supportive networks.

5.   CONCLUSIONS AND RECOMMENDATIONS

5.1   In conclusion, there have been various tangible products relating to the promotion of staff Health and Wellbeing during 2023, as shown in 3.1 above. Underneath this, the theme of caring for the wellbeing of our colleagues has been promoted through the support and development given to managers when dealing with individuals and teams. Whilst there is a common thread here, we aim to be able to evaluate this more stringently in the coming period so that we understand what works well in terms of staff wellbeing so that we can build a positive and healthy working environment in the Trust

5.2   It is recommended that the Board **NOTE** this report.

Activity	Resource Allocation	Deadline	Progress	Detail
Employee Relations Process Review	People and Relationship Team	Apr-24	On Target	
Building our Future Together Values Project	Head of OD	Mar-24	On Target	2nd phase of engagement with staff and service users during October prior to Board Development session 14 December 2023.
Health and Wellbeing Activity Evaluation	Head of OD	Sep-23	Completed	Surveys of Wellbeing Suport and Menopause Support conducted June 2023 - results used in drafting EAP tender.
Embed wellbeing plan into Trust Communication Strategy	Head of OD	Dec-23	Not Started	To be discussed with Comms Team.
Partner with Communications Team to develop bi-lingual offering to staff and patients	Welsh Language Manager	30-Nov-23	On Target	Part of Divisional work and response to Commissioner's report
Update the EQIA process	ED&I Manager	Apr-23	Completed	New Toolkit launched and Bitesize training delivered. Six month review taken to EMB 13.11.23
Trust response to Industrial Action	Head of Workforce		Completed	Trust reposne well planned and Trust is able to respond to any future action on that basis.
Monitor and Improve Performance Measures	Deputy Head of WOD	Apr-24	On Target	ED&I measures in PMF reviewed and updated - November 2023. Measures for Culture and Speaking Up Safely to be included in PMF.
Trust Policy and Procedure Reviews	Head of Workforce	Apr-24	On Target	EQIAs now esential element of policy review
Implement the Anti-racist action plan including the Workplace Race Equality Scheme	ED&I Manager	Dec-24	On Target	National WRES group in place. Preparing staff forums and Culture Competency work.
The Strategic Equality Plan 2020 – 2024 will be reviewed and renewed for 2024-2028	ED&I Manager	Mar-24	On Target	Proposal to EMB 18.9.23. Engagment with staff and the public underway during October and November 2023. Board Development Session 14.12.23
Analyse progress with HR inerventions and access to traning in light of protected characteristics	ED&I Manager	Mar-24	Not Started	
Develop a calendar of Diversity Events and the set up of diversity networks	ED&I Manager	Dec-23	Completed	Agreed with the Comms team and up and running
Achieve Disability Confident Level 3	ED&I Manager	Mar-24	On Target	Input from Widening Access Coordinator and Head of OD required
Review engagement approaches with patients and donors to check they are inclusive and help build better services in the future	ED&I Manager	Mar-24	On Target	ED&I manager working with Donor and Patient Engagement leads.

Structured Assessment 2023 – Velindre University NHS Trust

Audit year: 2023

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Contents

Summary report

About this report

1   This report sets out the findings from the Auditor General's 2023 structured assessment work at Velindre University NHS Trust (the Trust). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Our review of the Trust's corporate approach to setting new well-being objectives in accordance with the sustainable development principle is being undertaken to help discharge the Auditor General's duties under section 15 of the Well-being of Future Generations (Wales) Act 2015.

2   Our 2023 Structured Assessment work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies are also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

3   The key focus of the work has been on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on;

- Board transparency, cohesion, and effectiveness;
- Corporate systems of assurance;
- Corporate approach to planning; and
- Corporate approach to financial management.

We have not reviewed the Trust's operational arrangements as part of this work.

4   Our work has been informed by our previous structured assessment work, which has been developed and refined over several years. It has also been informed by:

- Model Standing Orders, Reservation and Delegation of Powers
- Model Standing Financial Instructions
- Relevant Welsh Government health circulars and guidance
- The Good Governance Guide for NHS Wales Boards (Second Edition)
- Other relevant good practice guides

We undertook our work between July 2023 and November 2023. The methods used to deliver our work are summarised in **Appendix 1**.

5   We also provide an update in this report on the Trust's progress in addressing outstanding recommendations identified in previous structured assessment reports in **Appendix 2**.

Key findings

6   We found that **overall, the Trust continues to be generally well led and governed, with a clear strategic vision and priorities, improving systems of assurance, and effective arrangements for managing its finances. However, opportunities remain to further enhance public transparency of Board business, strengthen strategic risk management arrangements, and ensure corporate plans and strategies contain clear objectives and actions for all Trust functions**.

Board transparency, effectiveness, and cohesion

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

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

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

10   The Board promotes and demonstrates a commitment to hear from patients and donors and is stepping up activities to enable Board members to hear from service users. The Board is stable and continues to demonstrate a positive commitment to continuous improvement. However, the Trust will need to ensure that appropriate arrangements are in place to ensure continued stability should there be changes to its Independent Member cohort.

Corporate systems of assurance

11   We found that **positive improvements have been made to key corporate systems of assurance, particularly in relation to managing performance, tracking recommendations, and responding to the new duties of quality and**

candour. However, progress in refreshing strategic risks has been slow, limiting the Board's ability to maintain effective oversight of them.

12   The Trust has continued to develop its Board Assurance Framework, but progress to refresh strategic risks has been slow. Consequently, the Board Assurance Framework has not been reviewed by the Board for more than six months. The Trust anticipates that the new template will be populated with the revised risks and associated controls and assurance in time for the November 2023 Board meeting. Improvements to information included in the Corporate Risk Register are providing better clarity about operational risks. This has drawn attention to the long-standing nature of many of the risks, and the Board wants to give more attention to the longest open risks over the coming months.

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

Corporate approach to planning

14   We found that **the Trust has effective arrangements for producing, overseeing, and scrutinising the development of strategies and corporate plans**. **However**, **the 2023-26 IMTP does not contain clear objectives which are supported by timescales for delivery and intended measurable outcomes in respect of cross-cutting corporate functions**.

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

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

Corporate approach to managing financial resources

17 We found that **the Trust continues to have good arrangements for financial planning and managing and monitoring its financial position**.

18 The Trust met its financial duties for 2022-2023 and is forecasting to break-even in 2023-24.

19 The Trust has a clear process for financial planning, with good involvement from the Board, although the development and the identification of recurrent savings plan has been a challenge. Its arrangements for controlling, overseeing, and scrutinising financial management are robust.

Recommendations

20 **Exhibit 1** details the recommendations arising from our work. These include timescales and our assessment of priority. The Trust's response to our recommendations is summarised in **Appendix 3**.

Exhibit 1: 2023 recommendations

Recommendations
Transparency of Board business   **R1**   The Trust rarely publicises its Board meetings on its social media channels. The Trust should establish a process to ensure more frequent reminders about Board meetings are posted on social media (**Medium Priority**).
Transparency of Board business   **R2**   The Trust does not publicise what is to be discussed in private Board or committee meetings or publish summaries of what is discussed. The Trust should: • include a list of the items to be discussed in private sessions on public Board and committee meeting agendas (**Medium Priority**); and   • provide (and publish) brief summaries of private Board and committee discussions (**Medium Priority**).
Transparency of Board business   **R3**   Committee minutes are published on the Trust's website when included in papers for the next meeting, usually two months later. The Trust should publish unconfirmed minutes as soon as possible after committee meetings,

Recommendations

following accuracy checking, whilst still retaining full confirmation of accuracy by committee members in the following meeting (**Medium Priority**).

Board and committee reports

R4   In Board and committee cover papers, the summary of previous discussions undertaken in other fora, often do not make evident what the outcome was and whether any agreed actions have been implemented. The Trust should establish a process to ensure that summaries of previous discussions include the resulting agreed actions, and whether they have been implemented (**Medium Priority**).

Operational risk assurance

R5   Recent cover papers on the Corporate Risk Register did not include the reasons why some risks no longer featured. This means that meeting members have no assurance that the reason for any omissions is a result of risk mitigation having a positive impact. In future Corporate Risk Register cover reports, the Trust should provide a summary on the reasons why risks have been removed from the Corporate Risk Register (**High Priority**).

Board and committee reports

R6   Often, Board and committee cover reports, papers and presentations are operationally detailed, and activity focused but provide less clarity on the impacts of initiatives or actions taken. The Trust should establish a process to ensure that Executive Lead sponsors review to make sure that cover reports, papers and presentations are focused on key issues and impacts (**Medium Priority**).

Detailed report

Board transparency, effectiveness, and cohesion

21   We considered whether the Trust's Board conducts its business appropriately, effectively, and transparently.

22   We found that **the Board and its committees generally operate well, with an ongoing commitment to public transparency, continuous improvement, and hearing from patients and donors**. **However, opportunities remain to enhance certain arrangements further**.

Public transparency of Board business

23   We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee:

- meetings that are accessible to the public;
- papers being made publicly available in advance of meetings;
- business and decision-making being conducted transparently; and
- meeting minutes being made publicly available in a timely manner.

24   We found that the **whilst the Board remains committed to conducting its business transparently, opportunities remain to increase public access to Board business**.

25   All public Board meetings continue to be live streamed to allow the public to observe virtually, with recordings made available on the Trust's website. The Trust's website sets out how members of the public can register to observe Board meetings; however, the Trust rarely publicises these meetings on its social media channels (**Recommendation 1**). The Trust, however, does not live-stream or record its public committee meetings (other than for the purpose of minute taking).

26   Board papers are published on the website in advance of meetings; however, committee papers are not. In our 2022 structured assessment report, we highlighted that papers for some committee meetings were missing from the Trust's website long after meetings had occurred (see **Appendix 2 R1 2022**). Whilst all meeting papers are now available on the website, during 2023 we found that some meeting papers were not available for many weeks after the meeting[1].The Trust is currently refreshing its Corporate Governance Handbook. I The Handbook now sets out a requirement for committee papers to be published one week in advance of meetings and the responsibilities for ensuring key

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[1] We reviewed the website on the 18 July 2023, and found that the 4 May 2023 Strategic Development Committee meeting papers were missing from the website. We also reviewed the website on the 4 October 2023, and noted that the 26 July 2023 Audit Committee papers were missing. All committee papers are now available on the website.

documents are published on the website once approved by a committee or the Board.

27   We observed open and candid discussions in public Board and committee meetings. The Trust minimises the use of private Board and committee sessions, reserving these for confidential and sensitive matters only. However, the Trust does not publicise what is to be discussed in private Board or committee meetings or publish summaries of what is discussed (**Recommendation 2**).

28   The Trust continues to log urgent decisions taken by the Chair between scheduled Board meetings. All urgent decisions are subsequently presented to the Board in writing for scrutiny and ratification.

29   Board minutes are published on the Trust's website (unconfirmed) in the papers for the next meeting, and once confirmed at the meeting, the agenda papers are republished. Committee meeting minutes are not available on the Trust's website until they have been confirmed at the next meeting and published in that meeting's papers, which is usually at least two months later. The Trust should aim to publish unconfirmed committee minutes as soon as possible after committee meetings (allowing time for accuracy checking by the meeting chair and relevant executive lead), whilst still retain full confirmation of accuracy by committee members in the following meeting (**Recommendation 3**). This would help members of the public to have a timelier understanding of committee business, particularly as the public is unable to attend or observe committee meetings.

Arrangements to support the conduct of Board business

30   We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of a formal, up-to-date, and publicly available:

- Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- policies and procedures in place to promote and ensure probity and propriety.

31   We found that **the Board has effective arrangements to support the conduct of its business**.

32   The Trust's governance arrangements continue to support the effective conduct of Board and committee business. The Trust reviews its Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions on a frequent basis. It last updated each of these documents in September 2023, with endorsement received from the Audit Committee in October. Board approval will be sought in November 2023. The current approved versions of the Standing Orders and Standing Financial Instructions are available on the Trust website.

33   Updates to the Standing Orders appropriately reflect necessary requirements relating to the Duties of Candour and Quality (Health and Social Care (Quality and Engagement) Act (2020).

34   The Audit Committee receives the Register of Declarations of Interest, Gifts, Sponsorship, Hospitality and Honoraria on a six-monthly basis. It last reviewed the register in October 2023. In our 2022 structured assessment report, we highlighted that whilst the register is available in Audit Committee papers, the Trust had not published it separately on its website. This has since been rectified (see **Appendix 2 R1, 2022**). We routinely observed declarations of interest taken at the start of Board and committee meetings as a standing item.

35   During 2022, the Trust undertook a comprehensive review of its arrangements for managing and updating Trust-wide policies. This work involved identifying policies that were either near to or past their review date, and risk assessing them to determine which should be reviewed as a priority. Consequently, there are revised procedures for the management of Trust policies in place, as well as a Control Register to record the status of these policies. There is a programme of work underway to update policies, and our sample review suggests that new policies are placed on the Trust website following approval.

Effectiveness of Board and committee meetings

36   We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;

- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework;

- well-chaired Board and committee meetings that follow agreed processes, with members observing meeting etiquette and providing a good balance of scrutiny, support, and challenge; and

- committees receiving and acting on required assurances and providing timely and appropriate assurances to the Board.

37   We found that **the Trust's Board and committee structure is operating effectively. Meetings are well-managed, with good scrutiny, challenge, and debate, but some committees are finding it difficult to run meetings to time**.

38   There is an appropriate and integrated committee structure in place, which is aligned to key strategic priorities and risks and meets statutory requirements. Terms of reference for all committees are up to date.

39   In previous years, we have focused our attention on the effectiveness of the Quality, Safety, and Performance Committee. In our 2022 structured assessment

report, we reported that committee meetings were running to time and there had been signs of more focused discussions on key matters.

40   The remit of the Quality, Safety, and Performance Committee is large. It covers quality, safety, and operational performance (including workforce and finance) with the aim of enabling better triangulation of information to identify 'cause and effect'. As a result, this necessitates many agenda items for the Committee to consider. However, the establishment of the Integrated Quality and Safety Group[2] has helped to reduce some of the information reported to the Quality, Safety and Performance Committee. Whilst Quality, Safety, and Performance Committee meetings generally run to time, this remains a challenge given the number of papers and detail provided within them (see **paragraph 49**). On occasions, it is difficult to achieve an appropriate balance of running committee meetings to time whilst allowing adequate time for scrutiny.

41   Helpfully, the agendas of Quality, Safety, and Performance Committee meetings have been reordered to ensure that key matters for discussion feature near the start of the meetings where energy levels are higher. Appropriate use is also made of consent agendas. In addition, the Committee's cycle of business has been aligned to the financial year. All annual reports are now prepared in time to support the Annual Governance Statement and received by the committee in its July meeting.

42   During 2023, we have also observed some Audit Committee meetings overrunning due to the large number of items on the agenda, the detail contained in papers, and the need to allow sufficient time for scrutiny.

43   Board and committee meetings are 'hybrid', with some members attending in person and others attending virtually. This approach generally works well. Board and committee meetings continue to be well chaired, and members observe good meeting etiquette. We have observed Independent Members offering robust scrutiny with a good balance of challenge and support.

44   There is good cross-referral of matters between committees and from committees to the Board. Committees produce good quality highlight papers that effectively draw attention to key matters for escalation and assurance for discussion at Board meetings. The Trust Chair and committee chairs meet regularly to triangulate information from across the committee structure and wider Trust matters.

[2] The Integrated Quality and Safety Group is a Trust-wide operational group which first met in October 2022 and now meets every month. Some items are now reported to the Integrated Quality and Safety Group, and by exception to the Quality, Safety, and Performance Committee.

Quality and timeliness of Board and committee papers

45 We considered whether the Board and committees receive timely, high-quality information that supports effective scrutiny, assurance, and decision making. We were specifically looking for evidence of:

- clear and timely Board and committee papers that contain the necessary / appropriate level of information needed for effective decision making, scrutiny, and assurance.

46 We found that **Board and committee papers often contain too much detail and do not provide enough assurance on the impact of initiatives or actions taken**.

47 Cover reports clearly identify if papers have previously been scrutinised by executives or by a committee. However, the summary of previous discussions is sometimes too brief, and the outcome of those discussions is not evident. Therefore, summaries of previous discussions should include the resulting agreed actions, and whether they have been implemented or not to help avoid unnecessary repeat discussions (**Recommendation 4**).

48 The Trust has recently mandated the use of a standard cover report, which requires commentary under the following headings: Situation, Background, Assessment, and Summary of Matters for consideration. In addition, for assurance agenda items, papers now include an assessment of the level of assurance[3] provided. This is beginning to help paper authors assess the adequacy of the assurance provided, and whether further action may be necessary.

49 However, there are signs that Independent Members are becoming a little frustrated that some cover papers and presentations are too detailed and do not adequately focus on key messages, and impact. The Trust recognises the amount of detail in some cover papers and presentations is still too great and is taking action to address this. In recent committee meetings, a clear steer has been given that cover papers and presentations must focus on the key messages, and provide evidence that improvements are being made. There is a tendency for presentations and papers to provide detail about activity, but less clarity about whether the desired outcomes or impact achieved, for instance:

- delivery of the IMTP actions (see **paragraph 109**);
- actions taken to reduce current/residual risk levels associated with strategic risks (see **paragraphs 69-70**); and
- in our Review of Workforce Planning Arrangements (August 2023) we highlighted that the Trust needs to strengthen how it reports on the impact of key workforce initiatives in committee reports.

[3] The Trust has adopted the seven levels of assurance model, with a zero score meaning there are no actions agreed and no improvement evident, and a level seven score equating to actions which address the root causes are agreed and all implemented and there are evident signs of improvement.

50   The Trust recognises that there needs to be more focus on outcomes and impacts, and we are seeing signs of improvements. There is scope to further strengthen arrangements for ensuring information provided in Board and committee, cover reports, papers and presentations is pitched appropriately, focuses on what is new or different, and provides clarity on the intended impacts or outcomes of initiatives or actions taken (**Recommendation 6**).

51   The Trust circulates Board and committee papers to attendees in advance of meetings, although we have noted on occasions some papers are made available only a day or two before committee meetings.

Board commitment to hearing from patients, donors and staff

52   We considered whether the Board promotes and demonstrates a commitment to hearing from patients, donors and staff. We were specifically looking for evidence of:

- the Board using a range of suitable approaches to hear from patients, donors and staff.

53   We found that **the Board promotes and demonstrates a positive commitment to hear from patients and donors**.

54   The Trust has continued to engage regularly with patient advocates via Llais[4]. Llais representatives also regularly attend Board and committee meetings and provide views on service changes and the public accessibility of Trust business.

55   Quality, Safety, and Performance Committee meetings commence with either a patient, donor, or staff story, which usefully sets the tone for the remainder of the meetings. From our observations, we note that Independent Members give robust scrutiny on the potential impact of decisions on patients and donors. The Quality, Safety, and Performance Committee also receives regular service user updates.

56   Since the pandemic, opportunities for Independent Members to take part in 15-Steps challenges[5] have been sporadic. We understand the Trust intends for each Independent Member to participate in at least two 15-Steps challenge visits a year.

57   We will comment on the Trust's arrangements for Board members to hear from staff as part of our follow-up review of quality governance arrangements in 2024.

[4] Llais is a patient representative body, which replaced the former Community Health Council.

[5] The 15-Steps Challenge is a toolkit to explore healthcare settings through the eyes of patients and relatives.

Board cohesiveness and commitment to continuous improvement

58   We considered whether the Board is stable, cohesive and demonstrates a commitment to continuous improvement. We were specifically looking for evidence of:

- a stable and cohesive Board with a cadre of senior leaders who have the appropriate capacity, skills, and experience;

- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and

- a relevant programme of Board development, support, and training in place.

59   We found that **the Board continues to demonstrate a positive commitment to ongoing improvement**.

60   The Trust has a stable Board. Independent Members have a diverse portfolio of skills and experiences, and there is a strong executive leadership team in place.

61   Terms of office for Independent Members are staggered, which minimises Board instability and helps reduce the risk of losing knowledge and experience when terms end. However, the current terms of office for both the Board Chair and the Audit Committee Chair are due to end in March 2024. Should new appointments be necessary, the Trust needs to take appropriate action soon, given the appointment process can be lengthy.

62   The Trust continues to provide a good range of Board training and development opportunities and seeks opportunities for further improvements. The Board will need to revisit and refresh its development programme if new Independent Members are appointed.

63   There is a commitment to review the effectiveness of Board and committee meetings and make necessary improvements, with committees undertaking annual reviews and putting appropriate action plans in place to address findings. Positively, the Trust continues to use a maturity assessment and in its Accountability Report 2022-23 the Board rated itself as level 4[6] out of a possible five levels. The Trust is one of only two NHS bodies in Wales that uses this maturity assessment.

[6] Defined as 'having well developed plans and processes and can demonstrate sustainable improvement throughout the organisation'.

Corporate systems of assurance

64   We considered whether the Trust has a sound corporate approach to managing risks, performance, and the quality and safety of services.

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

Corporate approach to overseeing strategic risks

66   We considered whether the Trust has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all the relevant information on the risks to achieving the organisation's strategic priorities / objectives; and

- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks.

67   We found that **the Trust has continued to develop its Board Assurance Framework, but its progress in refreshing strategic risks has been slow. Consequently, the Board Assurance Framework has not been reviewed by the Board for more than six months**.

68   We considered the Trust's Board Assurance Framework (Trust Assurance Framework) and risk management arrangements as part of our 2022 review of the organisation's quality governance arrangements and our 2022 structured assessment. At the time of our work in 2022, we found that scrutiny of the Trust Assurance Framework had concentrated on its development, rather than its content.

69   The Trust Assurance Framework was updated regularly in 2022 and the first quarter of 2023. However, conversations at Board and committee meetings continued to focus on format rather than content. In March 2023, a revised Trust Assurance Framework template was agreed. The template now includes the residual/current risk trend, signposting to relevant operational risks, more detailed SMART[7] action plans to address gaps in controls and assurances with implementation progress and resulting impacts.

70   At the end of 2022, the Trust began work to refresh its strategic risks with the aim of aligning them to the strategic priorities set out in its 2023-26 IMTP and the strategic objectives set out in its 10-year strategy, 'Destination 2033'. However,

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[7] Specific, Measurable, Achievable, Relevant, Timebound.

work to finalise the strategic risks has taken significantly longer than originally anticipated. The proposed strategic risks have received scrutiny by the Strategic Development Committee but were not quite ready for approval at the September 2023 Board meeting. Instead, it was agreed that approval would be sought by the full Board at a later time. When developing the next IMTP, it would be prudent to dedicate a Board Development Session (or series of sessions, as appropriate) to enable the full Board time and space to discuss and agree strategic priorities and any required adjustments to strategic risks. Final approval should then occur in a public Board meeting.

71   The Trust told us the Trust Assurance Framework continued to be updated however, the Trust Assurance Framework has not featured at a Board or committee meeting since March 2023, and Independent Members have expressed their concerns about the omission. The Trust recognises it would have been prudent to continue to update and maintain the existing Trust Assurance Framework until the new strategic risks had been approved. The completed Trust Assurance Framework, in the new format, is due to be received at the November 2023 Board meeting (**Appendix 2 R1a 2019**).

Corporate approach to overseeing corporate risks

72   We considered whether the Trust has a sound corporate approach to identifying, overseeing, and scrutinising corporate risks. We were specifically looking for evidence of:

- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities;

- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system; and

- the Board providing effective oversight and scrutiny of corporate risks.

73   We found that **improvements to the Corporate Risk Register are providing better clarity about operational risks and supporting more effective scrutiny**.

74   In our 2022 quality governance review, we reported that whilst the Trust had made progress to develop and improve corporate risk management arrangements, there were some outstanding areas of work. We also found that the Corporate Risk Register did not always include enough information to support good scrutiny and challenge, and whilst the rollout of risk management training had commenced, significant numbers of staff still needed to be trained.

75   Since then, the Trust has reviewed, revised, and approved its Risk Appetite and Risk Management Framework (**Appendix 2 R2b 2019**). Risk management training has been rolled out to senior leaders and Board members have been kept updated on risk training compliance. The rollout of training to staff is making good progress since it began in April 2023. As of 25 October 2023, 73% of staff had received the training, against the aim of reaching 85% compliance by the end of October 2023 (see **Appendix 2 R1c 2019**).

76   Since March 2023, the Corporate Risk Register has also included the target risk
      score, a chart showing risk score trend data, and SMART action plans to achieve
      the target risk score. Initially, there was variable detail about proposed actions to
      reduce risk scores. However, there is now a requirement to be specific about which
      controls are in place and those that are proposed, and all proposed mitigating
      actions must be SMART. Our review of the Corporate Risk Register found that
      since July 2023, progress has been made to ensure each risk has included a
      SMART action plan.

77   Improvements to the information included in the Corporate Risk Register has
      resulted in more clarity about operational risks. In the May 2023 Quality, Safety,
      and Performance Committee, a clear signal was set out that going forward,
      scrutiny of the Corporate Risk Register should focus on content not format. In each
      of the May, July and September 2023 committee meetings, two or more risks were
      discussed in detail, with good scrutiny provided by Independent Members. Since
      the inclusion of the risk score trends, Board and committee scrutiny has given
      attention to the long-standing nature of many of the risks. The September 2023
      Corporate Risk Register included nine risks, of which none had seen a reduction in
      their risk score for the period for which data is available[8]. Three risks had been
      open more than 19 months. The Board has agreed that papers and discussions on
      risk need to focus on ensuring that proposed actions to reduce risk are having a
      demonstrable impact. Independent Members have subsequently asked that from
      September 2023 onwards, a date by which the target risk score will be achieved
      must be specified. Strategic risks are broad and high-level in their nature, and
      consequently there may be limited movement possible in risk scores, particularly
      where actions to address risk are out of the control of the Trust.

78   The Quality, Safety and Performance Committee received the Corporate Risk
      Register in it November 2023 meeting. The number of risks had reduced from nine
      (in September 2023) to five. Whilst presumably this means that actions taken to
      reduce operational risks in respect of four risks are having a positive impact, there
      was no assurance provided to confirm this (**Recommendation 5**).

Corporate approach to overseeing organisational performance

79   We considered whether the Trust has a sound corporate approach to identifying,
      overseeing, and scrutinising organisational performance. We were specifically
      looking for evidence of:

      • an appropriate, comprehensive, and up-to-date performance management
        framework in place, underpinned by clear roles and responsibilities; and

[8] Of the nine risks, one had been on the corporate risk register since July 2023, two since
June 2023, and one since May 2023, the remaining five had been on the register for
longer, but the earliest available trend data is March 2023 for these risks.

- the Board and committees providing effective oversight and scrutiny of organisational performance.

80   We found that **the Trust continues to strengthen its approach to reporting, overseeing, and scrutinising organisational performance**.

81   In our previous structured assessment reports, we set out that the Trust had plans to enhance its Performance Management Framework. Following extensive engagement across the Trust, the new framework was launched in 2023. It adopts a 'balanced scorecard' approach aligned to the six domains of care – safe, effective, service user centred, timely, efficient, and equitable care. The Quality, Safety, and Performance Committee and Board received the new look Performance Management Framework report at their March 2023 meetings. The new report contains more nuanced data and narrative to explain performance, the immediate and longer-term actions planned to drive improvement, and the risks which may impact future performance.

82   The next steps include identifying a Business Intelligence solution to automate the collection, collation, and reporting of key measures, and approaching potential benchmarking partners. The Trust also intends to develop further measures in some areas, including patient outcome and experience, staff experience, diversity, and the Welsh language.

83   The accountability and frequency for reviewing performance at service, management, committee, and Board levels is appropriate. The Board effectively discusses and challenges where performance is off track. However, as there are 113 performance indicators in the Board report, the Board might wish to focus on fewer key performance risks and place greater assurance from the detailed review and scrutiny undertaken by the Quality, Safety, and Performance Committee. This would also create more time for the Board to discuss other matters requiring its attention.

Corporate approach to overseeing the quality and safety of services

84   We considered whether the Trust has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- corporate arrangements in place that set out how the organisation will deliver its requirements under the new Health and Social Care (Quality and Engagement) Act (2020);
- a framework (or similar) in place that supports effective quality governance;
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

85   We found that **the Trust is taking appropriate steps to comply with the new duties of quality and candour**.

86   Our 2022 quality governance review found that significant progress had been made to improve the Trust's quality governance arrangements but identified opportunities for improvement. At the time of our work, the new Quality and Safety Framework had just been approved, and there was work to do to implement and embed new arrangements. We intend to follow-up our review in 2024.

87   The Trust has made appropriate arrangements to ensure compliance with the Health and Social Care (Quality and Engagement) Act (2020). An implementation group, chaired by the Director of Nursing Allied Health Professionals and Health Science, oversaw the implementation. In July 2023, it was agreed that the implementation group could be stood down, with remaining actions to be overseen by the Integrated Quality and Safety Group. Implementation has been supported by a series of training and engagement events with staff to raise awareness. Work is still underway to develop a prioritised list of quality metrics, to be included in a Quality Dashboard, and to develop a quality management system. Regular updates on implementation of the Duty of Candour have been provided to the Quality, Safety, and Performance Committee.

Corporate approach to tracking recommendations

88   We considered whether the Trust has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

89   We found that **the Trust has good arrangements for overseeing and scrutinising progress in addressing audit and review recommendations**.

90   The Trust has an effective system for tracking recommendations. The recommendations tracker, which is reviewed at each Audit Committee meeting, contains the overdue and closed recommendations. The Audit Committee is asked to approve the closed recommendations once assured that action taken is appropriate. Twice a year, the Audit Committee receives the full tracker, which also includes recommendations that are not overdue. Options are being explored to automate the tracking system by providing wider access to update progress made.

91   There is a separate Legislative and Compliance Register to ensure compliance with legislative and regulatory requirements. It is appropriately reviewed by the Audit Committee twice a year.

92   In our structured assessment report last year, we recommended that the Quality, Safety, and Performance Committee reinstate its arrangements for tracking recommendations relating to the quality, safety, and performance of services made by other inspectorates and regulators. The committee received the new tracker in May 2023. A review was undertaken to ensure that all relevant recommendations

were included since the tracker was last updated in June 2020. The tracker contains the recommendation, the outcome required, proposed actions, oversight responsibilities, delivery date, and summary of progress. (**Appendix 2 R2 2022)**.

Corporate approach to planning

93   We considered whether the Trust has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

94   We found that **the Trust has effective arrangements for producing, overseeing, and scrutinising the development of strategies and corporate plans**. However, **the 2023-26 IMTP does not contain clear objectives which are supported by timescales for delivery and intended measurable outcomes in respect of cross-cutting corporate functions**.

Corporate approach to producing strategies and plans

95   We considered whether the Trust has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision and long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;

- an appropriate Board approved long-term clinical strategy;

- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and

- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

96   We found that **the Trust has effective arrangements for producing, overseeing, and scrutinising the development of strategies and corporate plans**.

97   In last year's structured assessment report, we noted that the Trust had set out a clear vision and strategic goals in its long-term strategy, 'Destination 2033', and suite of enabling strategies. The Trust has separate underpinning strategies for Velindre Cancer Servies and the Welsh Blood Service, which are both framed in the context of 'Destination 2033'. Last year, we reported that whilst 'Destination 2033' and its enabling strategies were available in Board papers, they were not published separately on the Trust's website. 'Destination 2033' was subsequently published on the website in October 2023, although the enabling strategies were published at different points earlier in the year (**Appendix 2 R1 2022**).

98   The Trust has effective corporate planning arrangements. The planning process is coordinated by the Trust's Strategic Planning Team. They are supported by

Planning Managers in each division as well as the Finance Team and overseen by the Executive Management Board. The Trust also involves internal and external stakeholders in developing corporate strategies and plans. Central planning guidance supports the preparation of the IMTP development plans of divisions and enabling services.

99   The Trust's 2023-26 IMTP gave good consideration of the demand for blood and cancer services following engagement with key stakeholders and commissioners. It was also informed by service user feedback. There are numerous risks associated with the delivery of the IMTP and these are well understood by the Trust. Risks include balancing demand and capacity, ability to recruit workforce, staff well-being, increasing capacity and capability to deliver complex transformation programmes, and having sufficient finances.

100   There was good Board-level engagement throughout the development of the 2023-26 IMTP. We found that the Board and the Strategic Development Committee effectively scrutinised and challenged the draft version. The Board formally approved the IMTP in March 2023 and it was submitted to Welsh Government within the required timeframe. The IMTP was prepared in accordance with Welsh Government planning guidance and has appropriate coverage of the Trust's operations for the three-year period. It was approved by the Welsh Government in October 2023.

101   The Trust is undergoing a period of strategic, organisational, and operational change. Changes range from major capital programmes requiring operational changes to service delivery in both divisions; workforce redesign; and the development, enhancement, and implementation of key governance mechanisms. To ensure appropriate prioritisation and resource availability, during 2022 the Trust contracted an external consultant to help design a prioritisation framework to deliver against its strategies. An Internal Audit report on the Trust's priorities (July 2023) gave reasonable assurance on its prioritisation process. It found that the Trust had good governance mechanisms and arrangements for reporting and scrutiny. However, it also found that whilst necessary finances and resources (and associated risks) to deliver individual priorities were considered during the 2023-26 IMTP planning process, enhancements would be necessary in future to consider the deliverability of the priorities collectively.

102   The Trust recognises that in developing the 2024-27 IMTP and future IMTPs, it must ensure that it clearly identifies essential priorities and the collective required resources to deliver these. Following that exercise, a reality check is necessary to determine whether it is possible to deliver non-essential desirable priorities without comprising the essential ones.

Corporate approach to overseeing the delivery of strategies and plans

103 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART milestones, targets, and outcomes that aid monitoring and reporting; and

- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

104 We found that **whilst the IMTP contains clear objectives and actions, supported by timescales for delivery and intended measurable outcomes for blood and cancer services, this is not the case for cross-cutting corporate functions**.

105 In our structured assessment report last year, we reported that the Trust had translated its strategic priorities into specific objectives and supporting actions in the 2022-25 IMTP. Whilst timescales for delivery were set out, we found that the actions did not include supporting intended measurable outcomes. We recommended that in future IMTPs, the Trust should articulate intended outcomes for each strategic objective/action, and how success will be measured.

106 We reviewed the objectives/actions set out in the 2023-26 IMTP. Positively, in respect of Velindre Cancer Service and Welsh Blood and Transplant Services, we found that each objective/supporting action included appropriate measurable intended benefits, and in the main they were measurable. Benefits related to improving user experience and outcomes are not yet measurable because the Trust has not yet agreed performance measures in this area. However, whilst objectives for the corporate and cross-cutting functions (such as digital, workforce, estates, sustainability, and quality) were set out in the IMTP, they were not underpinned by specific actions, and nor were they time-bound or measurable. Whilst accepting that it is not always easy, underpinning objectives/actions with both the intended benefit and how it will be measured would help the Trust to judge whether the intended benefit has been achieved or whether further action is needed (**Appendix 2 R3 2022**).

107 Quarterly progress reports for the 2022-25 IMTP were presented to the Quality, Safety, and Performance Committee and the Board. Progress reports use Red, Amber, Green (RAG) ratings to highlight whether progress is on track, and against each action is a summary of progress to date. Where delivery was off track, in our view, the reports did not give enough detail about the associated impacts and whether remedial actions would bring delivery back on track or a new deadline had been established (**Appendix 2 R4 2022)**.

108 The Quarter 1 2023-2026 IMTP progress report was shared with the Quality, Safety, and Performance Committee in July 2023. However, the report was limited

to reporting progress on objectives/and supporting actions for Velindre Cancer Service and Welsh Blood and Transplant Service. It did not include any of the objectives for the corporate and cross-cutting functions. Given that not all Independent Members attend Quality, Safety, and Performance Committee meetings, consideration needs to be given as to ensuring IMTP progress reports continue to be received by the full Board (as was the case for 2022-25 IMTP progress reports).

109   The Trust recognises that IMTP progress reports need to provide better narrative to explain the resulting impact of both delivered and non-delivered actions on service quality and performance. As the year progresses, the Trust will consider how it provides clarity on whether the intended impacts have been achieved or not (**Appendix 2 R4 2022**).

Corporate approach to managing financial resources

110   We considered whether the Trust has a sound corporate approach to managing its financial resources.

111   We found that **the Trust continues to have good arrangements for financial planning and managing and monitoring its financial position**.

Financial objectives

112   We considered whether the Trust has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of the organisation:

- meeting its financial objectives and duties for 2022-23, and the rolling three-year period of 2020-21 to 2022-23; and

- being on course to meet its objectives and duties in 2023-24.

113   We found that **the Trust met its financial duties for 2022-2023 and is forecasting to break-even in 2023-24**.

114   The Trust met its financial duties in 2022-23, reporting a small surplus of £76,000 at the end of the financial year. The Trust also achieved its statutory financial duty to achieve break-even over the three-year rolling period 2020-23, reporting an overall three-year surplus of £155,000[9]. The Trust spending on capital programmes was in line with the capital allocation.

115   As of Month 6 2023-24 (end of September 2023), the Trust was forecasting a year end breakeven position. However, this assumes that all planned income is

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[9] Of the £76,000 surplus, £64,000 relates to the core Trust, and the remainder to NHS Wales Shared Services Partnership.

received, saving plan targets are achieved, and all financial risks are mitigated during 2023-24.

Corporate approach to financial planning

116 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;

- the Board appropriately scrutinising financial plans prior to their approval;

- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and

- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

117 We found that **the Trust has a sound approach to financial planning.**

118 The Trust's core business Financial Plan for 2023-24 was scrutinised by the Strategic Development Committee in February 2023 and approved by Board in March 2023. The plan acknowledges the financial challenge within its internal and external operating environment. The plan is based on a clear series of assumptions regarding the Trust's expected income from its commissioners, and Welsh Government funding in respect of pension contributions, pay inflation and personal protective equipment. Financial risks to the successful delivery of the plan are clearly set out, as well as the actions the Trust is taking to manage and mitigate against them.

119 For 2023-24, the Trust set a savings requirement of £1.8 million, of which £1 million was recurrent and £800,000 non-recurrent. Of the £1.8 million, £1.28 were categorised as savings schemes and the balance (£530,000) income generating schemes.

120 At the end of Month 4 2023-24, the Trust reported that following an in-depth assessment of savings schemes, several workforce and supply chain schemes had been assessed as non-deliverable. The Trust said that whilst remaining committed to redesigning services to find efficiencies, the ability to enact change is challenging due to the high levels of vacancies and sickness. The ability to find procurement supply chain savings has been affected by both procurement team capacity and market conditions which have seen a significant increase in costs for materials and services.

121 Consequently, replacement non-recurrent schemes have been identified to ensure the overall savings target is achieved, and so the proportion relating to non-recurrent schemes will be larger than originally planned.

122 The Auditor General will be commenting further on the Health Board's approach to identifying, delivering, and monitoring financial savings in a separate piece of work that we will report in the early part of 2024.

Corporate approach to financial management

123 We considered whether the Trust has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;

- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;

- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and

- the organisation's financial statements for 2022-23 were submitted on time, contained no material misstatements, and received a clean audit opinion.

124 We found that **the Trust continues to have good controls for managing the use of its financial resources**.

125 The Trust continues to have effective controls in place to ensure compliance with its Standing Financial Instructions and Scheme of Reservation and Delegation. Work is underway to tighten controls relating to income from private patients. We did not identify any significant control weaknesses from our review of the Trust's 2022-23 financial statements.

126 The Trust continues to report regularly to the Audit Committee on procurement, losses, special payments, and counter-fraud matters to support effective oversight, scrutiny, and challenge. Procurement reports continue to clearly set out the number of Single Tender Actions and Single Quotation Authorisations and the reasons why standard procurement procedures have not been followed.

127 Financial management arrangements are effective. The Trust has set clear budgets and savings targets for each of the divisions and corporate cross-cutting functions. The Trust has a good understanding of its cost pressures which are clearly set out in its Financial Plan. These include issues with ensuring that activity data is fully captured and reimbursed[10], and operational cost pressures that may be greater than could normally be managed through budgetary control pressures or through utilisation of the Trust's reserve. In addition, whilst the Trust has received assurance from the Welsh Government that it will fund the implementation of same day emergency care pathways across Velindre Cancer Services during 2023-24, there has not been confirmation that this funding will be recurrent.

[10] The Digital Health Care Record system was implemented in the Trust in 2022-23, but there have been some issues relating to the accurate recording of all activity data, any activity not captured will not be charged to the Trust's commissioners. At the time of reporting, plans were being put in place to address the issue.

128   In the private extraordinary Board meeting in August 2023, the Trust set out enhanced monitoring arrangements to strengthen internal cost controls in response to the financial challenges faces by NHS Wales.

129   The Trust submitted good quality draft financial statements for audit by the Welsh Government deadline. The Audit Committee considered these on 26 July 2023. Our audit identified no material misstatements, and we issued an unqualified audit opinion.

Board oversight of financial performance

130   We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:

- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and

- the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.

131   We found that **the Trust continues to produce clear and accessible financial reports that support effective monitoring and scrutiny**.

132   The Trust continues to report financial performance at every public Board meeting and Quality, Safety, and Performance Committee meeting. The Trust publishes this information on its website alongside its Board and committee papers. Finance reports provide timely and high-quality information and contain a good mixture of text and exhibits to convey key messages. The reports set out the revenue, capital, and savings position of the Trust, and clearly highlights key financial risks with their associated mitigating actions and cost implications. We have observed good scrutiny and challenge around the organisation's financial position at both Board and Quality, Safety, and Performance Committee meetings.

Appendix 1

Audit methods

Exhibit 2 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods set out.

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following committees: • Quality, Safety, and Performance Committee; • Strategic Development Committee; and • Audit Committee
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • Key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • Key organisational strategies and plans, including the IMTP; • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • Key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • Relevant policies and procedures; and • Reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Element of audit approach	Description
Interviews	We interviewed the following Senior Officers and Independent Members: • Chair of the Board; • Chair of the Quality, Safety, and Performance Committee; • Chief Executive; and • Director of Corporate Governance and Chief of Staff.

Appendix 2

Progress made on previous-year recommendations

Exhibit 3 below sets out the progress made by the Trust in implementing recommendations from previous structure assessment reports

Recommendation	Description of progress

Improving administrative governance arrangements
R1   We found that opportunities remain for the Trust to improve the public availability of key papers and documents on its website. This includes publishing:
   • missing committee meeting papers;
   • the Register for Gifts, Hospitality and Sponsorship and the Declarations of Interest Register; and
   • the ten-year strategy and enabling strategies.
The Trust should establish a clear and robust process to ensure it publishes key papers and documents on its website in a timely and ongoing basis (**2022 Structured Assessment**).
	Completed - See **paragraphs 26**, **34** and **97**.

Reinstating arrangements for tracking recommendations made by external inspection and regulatory bodies R2 The Quality, Safety, and Performance Committee has not received the log which tracks recommendations relating to the quality and safety of services	**Completed** - See **paragraph 92**.

Recommendation	Description of progress
made by external inspection and regulatory bodies since early in 2020. The Trust should immediately reinstate the tracker to enable the committee to oversee, scrutinise, and challenge the progress it is making in addressing both quality and safety recommendations and any relating to performance (**2022**).	
Establishing measurable outcomes for strategic priorities R3 The Trust has translated its strategic priorities into specific objectives and actions in the 2022-25 IMTP (including timescales for delivery). The Trust should seek to articulate the intended outcomes for each strategic objective/action in future IMTPs, including what success would look like (**2022**).	**Ongoing** - See **paragraph 106**.
Enhancing reporting on IMTP delivery R4 The Trust's arrangements for reporting delivery of the IMTP are reasonable, but it needs to better describe the impact the actions are making. The Trust should report on the impact of actions delivered to date to allow the Board to better understand the extent that delivery of the IMTP is making a difference and determine any actions that need to be rolled forward to the next IMTP (**2022**).	**Ongoing** - See **paragraph 107** and **109**.
Improving reporting on the benefits arising from digital investments R5 Whilst there is good reporting on progress in delivering key digital projects and programmes, the reports do not provide an assessment of what difference they are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment	**Completed** - Business cases now provide better clarity of the intended benefits. Digital Reports now show the intended benefits for each digital activity. The Trust is developing a range of digital performance indicators to help measure the

Recommendation	Description of progress
to demonstrate the extent that it is delivering the intended impacts and outcomes (**2022**).	benefits of digital investment and demonstrate their impact on quality, experience, and outcomes.
Board assurance and risk management **R1** The Trust should complete the development of its Board Assurance Framework with pace, ensuring that it is appropriately underpinned by up-to-date risk management arrangements. Specifically, the Trust should: a) review the principal risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new Board Assurance Framework; b) update the Risk Management Framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; and c) provide risk management training to staff and Board members on resulting changes to the risk management framework (2019).	**Ongoing** - See **paragraph 69** to **71**. **Completed** - See **paragraph 75**. **Completed** - See **paragraph 75**.
Clinical audit scrutiny R5a The Quality, Safety and Performance Committee should review and approve clinical audit plans, ensuring that clinical audit plans address any risks to achieving strategic priorities and organisational risks (2018).	**Completed** - The Clinical Audit Plan, covering both Velindre Cancer Service and Welsh Blood and Transplant Service, is received and approved annually by the Quality, Safety, and Performance Committee. The 2023-24 Clinical Audit Plan was approved at its May 2023 meeting. Internal Audit's Velindre Cancer Service Clinical Audit Review (January 2023) gave reasonable assurance, and identified instances where clinical audit was used to mitigate risks. There are appropriate arrangements to identify and approve audits for inclusion in the plan.

Recommendation	Description of progress
Clinical audit scrutiny **R5b** Improvements should be made to the content of clinical audit reports from both VCC and WBS to clearly identify the audit findings, any associated risks and actions for improvement and follow-up (2018).	**Completed** - The annual Clinical Audit Report provides an overview of clinical audit activity undertaken at Velindre Cancer Service and the Welsh Blood and Transport Service Centre. The Quality, Safety, and Performance Committee received the most recent Clinical Audit Report in July 2023. The report includes a summary of each audit, the results/progress made, areas of good practice or improvement identified and recommendations.
Clinical audit scrutiny R5c The Quality and Safety Committee should assure itself that clinical audit findings are addressed (2018).	**Ongoing** - Internal Audit's Velindre Cancer Service Clinical Audit Review (January 2023) found that whilst mechanisms for monitoring action implementation / benefit realisation existed, there were opportunities to enhance scrutiny and oversight at committee level. It is currently unclear how the Quality, Safety, and Performance Committee receives assurance that audit findings are addressed and learning shared. We understand that the Integrated Quality and Safety Group will seek to enhance the triangulation of clinical audit outcomes findings across the Trust and ensure there are appropriate assurance mechanisms and escalation arrangements to the Quality, Safety, and Performance Committee.
Clinical audit scrutiny R5d The Audit Committee should clarify how it assures itself that the clinical audit function is effective (2018).	**Completed** - The Audit Committee received the Clinical Audit Plan and Clinical Audit Report, most recently in April 2023 and July 2023 respectively. Clinical audit arrangements and responsibilities were set out in the Clinical Audit report.

Recommendation	Description of progress
	In January 2023, the Audit Committee also received Internal Audit's Velindre Cancer Service Clinical Audit review.

Appendix 3

Organisational response to audit recommendations

Exhibit 4 sets out Velindre University NHS Trust's response to our audit recommendations

Ref	Recommendation	Organisational response	Completion date	Responsible officer
R1	**Transparency of Board business** The Trust rarely publicises its Board meetings on its social media channels. The Trust should establish a process to ensure more frequent reminders about Board meetings are posted on social media.	The Governance and Communications teams have a pre-Trust board meeting process to confirm the communications plan for promoting the meetings which will include messaging via the Trust's external and internal digital channels. Messages will be promoted two weeks in advance and in the lead up the meeting.	Completed	Director of Corporate Governance and Chief of Staff

Ref	Recommendation	Organisational response	Completion date	Responsible officer
R2	**Transparency of Board business** The Trust does not publicise what is to be discussed in private Board or committee meetings or publish summaries of what is discussed. The Trust should: • include a list of the items to be discussed in private sessions on public Board and committee meeting agendas; and • provide (and publish) brief summaries of private Board and committee discussions.	The refresh of the Corporate Governance Manual includes revisions to the meeting secretariat documentation. • The revised agenda template includes an agenda item, 'Summary from the PRIVATE / PART B Board or Committee meeting held on DD/MM/YYYY' • Brief summary to be included in Chair Report (for Trust Board) or Committee Highlight reports	End of March 2024 End of March 2024	Director of Corporate Governance and Chief of Staff Director of Corporate Governance and Chief of Staff
R3	**Transparency of Board business** Committee minutes are published on the Trust's website when included in papers for the next meeting, usually two months later. The Trust should publish unconfirmed minutes as soon as possible after committee meetings, following accuracy checking, whilst still retaining full confirmation of accuracy by committee members in the following meeting.	The refresh of the Corporate Governance Manual has a timescale for completion of the DRAFT UNCONFIRMED minutes of the previous meeting, which is 16 working days and then five working days to allow for Welsh translation to be able to upload the English and Welsh versions at the same time.	End of March 2024	Director of Corporate Governance and Chief of Staff

Ref	Recommendation	Organisational response	Completion date	Responsible officer
		DRAFT UNCONFIRMED minutes will be published within 22 working days of the Board or Committee.		
R4	**Board and committee reports** In Board and committee cover papers, the summary of previous discussions undertaken in other fora often do not make evident what the outcome was and whether any agreed actions have been implemented. The Trust should establish a process to ensure that summaries of previous discussions include the resulting agreed actions, and whether they have been implemented.	The revised Board/Committee Report Template has a section 'Governance Route' which lists the names of the previous Fora and dates together with a summary and outcome of previous governance discussions. The revised Corporate Governance Manual will be updated to ensure that that the Governance Route section of the Board/Committee Report template is updated to reflect the summary and outcome of any previous discussions by the report author and signed off by the Executive Sponsor/Lead.	End of March 2024	Corporate Governance Manager
R5	**Operational risk assurance** Recent cover papers on the Corporate Risk Register did not include the reasons why some risks are no longer featured. This means that meeting members have no assurance that the	The Risk Register cover paper will include additional tracking information of risks ie: • new with reason for inclusion;	End of January 2024	Director of Corporate Governance and Chief of Staff

Ref	Recommendation	Organisational response	Completion date	Responsible officer
	reason for any omissions is a result of risk mitigation having a positive impact. In future Corporate Risk Register cover reports, the Trust should provide a summary on the reasons why risks have been removed from the Corporate Risk Register.	• removed with justification for removal; and • revised with reason for revision.		
R6	**Board and committee reports** Often, Board and committee cover reports, papers and presentations are operationally detailed, and activity focused but provide less clarity on the impacts of initiatives or actions taken. The Trust should establish a process to ensure that Executive Lead sponsors review to make sure that cover reports, papers and presentations are focused on key issues and impacts.	The refresh of the Corporate Governance Manual is explicit in relation to the responsibilities of the report author and Executive Lead regarding the report content and focus.	End of March 2024	All Executive Directors

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

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	30.01.2023

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 GOVERNANCE AND CHIEF OF STAFF
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the Committee 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 Committee is asked to: • **NOTE** the risks of 15, as well as risks in the

1

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	2.1.2024
Quality, Safety & Performance Committee	16.1.2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

1. **Quality Safety and Performance Committee** in January meeting noted risk register and the development activities listed in section 4. The Committee were in agreement with the decisions and questions raised by Executive Management Board. Further discussion on risk 3125 (as explained on page 4 of this report). A request was also made to ensure that the Datix record was clearly updated in line with the wording in the cover paper, which has been addressed in this version.

2. **Executive Management Board** reviewed in January meeting and decisions and questions raised are articulated in this report.

3. **Audit Committee** had reviewed the November extract in the December meeting and feedback regarding the development activities from the Committee is included in section 4.

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

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

APPENDICES

1	Current risk register data.

1. SITUATION

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

2. BACKGROUND

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

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 7 risks to report to Board and Committee on Datix 14, this includes 4 risks with a current score over 15 and 3 risks with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

Changes since December reporting:

3.2 Risks which were proposed to be closed/ no longer at Board risk appetite reporting levels - and outcome of Executive Management Board consideration

- **3184 – Risk closed - Executive Management Board confirmed agreement with proposal to close:**

  "There is a risk to Velindre Cancer Centre as a result of no Lead Digital Pharmacist in post, resulting in multiple risks for Velindre Cancer Centre and the Trust."

  January reporting update: *Appointment made and in post.*

- **3222 – Risk closed - Executive Management Board confirmed agreement with proposal to close:**

Page 3 of 14

"There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of the Trust."

January reporting update: *Appointment made and in post.*

- **3215 – Risk was proposed to be closed, however Executive Management Board requested further assurance of compliance with all required standards before it could be closed. Therefore remaining open until this assurance is received.**

  "There is a risk that clinical instruction or information may not be received or acted on by primary or secondary care medical colleagues for patient management due to clinical correspondence not being signed off via the Document Management System (DMS)."

  December reporting update: Review of letters complete. Escalation process in place. Harm review completed and no harm identified.

  Further comments through Committee Governance:

  In addition, at the ***December 19th Audit Committee***, it was requested by the Chair of Quality, Safety & Performance Committee that the action plan from the incident be brought to Quality, Safety & Performance Committee, to include clear assurance that this would not be repeated.

  Further discussion at ***January 16th Quality, Safety & Performance Committee*** in Risk Register item and also as separate paper "Patient Administrative Processes." Due to timing of this paper being completed, it was not considered by the January Executive Management Board. Therefore the Committee confirmed agreement that following the Executive Management Board review of this action plan in the next meeting will allow a recommendation on closure of the risk to be reconsidered.

3.3. <u>**Risks which Executive Management Board accepted as appropriate that score not changed during this reporting period:**</u>

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

  "There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work."

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

- **3230 – Risk score remains at 12, expected reduction in January as a result of actions taken**

  "There is a risk to patient safety regarding the referral of patients into VCC, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information caused by the variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care."

  December reporting update: New short-term central management of new patient referrals agreed and will be implemented by end January 2024.

  Executive Management Board confirmed that it still agrees appropriate for risk score to remain at 12 until new process implemented by end January as documented. Executive Management Board also requested that the process would need to be fully evaluated, with assurance being presented to Executive Management Board, before the risk could be proposed to close.

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

  "There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information."

  December reporting update: Audit complete and received at Senior Leadership Team in December - Operational services to oversee Divisional

wide working group to develop plan to develop recommendations and support implementation. Included in draft Integrated Medium Term Plan 2046-27.

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

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

"new Velindre Cancer Centre - There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs."

December reporting update: This risk is expected to decrease in score in next reporting period due to good progress made to Financial Close requirements.

Executive Management Board confirmed that it still agrees appropriate for risk score to remain at 16 until publically reportable (as appropriate with live procurement) governance leading up to Financial Close.

- **3153 – Risk score currently remains at 15, expected reduction in January reporting cycle as a result of actions taken**

"There is a risk to patient safety due to using a Medical Device contrary to the vendors requirements, potentially leading to incorrect patient radiotherapy dose being delivered and patient harm."

December reporting update: Meeting held - Digital / Physics liaison meeting on 06/12/23 for discussion to ensure all parties fully understand the risk. Actions agreed and will be implemented by end December - this would then reduce the risk for January reporting if implemented as planned. No performance issues had been raised with the Digital Service Desk since the risk was originally raised. Confirmed on 7/1/24 that exclusions to real time scanning have been applied in line with requirements from the manufacturer of the medical device. This is now therefore expected to go through January Senior Leadership governance and propose to be closed/ score reduced for February Executive Management Board consideration (and onwards reporting to Quality, Safety & Performance Committee in March).

3.5   Risks which Executive Management Board requested further review

- **Risks 2187 and 2515 – both at score 15 – Executive Management Board in December requested further review at February Executive Management Board**

  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."*

  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."*

  Velindre Cancer Services team will ensure Datix updated to ensure clear update to evidence risk being actively managed. The Team advised that the Velindre Cancer Services Senior Leadership Team discuss regularly and currently there has not been sufficient progress which would reduce risk scores.

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

Matters 1 – 7 were reported to the Trust Board on 30th November.

Matters 8 and 9 were recommended from the Trust Risk Group and supported by Executive Management Board in December.

Matter 10 was raised at December Audit Committee.

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe/ Update	Status to report in January reporting cycle
1	Risk scores and target risk scores	Following Executive Management Board review and Divisional Leadership Team	December- January reporting cycle	**Closed** – updated in December Audit Committee and in this paper for

		work, a number of scores were challenged and are being reassessed through the December- January cycle		January reporting cycle
2	Digital Risks	Separate paper to be brought back on the enterprise digital risk landscape to the next Committee meeting.	January Quality, Safety & Performance Committee	**Closed** – On January Quality, Safety & Performance Committee agenda
3	Administration systems and processes	This will be considered by the Divisional leadership teams and appropriate risk(s) articulated and scored	December- January reporting cycle	**Closed** – No further risks proposed by SLT following consideration
4	15 level risks are related to workforce issues in Velindre Cancer Services – triangulated to TAF 03	Workforce Risk 03 will include this in next review	December- January reporting cycle	**Closed** – addressed in TAF 03
5	Formatting of report to be clear on active risk management in the period	New updates from Datix are included in this cover paper as well as in a separate column in the Risk Register appendix	Addressed in this paper	**Closed** – cover paper style re-vamped and positive feedback in December Audit Committee
6	Datix information for risk 2515 required updating	Updated since November Quality, Safety & Performance Committee	Addressed in this paper	**Closed**
7a	Assurance level considerations by Audit Committee	Active risk management has resulted in a number of scores being reduced	December- January reporting cycle	**Closed** – Audit Committee confirmed that due to progress made in

		however not yet evidence of impact of actions on remaining risks – This will be further addressed and challenged in next period and explicit comment from the Executive Management Board (EMB) will be included for the next report – to demonstrate why EMB is comfortable with the current risk score or if not, what action is being taken.		December reporting cycle that Assurance Level could remain at 2
7b	Assurance level considerations by Audit Committee	In addition, any decrease in scores which result is no longer being currently reported at Trust Board level will be summarised for the next report in a separate table in the cover paper also.	Current risks have been reviewed against the previous report. There are no risks which have reduced to a level below that reportable to Trust Board.	**Closed** – now included in re-vamped style of cover paper
Recommendations from Trust Risk Group				
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	March (for Trust Board approval) March	Deep dive work underway for March cycle reporting.

		review categorisation		
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	March reporting cycle	Process discussed with Risk Group to be implemented for March Board cycle reporting
Requested by December Audit Committee				
10	Risk report to track overall number of risks at different scores in Datix	To action for March reporting cycle	March reporting cycle	

Next Steps in Engagement and Embedding

As of 23rd January 2023 an Introduction to Risk training has a completion rate of 78% across VCS, WBS and Corporate.

As the initial six month initial completion deadline (end November) has now passed, work is being undertaken with managers to ensure completion of level one training, as well as sharing the training through Trust wide communications. Target of 85%.

5.   IMPACT ASSESSMENT

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

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

RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains.
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required
	There are no socio economic impacts linked directly to the current risks in paper.

TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item.
	There are no direct well-being goal implications or impact in the current risks in this paper.

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

	Click or tap here to enter text.

6. RISKS

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

APPENDIX 1

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

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

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Progress Update	Risk Type	Opened	Division	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	ACTION Due date	ACTION Description	Risk Trend Graph
3153	There is a risk to patient safety due to using a Medical Device contrary to the vendors requirements, potentially leading to incorrect patient radiotherapy dose being delivered and patient harm.	There is a risk to patient safety due to using a Medical Device contrary to the vendors requirements, potentially leading to incorrect patient radiotherapy dose being delivered and patient harm. We use a package called ProSoma (which is a Medical Device) for creating target volumes and treatment plans as part of the Radiotherapy pre-treatment process. The manufacturer has supplied lists of folders to exclude from real time anti-virus scanning to avoid interfering with the correct operation of the software. Digital have implemented real time scanning of these folders contrary to the advice of the manufacturers and Medical Physics Experts in Radiotherapy.	- Advised Digital of the manufacturer requirements and the radiation risks to patients from realtime scanning. -Regular 'liaison' meetings between RT Physics and digital are in place to ensure any future system upgrades are planned in line with manufacturer recommendations and ensure the risk to immediate patient safety / the radiation risks are considered in addition to the risk of cyber attack. There is still significant risk from Prosoma radiation incidents.	Confirmed on 7/1/24 that exclusions to real time scanning have been applied in line with requirements from the manufacturer of the medical device. This is now therefore expected to go through January Senior Leadership governance and propose to be closed/ score reduced for February Executive Management Board consideration (and onwards reporting to Quality, Safety & Performance Committee in March). 18/10 Update: Kept risk at 15 until Digital confirm that realtime antivirus scanning of these folders has ceased. Will update risk as soon as have confirmation. It is Physics understanding that realtime scanning of these folders is still happening, risk to remain at 15. Some incidents have been reported whereby saving of patient scans and delineated tumour volumes has not been possible, thus impacting the patient pathway. The full detail of these incidents are to be submitted as Datix incidents to enable appropriate investigation.	Safety	12/07/2023	Velindre Cancer Centre	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	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	1- Negligible	1	30/11/2023		Jan 2024 update: Actions being taken as per progress column. 6/12 update - Meeting held - Digital / Physics liaison meeting on 06/12/23 for discussion to ensure all parties fully understand the risk. Actions agreed and will be implemented by end December - this would then reduce the risk for January reporting if implemented as planned. No performance issues had been raised with the Digital Service Desk since the risk was originally raised.	3156
3227	new Velindre Cancer Centre - There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs.	changes during the design development process lead to a design which costs more overall, increasing project costs.	1.Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial boot camp 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	Risk increase is due to Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury.	Financial Sustainability	16/10/2023	Transforming Cancer Services	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	31/10/2023	14/12/2023	Jan 2024 update: This risk is expected to decrease in score in next reporting period due to good progress made to Financial Close requirements.	3227
2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks. Inadequate staffing may result in: - Patient treatment delay and breaches - Key projects not keeping to time with an impact on radiotherapy capacity e.g. commissioning and implementation of IRS systems, system upgrades of essential radiotherapy software and hardware - Suboptimal patient treatment - either due to lack of planning time or lack of developmental time - Radiotherapy treatment errors; individual patient errors or errors affecting multiple patients due to insufficient developmental, commissioning or training time, or too few staff with the specialist skills required. This staff group comprises highly trained, specialist scientific and technical staff key to ensuring quality and safety of radiotherapy treatments. The Engineering Section in particular is identified as an area of risk to the radiotherapy service, with 2 recent retirements and an additional 4 engineers due to retire within the next 4 years. Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include I. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. RTDS data submissions v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. The risk rating did reduce to 10 following recruitment of surge posts but has since increased to 15 as the number of Physics posts required for the implementation of the IRS is significantly greater than the posts recruited to, with the resource gap being filled by staff within the service.	A comprehensive 5 year workforce plan is underway to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC. This includes recruiting to the 13.5 posts within the satellite centre business case and additional posts for the IRS commissioning schedule at nVCC. Financial support of the workforce plan will be required to enable the target risk rating to be achieved. A process of continual prioritisation of business critical tasks is in place and it is ensured that detailed project and resource plans are kept up to date. Every occurrence when developmental / IRS work is put on hold to meet urgent radiotherapy treatment planning demand is being logged.	Safety	14/09/2020	Velindre Cancer Centre	Expected - Will occur/reoccur and likely to be frequent.	5 - Critical	25	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Unlikely - Not expected to occur/reoccur but there is some possibility.	5 - Critical	10	29/12/2023 30/11/2023	31/10/2023	Jan 2024 update: Velindre Cancer Services team will ensure Datix updated to ensure clear update to evidence risk being actively managed. The Team advised that the Velindre Cancer Services Senior Leadership Team discuss regularly and currently there has not been sufficient progress which would reduce risk scores.	2187

2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service.	Service provision across all specialties is managed by careful examination of rotas and managing leave within the teams.	Options appraisal to be delayed due high current service demand.

Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service.

Clinical Oncology:
There is one ARSAC Practioner Licence holder in urology and two in gynaecology and this is recognised as position of low resilience.
A Speciality Doctor was appointed from Prostate Expansion Business case is currently working with Breast SST

Radiotherapy:
Not all Brachytherapy Advanced Practioners can cover all tasks required within the section to provide resilient service cross cover.
Time demands from DXR administration and treatments conflict with brachytherapy service provision and training.

Theatre:
One member of the team is currently on long term sick. Return to work due May 2023.

Physics:
Currently two Brachytherapy MPEs appointed. A recent resignation (April 2023) of a staff member in MPE training and one MPE due to start maternity leave in July 2023 has left the service vulnerable to a future MPE single point of failure. This could lead to service discontinuity.

Service provision across all specialties is managed by careful examination of rotas and managing leave within the teams.

Clinical Oncology:
One Consultant Oncologist in Urology is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted.
A locum Consultant Clinical Oncologist was appointed in Nov 2022 is currently in Brachytherapy training. Previous experience in brachytherapy will expedite local training. On completion she may practice under Delegated Authority (September 2023) with the aim to apply for an ARSAC Practioner Licence.

Radiotherapy:
Four Brachytherapy Advanced Practioners (3.2WTE) were appointed in October 2022 to address lack of resilience within the team.
A training schedule for staff is in place to ensure increased resilience from cross cover of tasks.
A plan for capacity/demand management and to handover DXR administration tasks to RT is under construction. Timeframe not established. DXR treatments to be handed over with introduction of nVCC.

Theatre:
Staffing hours have been increased (March 2023) to improve resilience of the service provision. Training plans are under consideration to further increase resilience through cross cover of tasks.
Vacant HCA post was filled (March 2023).

Physics:
A training plan is under implementation to increase the number of Brachytherapy MPE and Registered Clinical Scientists competent to perform MPE duties under written guidelines and supervision. Resourcing this plan has been recognised within Radiotherapy Physics at the highest priority level to ensure a safe and continued service.

Future Planning:
An options appraisal is to be agreed through the Brachytherapy Operational Group (May-2023) to determine the most appropriate service model to meet forecast demand over a 1 to 5 year period. A workforce paper will be drawn up to staff the model to include resilience and succession planning. A business case will be submitted if required.   Staff model completion due September 2023

Options appraisal to be delayed due high current service demand.
The current on resources to support the shift to a paperless radiotherapy service required for the satellite centre (due for completion by May 2024) and ongoing IRS demands.
Options appraisal review delayed until early 2024.

Performance and Service Sustainability	09/02/2022	Velindre Cancer Centre	Probable - Will probably occur/reoccur but will not be a persistent issue.	5 - Critical	20	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Unlikely - Not expected to occur/reoccur but there is some possibility.	5 - Critical	10	30/12/2023	30/09/2023

31/07/2023

Jan 2024 update: Velindre Cancer Services team will ensure Datix updated to ensure clear update to evidence risk being actively managed. The Team advised that the Velindre Cancer Services Senior Leadership Team discuss regularly and currently there has not been sufficient progress which would reduce risk scores.

2515

15   15   15   15

AUG   OCT   NOV   CURRENT

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Progress Update Since Last Governance Cycle	Risk Type	Opened	Division	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	ACTION Due date	ACTION Description	Risk Trend Graph
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	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	Meeting took place to review the risk with the senior WOD SLT and Exec Director. Confirmation was received that the Healthy and Engaged Workforce Steering Group is the meeting to oversee this risk and to review on a quarterly basis	Safety	09/12/2022	Corporate Services	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	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	31/12/2023	31/03/2024	Jan 2024 update: Healthy and Engaged Steering Group to agree arrangements to monitor and evaluate wellbeing interventions	3001 trend graph (12, 12, 12, 12, 12) AUG SEPT OCT NOV CURRENT
																		22/12/2023	Jan 2024 update: The Trust needs to use evidence to determine what the organisational factors are that are impacting on levels of stress on individuals. These factors need to be understood and communicated. Plans in those areas of work already in place need to be aligned to this risk or new plans developed. The work plan derived from this should sit under the 'Building Our Future Together' Portfolio.	
																		31/04/2024	Jan 2024 update: Divisions/Departments should have proactive stress risk assessments	
3230	There is a risk to patient safety regarding the referral of patients into VCC, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information caused by the variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care	Multiple methods for the communication of new patient referrals to Velindre Cancer Centre	Monitoring the receipt of paper and electronic communications specific to new patient referrals to ensure timely actions to be taken.	Standard referral form in draft. Links with the Digital Team established to look at e-form solutions. Central e-mail box set up in readiness. Meeting with DHCW to be scheduled to review the e-referral solution (Hospital to Hospital). Demonstration Recording shared for background/further information to support discussion.	Safety	19/10/2023	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	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very low risk	4 - Major	4	45260	31/01/2024	Jan 2024 update: New short-term central management of new patient referrals agreed and will be implemented by end January 2024	3230 trend graph (12, 12) OCTOBER NOVEMBER
																		31/12/2024	Electronic Solution (Long Term)	
2465	There is a risk to patient safety caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	There is a risk of severe harm due to the excessive use of email both internally and externally to the Trust. This is because processes and procedures are not carried out in a manner that is appropriate. in particular, emails containing time critical clinical information is being sent to and received by individuals who may not be in work. The impact is severe harm, which may result in National reportable incidents.	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal audit of the underlying causes of this risk is underway. Reporting to VCC SLT is required on a regular basis in order to provide assurance that the issue is being addressed.	In interim work has commenced to move to centralised email boxes by SST for clinical issues. Communication to highlight all urgent request should not use email as means of communication, clarified with key areas eg. SACT, Med sec roles and responsibilities and to not send emails 'just in case'.	Safety	05/11/2021	Velindre Cancer Centre	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	Unlikely - Not expected to occur/reoccur but there is some possibility.	2 - Minor	4	29/12/2023	09/10/2023	Jan 2024 update: Audit complete and received at Senior Leadership Team in December - Operational services to oversee Divisional wide working group to develop plan to develop recommendations and support implementation. Included in draft Integrated Medium Term Plan 2046-27.	2465 trend graph (16, 16, 16, 12, 12) JULY AUGUST SEPTEMBER OCTOBER NOVEMBER

TRUST BOARD

Trust Assurance Framework

DATE OF MEETING	30.1.2024

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

| EXECUTIVE SUMMARY | A review of the Trust Assurance Framework, including a refresh of the Strategic Risks has been undertaken and this paper proposes approval by Trust Board.

The Quality, Safety & Performance Committee and the Strategic Development Committee have endorsed the Strategic Risks for approval in the January Committees. |
|---|---|

RECOMMENDATION / ACTIONS	The Committee is asked to **ENDORSE** the Trust Assurance Framework for Trust Board approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Audit Committee (risks 1-6) - Noted	19.12.2023
Executive Management Board – Endorsed	2.1.2024
Quality, Safety & Performance Committee – Endorsed	16.1.2024
Strategic Development Committee – Endorsed	18.1.2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

- Of the refreshed Trust Assurance Framework risks, risks one to six were included in the November cycle of governance for noting. It was agreed in the **December Audit Committee** to present the full set of eight to the Trust Board when completed in January 2024.

- In **November and January Quality, Safety and Performance Committee** it was discussed and agreed that there needed to be alignment to the Integrated Medium Term Plan goals and then triangulation against the progress on these goals is an important element of first line of defence assurance. This is now included in TAF 06 as a key control and associated action.

- Prior to the **January Quality, Safety and Performance Committee**, the Committee Chair provided detailed feedback on each of the refreshed Strategic Risks. These have been completed by Executive Leads. This feedback was also shared with members of the Strategic Development Committee to provide opportunity for any further feedback to be incorporated into this version. Further feedback will now be incorporated on an on-going basis once approved as a baseline position.

7 LEVELS OF ASSURANCE
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	*Report for Noting*

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

1.   SITUATION

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

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

The revised Trust Assurance Framework is appended.

2.   ASSESSMENT

2.1   Following the Strategic Risk Refresh the outcome is included in Appendix 1.

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

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

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe
1	Populate refreshed TAF on Bower BI template	Work completed in background on Power BI	March reporting cycle

		and refreshed information to be populated from March reporting cycle.	
2	Finalise template for remaining two newest TAF risks – TAF 07 and 08	Work continued to progress well since Quality, Safety & Performance Committee with Executive leads.	**Closed** – Included in this paper
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Progress made since Quality, Safety & Performance Committee – with the Risk & Assurance lead working with the Planning team to map and then populate with Executive leads at next review.	March reporting cycle
4	Deep dive of two risks at Quality, Safety & Performance Committee going forwards	Following reporting of refresh framework of strategic risks, this will recommence from the next reporting cycle.	March reporting cycle
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional Leadership and senior management as a valuable management tool c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions and responsibilities. This may including further Board development time etc.	December- April, in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

3.   SUMMARY OF MATTERS FOR CONSIDERATION

The Committee are asked to:

- Consider and **ENDORSE** the Strategic Risk Refresh, as detailed in Appendix 1 of this report.
- **NOTE** the next steps, both in respect of governance and operationalisation, as detailed in section 2.2 of this report.

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*	**Choose an item** All Strategic Risks are related.	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).
	All domains are relevant to this work, as the strategic risks span all areas of the Trust business and are imperative to quality and safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected:

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

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risks are detailed in the new Trust Assurance Framework dashboard.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Action plans for strategic risks are included in the Trust Assurance Framework Dashboard.

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

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

SECTION 4							
ASSOCIATED OPERATIONAL RISKS - According to risk appetite							
DATIX RISK REF	**RISK TITLE**					**CURRENT RISK**	**RISK TREND**
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.					15	Risk Decreasing

SECTION 5							
SMART ACTION PLAN							
Action Ref	**Action Plan**	**Owner**	**Assurance Level**	**Due Date**	**Progress Update**	**Date of Update**	**Impact of Changes on Risk**	**When the action is complete, detail the impact on assurance level/control**
A1	Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	IA	Jul-25	National oversight group is currently discussing with CAV in light of new supplier for All Wales LIMS soplution.	14.11.23	No current funding route idetified within LIMS and may be identified as a core recommendation through Infected Blood Inquiry (IBI).	
A1.1	Working with DCHW to support the Blood Transfution Model of the new All Wales LIMS 2.0 , Track Care Lab Enterprise (TCLE).	Lee Wong	IA		Discussions ongoing about funding solutions	14.11.23		
A2	Blood Health National Oversight Group key work streams are underway identifying inappropriate use of blood.	Lee Wong	PA		Ongoing work under the remit of the BHNOG to support patient blood management initiatives, including - preoptimisation of anaemia patients - Intraoperative cell salvage (ICS) - Quality insights QS138 Audit (NICE standard, ongoing audit tool to monitor patient blood management quality standards) - Appropriate use of OD neg red cells - Appropriate use of platelets	14.11.23	All Wales programmes which will ensure equity of care for patients.	
	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 on commencing role ?Dec 2023			

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

						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				X	PE	Linked through performance framework	IA	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in	PA	Strategic Development	PA	Regulatory scope re MHRA tbc; clear	E
3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	PA	Strategic Development	PA	Wales Audit Office	E
4.1	South Wales Collaborative Cancer Leadership Group system			X		PE	Agreed to model for next phase	IA	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards			X		E	Agreed to model for each organisation	PA	Strategic Development	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

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further	First line and second lines of defence assurance are in place to a certain extent	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.4	Development of Phase 2 of PMF with additionalperfromance measures/quality metrics	Carl James	Mar-24	Design stage commenced		Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce	Programme outputs to be confirmed	Programme established and staff on-boarded	09/11/2023	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liason)	tbc	1. CEO agreement to Cancer programme sept 23 2. CEO lead identiifed 3. Programme Manager and resources partially identied 4. Commencement of programme (tbc)	target date Feb 2024 (tbc by CEOs	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase
1.7	WG review of NHS Wales strategic management / accountabilioty arrangements will potentially identify how	Carl James	April/May 2024	Trust received request to feed into the review process	22-Dec-23	Unknonw at this state	The level of assurance should increase
1.8	Trust included in SE Wales regional strategic planning programme (for wide range of services i.e. not only cancer (e.g. diagnostics etc)	Carl James	tbc subject to the programme dates	Chief Executive/Executive Director of Transformation/Executive Medical Director attended regional workshop to discuss shape of programme/strategic aligment on 6th December 2023	22-Dec-23	Anticipated it will reduce the level of risk regarding strategic mis-alignment between the Trust/partners and the wider healthcare system	The level of assurance should increase

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / SOURCES OF ASSURANCE

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

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	IA	Mar-24	The annual workplan has been reviewed at the Healthy and Engaged Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff.	21/12/2023	Plan is moniitoted via Health and Engaged Steering group and plan in place until March 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	Mar-24	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB	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	Mar-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy	21/12/2023	Presenting update to EMB Shape on 18.12.2023	
1.6	Development of a Trust Retention Plan	Susan Thomas	IA	Feb-24	Retention plan to be developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly	21/12/2023	Appointed Nurse Retention Lead who is developing a plan which will be updated to EMB in February 2024.	
1.7	Review Exit Interview Process	Susan Thomas	IA	Feb-24	Task and Finish group to consider Exit interview process	21/12/2023	T and F group piloting improved processes to be finally implemented in Feb 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)

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

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	Development of 3rd Line of defence assurance to be completed	
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

	SMART ACTION PLAN							
Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		Mar-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message.	21/12/2023		
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley		May-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey will be distilled to further develop our work programme	21/12/2023		
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley		Feb-24	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023.	21/12/2023		
1.4	Implementation of the Speaking Up Safely Framework	Sarah Morley		Mar-24	The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. An initial exercise on Employee Voice is being undertaken to gain a baseline on speaking up safely which will link with the ongoing listening exercise within the Trust. An Independent Member Champion in this work has been identified to ensure effective scrutiny and oversight. The full implementation of the framework is expected by March 2024. Updates will be reported via EMB Run.	21/12/2023	A programme of work is in train with three work streams, leads attached. The programme will provide an update in March 2024.	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		E						
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS, EPMA	Chief Digital Officer		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital Officer	X			PE	Staff feedback - KLAS Survey	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board Digital IMTP	IA	EMB Shape / EMB Run	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ Centre for Digital Public Services	PA
C7	Digital inclusiion in wider community	Chief Digital Officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales	Not Assessed
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			PE	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting Digital Programme Board	PA	EMB Shape / EMB Run / Cyber Action Plan	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C11	Trust digital Governance	Carl James		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	Wales Audit OfficeSIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital Officer			X	PE	Review via Divisional SMT/SLT	PA	EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C13	Cyber Assurance Controls in place	Chief Digital Officer			X	PE	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	PA	EMB Shape / EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS	PA
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE	Digital Programme Board Digital Design Authority being established	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Agreed Digital Inclusion plan - C4,C7	Assurance Arrangements for Digital Architecture will need to be established - intent would be to use Strategic Devleopment Committee	
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority is in the process of being set up	Data and Insight prioritisation as this becomes part of the Digital Services team	
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND

3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.	15	Cyber Security Manager has been recruited and has started at the Trust - risk will be closed post induction.
92	There is a risk to COMPLIANCE as a result of the inadequate oversight of supplier contracts, procurement governance etc., leading to difficulties in complying with internal governance for contract management, renewals and procurement activity.	12	Risk trend is increasing with capacity constraints in the procurement teams supporting the Trust
R022 (EPMA)	There is a risk that there will not be a resource available from the Pharmacy team to both lead and support the evaluation panel activities (before and during) from a clinical perspective, caused by staff shortages, resulting in slippage of timescales in publishing and awarding the supplier	16	Lead Digital Pharmacist has now been recruited with the expectation that the risk will trend down to target
R008 (BECS)	There is a risk to QUALITY as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform leading to degradation of critical WBS (NHS Wales) supply chain activities	20	Commercial agreement on BECS contract established with Trust Board - Business case underdevelopment - Risk will remain high until funding is secured.
R008 (WHAIS)	There is a risk that the LIMS solution will not support the required interactions between WHAIS and WBMDR because commercial H&I solutions are not designed to support an integrated donor registry. If no workaround is identified this would prevent WHAIS from being able to maintain its current HSCT clinical services.	20	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. This includes identifying the future relationship between WHAIS and WBMDR. Appropriate requirements will be stimulated in the URS.
2651	There is a risk to Financial Sustainability as a result of the introduction of a new interfacing policy by MAK-System for devices connected to ePROGESA, leading to organisational cost pressures, reputational damage and/or delays in realising IMTP and other strategic benefits.	12	Additional funding needs to be made available for a Blood Establishment Computer System re-procurement through to 2027

SMART ACTION PLAN							
Action Ref	Action Plan	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

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	Nov-22	Digital Programme has now been established from Oct '23 Now meets on a bi-monthly basis	Dec-23	As the Programme continues to develop the overall level of risk should reduce by reducing the likelihood scores	The level of asurance should increase.
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	IA	Feb-23	Digital Programme has now been established from Oct '23. This includes a Digital Design Authority to oversee the reference architecture. The Digital Strategy has now been published and a draft infsrastructure strategy (reference architecture) is available.	Dec-23	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.	The level of asurance should increase.
1.3	Approve the Digital Inclusion plan so that it can be used as the control point	Chief Digital Officer IA		Feb-24	Non-Recurrent Revenue has been made availanble to support the creation of the plan	Dec-23	improvement in the position on C7	The level of asurance should increase.
1.4	C13 - Embed new Head of Cyber Security	Chief Digital Officer IA		Mar-24	Head of Cyber Security has been appointed from Dec	Dec-23	Dedicated post now in place to lead on cyber - will still be a single point of failure	C13 to move to Effective
1.5	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Chief Digital Officer IA		Apr-24	Assistant Director of Data and Insight starts in post on 3rd Jan 24. Future model for Data and Insight to be established	Dec-23	Will contribute to reduction in likelihood of risk	C9 would move to Effective
1.6	Identify external benchmark / standards for the Digital Services (e.g. ISO27001 ./ ITIL)	Chief Digital Officer IA		Apr-24	Will start with identification of standards for Digital Service (through new ITSM tool) and Cyber Security	Dec-23	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice
1.7	Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment	Chief Digital Officer IA		Mar-24	To be reviewed at March EMB	Jan-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	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	Apr-24	Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work progressing well through 2023/24, final analysis of progress to be confirmed and agreed in February 2024 Board Development session	18.1.24	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	18.1.24	Requirement for C7 to be put in place
3.0	Revised reporting mechanism to be developed	Lauren Fear	4	Apr-24	Project TAF 3.0 within the GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams. Good progress made however further embedding required with Senior Leadership Teams.	18.1.24	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	18.1.24	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	Apr-24	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	18.1.24	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	Apr-24	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	18.1.24	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	Cath O'Brien	**RISK THEME**	Patient Outcomes	

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)			X								
C2	Capacity and demand planning and forecasting	Interim Director VCS / COO					As per TAF 01 C12					
C3	Multiprofessional Workforce Planning	Interim Director VCS / Director OD & Workforce	X	X		NE	Velindre Cancer Service Senior Leadership Team	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C4	Quality and safety monitoring (Via PMF)	Interim Director VCS / Exec Director Strategic Tranformation, Planning and Digital / Exec Director Nurisng, AHP & HCS			X	NE	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	NE
C5	Pathway delivery programme/Service Improvement Programmes: focus on delivery against national optimum pathways, reduction in variation, quality & safety priorities (via the Safe Care Collaborative), realignment of roles and responsibilities ensuring patients remain at centre of service delivery (also see TAF 01)	Interim Director VCS / COO	X			PE	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C6	Effective processes in place to capture patient experience, ensuring effective listening and learning	Interim Director VCS / Exec Director Nursing, AHP & HCS			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C7	Mortality review process and monitoring	Interim Director VCS / Exec Medical Director			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C8	Patient reported outcome monitoring (SST level to Board)	Interim Director VCS / Exec Medical Director / Exec Director Finance			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C9	Velindre Oncology Acadamy establishment	Exec Director Nursing, AHP & HCS	X	X		NE	VOA Implementation Group	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C10	Clinical audit process and systems in place	Head of Nursing / CD VCS / Exec Medical Director	X	X	X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C11	Quality & Safety Tracker (improvement monotoring)	Interim Director VCS / Exec Director Nursing, AHP & HCS		X	X	NE	VCS Quality & Safety Group / VCS SLT	NA	Integrated Quality & Saefty Group / Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Service level to Board monitoring of national standards delivery eg. NICE		A1
Service level to Board intergrated dashboards		A2
Patient reported outcome measures across all SSTs, with service level to Board reporting		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	20/01/2024	Change will reduce risk through having enhanced mechanisms to implement new clinical changes in a timely manner	
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.	20/01/2024	Change will reduce risk by having effective mechanisms to ensure that identified quality and safty improvements have been implemented and had the desired impact	
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	08/01/2024		
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	TBC	Working Group established within VCS, Lead by the VBHC Team & external company PCS	08/01/2024		
A5	Single electronic patient referral system into the Cancer Service to be developed and implemented	Interim Director VCS / Head of Operations VCS	1	TBC		08/01/2024		
A6	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Interim Director VCS / Head of Operations VCS /	1	TBC		08/01/2024		
A7	Recommendations from SACT treatment helpline peer review to be fully implimented	Interim Director VCS	0	TBC	SACT telephone helpline improvement project underway (revised triage tool and escalation process implimented) External SACT treatment helpline peer review undertaken December 2023 - report expected January 2024	20/01/2024	Change will reduce risk by further enhancing safety of the SACT Telephone helpline	
A8	Transformational multi professional workforce plans across all areas of the cancer service	Director OD & Workforce		TBC		08/01/2024		
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 Transfromation, planning, performance and digital	0	TBC	Data tool in development, system validation issues identified	20/01/2024	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	
A10	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	Aug-24	Benchmarking undertaken and Trust process being drafted based on benchmarking outcomes and review of national standards	20/01/2024	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	
A11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corportae Governance	1	TBC	Project group being established, project leads identified. Trust wide Q-Pulse system procured	20/01/2024	This enhanced document management system will reduce risk by having far greater governance in respect of SOP's, policies procedures, guidelines etc	
A12	Implementation of the patient engagement framework	Director Corporate Governance e	2	TBC		08/01/2024		
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.	20/01/2024	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effectve prioritisation and decision making	
A14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	Strategy under development following extensive engagement. Draft strategy will be developed by March 2024, followed by consultation period. .	20/01/2024	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	

| 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 | | 20/01/2024 | Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways | |

SECTION 1

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

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E	Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE	Directorate Level Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE	Divisional Senior Leadership Teams, reports	not assessed	Executive Finance Reports; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	PA	Internal Audit / External Audit	PA
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	PA	Welsh Government / NHS Executive (FP&D) / External Audit	PA
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE	Directorate Level Budget holders, reports and training	not assessed	Collective Commissioning Group LTA reporting	IA	LHB Commissioners	IA
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planing & Digital	X			PE	Executive Budget Holders / Programme SROs	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	not assessed	LHB Commissioners / Welsh Government / Internal Audit / External Audit	IA
FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			E	Executive Budget Holders / Programme SROs	not assessed	Trust Board and Committees	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X			PE	Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	not assessed	Trust Board and Committees; Delegated Financial Limits	PA	Internal Audit / External Audit	IA
FSLTV11	Value Based Healthcare programme	Executive Director of Finance / Executive Medical Director	X			PE	Value Based Healthcare project leads; VBH programme SROs	not assessed	Value Based Healthcare steering committee / Executive Management Board	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Requisitioners / Budget Holders	not assessed	Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	PA	Internal Audit / External Audit	PA
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Budget Holders; Private Patients lead; reports	not assessed	Debtors Reporting; Senior Finance Team;	PA	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit	PA

Ref	Title	Owner					Sources of Assurance		Assurance			
FSLTV14	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting			X	E	Budget Holders; Heads of Division; Divisional Directors	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Fixed Assets Register Reporting	PA	Internal Audit / External Audit	PA
FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	PE	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board	IA	Internal Audit / External Audit	IA
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations		X		E	Budget Holders, reports and training	not assessed	Counter Fraud Reports; Audit Committee	PA	Internal Audit / External Audit	PA
FSLTV17	Tax management	Deputy Director of Finance / Head of Financial Operations			X	E	Budget holders, requisitioners, reports and training	not assessed	Financial Operations Team; VAT working group	PA	External Advisory (EY) / Internal Audit / External Audit / HMRC	PA
FSLTV18	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			PE	Exec Directors, Divisional Directors, Budget Holders, reporting and training	not assessed	Procurement Compliance reporting; Audit Committee	PA	Internal Audit / External Audit	IA

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3227	There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs. [Note added here outside of Datix that this relates to nVCC]	16	Risk Increasing

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
F1	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / EMD / COO	4	Ongoing	VBH Programme of work under way overseen by the VBH Steering Group, including WBS Pre-Operative Anaemia project; Value Intelligence Centre and Food Mission	Dec-23	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.	Dec-23	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	Dec-23	Strengthened control procedures will support risk mitigation	tbc
F4	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Sep-24	Criteria have been drafted and Board Reporting Template updated to reflect types of initiatives and sources of funding available for investments	Dec-23	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	tbc
F5	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	4	Mar-24	Cardiff Cancer Research Hub market engagement exercise to identify potential sources of external funding to support development. Strengthening private patient cash collection and pricing	Dec-23	Attracting external / alternative sources of income will decrease pressure on WG allocation of funds	tbc
F6	Develop Scheme of Delegation and Governance Framework for the nVCC	EDoF / DDoF	4	Jun-24	Scheme of Delegation and Governance Framework was approved in June-23 by the Trust Board. The first major programme this has been applied to is the IRS programme. A Scheme of Delegation and Governance Framework needs to be developed for nVCC	Dec-23	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	tbc

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Service Capacity**	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.	**Cath O'Brien Rachel Hennessey Alan Prosser**
02	**Partnership Alignment**	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.	**Carl James Nicola Williams Jacinta Abraham**
03	**Workforce Supply and Shape**	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.	**Sarah Morley**
04	**Organisational Culture**	There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes.	**Sarah Morley**

05	**Digital Transformation**	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	**Carl James**
06	**Organisational and Clinical 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.	**Lauren Fear**
07	**Patient Outcomes**	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.	**Nicola Williams Jacinta Abraham Cath O'Brien**
08	**Financial Sustainability**	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.	**Matt Bunce**

DEFINITIONS

CONTROL EFFECTIVENESS

Effective	Control in implemented/ embedded; working as designed; with associated sources of assurance	E
Partially Effective	Some aspects of control to be implemented/ embedded; some aspects therefore not yet operating as designed; and may be gaps in associated sources of assurance	PE
Not yet Effective	Significant aspects of control be implemented/ embedded; significant aspects therefore not yet operating as designed; and gaps in associated sources of assurance	NE

ASSURANCE RATING		
Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA
Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA
Not Assessed	Assessment of the assurance arrangements is pending.	Not Assessed

LEVELS OF ASSURANCE DESCRIPTORS

First Line of Defence	Second Line of Defence	Third Line of Defence
functions that own and manage risk	functions that oversee or specialise in risk management	functions that provide independent assurance

Self-Assurance	Internal oversight/specialist control teams, such as:	Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight, such as:
Risk and control management as part of day-to-day business management	Quality & Safety	External Audit
Staff training and compliance with policy guidance	IT	Regulators & Commissioners
Teams take responsibility for their own risk identification and mitigation	Governance (corporate/Clinical)	Wales Audit Office reviews
		Stakeholder reviews
		Scrutiny from public, Parliament, and the media
Examples of assurance	*Examples of assurance*	*Examples of assurance*
Management Controls / Internal Control Measures	*Board, Committee and Management Structures which receive evidence from*	*Recent internal audit reviews and levels of assurance*
Local management information / departmental management reporting	*Finance reports*	*External Audit coverage*
Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)	*KPI's and management information*	*Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews*
Operational planning / Business Plans - Delivery Plans and Action Plans	*Quality, Safety and Risk reports*	*Patient Feedback / Patient experience feedback*
Governance statements / self-certification	*Training records and statistics*	*Staff surveys / feedback*
Local procedures	*Performance reports*	*Comparative data, statistics, benchmarking*
Exceptions reporting	*BAF, VUNHS risk register*	
Targets, Standards and KPIs	*Policies and Procedures including Risk Management Policy*	
Incident Reporting	*Compliance against Policies*	
Staff Training Programmes		

STRATEGIC GOALS
1 - Outstanding for quality, safety and experience
2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations

KEY CONTROLS		
CONTROL TYPE	DESCRIPTION	EXAMPLES
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate	• Authorisation limits of and separation of duties • Pre-employment screening of potential staff

3 - A beacon for research, development and innovation in our stated areas of priority	
4 - An established 'University' Trust which provides highly valued knowledge and learning for all	
5 - A sustainable organisation that plays it part in creating a better future for people across the globe	

RISK DESCRIPTORS	
Inherent Risk	Score the exposure before any action has been taken to manage it or if existing controls failed entirely
Residual risk	The threat that remains after all existing controls have been applied
Target risk	Where risks are outside acceptable levels, a target risk score is agreed. This is the level that future mitigation that should be achieved which will vary over time

	implement appropriate preventative controls.	
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performance reporting • Regular review

RISK SCORE

LIKELIHOOD MATRIX					
LIKELIHOOD (*)					
LIKELIHOOD SCORE	1	2	3	4	5
DESCRIPTOR	RARE	UNLIKELY	POSSIBLE	PROBABLE	EXPECTED
Frequency: How often might it/does it happen	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

RISK RATING MATRIX - IMPACT X LIKELIHOOD					
RISK MATRIX	**LIKELIHOOD(*)**				
CONSEQUENCE(**)	1- Rare	2- Unlikely	3 - Possible	4 - Probable	5 - Expected
1 -Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

IMPACT MATRIX

RISK DOMAINS — Impact, consequence score (severity levels) and examples.

RISK DOMAINS	1 NEGLIGIBLE	2 MINOR	3 MODERATE	4 MAJOR	5 CATASTROPHIC
01 Compliance *Statutory duty/ inspections*	No or minimal impact or breach of guidance/statutory duty	Minor breach of guidance/statutory duty Reduced performance rating if unresolved Verbal reports from Regulator	One breach guidance/statutory duty Challenging recommendations Observation reports from regulator	Multiple breaches in statutory duty Enforcement action Improvement notices	Multiple breeches in statutory duty Prosecution Severely critical report
02 Environmental *Environmental impact*	No or minimal impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
03 Financial Sustainability *Including claims*	Insignificant cost increase Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim(s) less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million	Loss of >1 per cent of budget Claim(s) >£1million
04 Information Governance General Data Protection *Regulation (GDPR)*	Minimal privacy impact requiring no or minimal intervention	Minor impact on an individual's privacy	Moderate privacy impact requiring professional intervention Possible ICO reportable breach Could result in an event which impacts on a moderate (less than 100) number of patients/donors	Major breach leading to possible larger scale privacy breaches Likely ICO reportable breach if IG standard not adhered to Could result in an event which impacts on a major (between 100 and 1000) number of patients/donors	Serious breaches and non-compliance Definite ICO report required if breach occurs Could result in an event which impacts on a major (more than 1000) number of patients/donors
05 Partnerships Relationships with internal and external stakeholders and in working with system partners	No or minimal issues in establishing and maintaining effective relationships with internal and external stakeholders No or minimal misalignment of operational actions or strategic approach with system partners Minimal issues with collaborative working initiatives within our cancer and blood and transplant systems	Minor issues in establishing and maintaining effective relationships with internal and external stakeholders Minor misalignment of operational actions or strategic approach with system partners Minor issues with collaborative working initiatives within our cancer and blood and transplant systems	Moderate issues in establishing and maintaining effective relationships with internal and external stakeholders Moderate misalignment of operational actions or strategic approach with system partners Moderate issues with collaborative working initiatives within our cancer and blood and transplant systems	Major issues in establishing and maintaining effective relationships with internal and external stakeholders Major misalignment of operational actions or strategic approach with system partners Major issues with collaborative working initiatives within our cancer and blood and transplant systems	Failure to establish and maintain effective relationships with internal and external stakeholders Severe misalignment of operational actions or strategic approach with system partners Severe issues with collaborative working initiatives within our cancer and blood and transplant systems

RISK DOMAINS — Impact, consequence score (severity levels) and examples.

RISK DOMAINS	1 NEGLIGIBLE	2 MINOR	3 MODERATE	4 MAJOR	5 CATASTROPHIC
06 Performance and Service Sustainability *Business objectives/projects* *Service/business interruption*	Failure to achieve minor objective No or minimal service issue **Programme/ projects** Insignificant cost increase Less than 5 per cent schedule slippage against timescales	Failure to achieve significant/key objective Minor impact on service. **Programme/ projects** 1-10 per cent over project budget. 5-10 per cent schedule slippage against timescales	Failure to achieve multiple significant/ key objectives. Moderate impact on service. **Programme/ projects** 10-25 per cent over project budget. 10-40 per cent schedule slippage against timescales	Failure to achieve crucial objectives. Major impact on service. **Programme/ projects** 25-50 per cent over project budget. 40-100 per cent schedule slippage against timescales	Gross failure to achieve multiple crucial objectives Service failure **Programme/ projects** >50 per cent over project budget More than 100 per cent schedule slippage against timescales
07 Quality *Quality/complaints/ audit / G&E*	Peripheral element of treatment or service suboptimal Informal complaint/enquiry Temporary insignificant impact upon process or performance with no impact on quality or safety of components produced. Donor/patient/staff discomfort	Overall treatment or service suboptimal Formal complaint (stage 1) Local Resolution Single failure to meet internal standards Temporary minor decline in existing performance or process, no impact on quality or safety of components produced. Donor/patient/staff discomfort, minor interventions required e.g.. reassurance.	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Multiple failures to meet internal standards Temporary moderate erosion of existing performance or process, with the potential for impact on quality or safety of components produced. Short term harm, donor/patient/staff requiring treatment from medical practitioner	Non-compliance with national standards with significant risk to patients or donors if unresolved Multiple complaints/ independent review Multiple failures to meet national standards Sustained erosion of existing performance or process, tis has an effect on quality or safety of components produced. Donor/ /staff admission to hospital required, or increased stay in hospital >3days.	Non-compliance with national standards with severe risk to patients or donors if unresolved Inquest/ombudsman inquiry. Gross failure to meet national standards Significant uncontrolled erosion of performance or process which has a serious effect on the quality and safety of components produced. Fatal, life threatening, disabling, prolonged hospitalisation, incapacitating the donor or patient if transfused. (SABRE)

#	Risk Domain		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
08	Reputational *Adverse publicity/ reputation*		Local media coverage	Local media coverage	National media Coverage with <3 days service well below reasonable public expectation	National media Coverage with >3 days service well below reasonable public expectation
		Potential for public concern	Minor reduction in public confidence	Moderate reduction in public confidence	Major reduction in public confidence	Gross loss of public confidence
09	Research and Development	Departure from: Established good practice guidelines, and/or Procedural requirements	Departure from: Applicable legislative requirements, and/or Established Good Clinical Practice (GCP) guidelines, and/or	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "major" and/or "other" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" and/or "major" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" that leads to recommendations of: Communication of the critical findings to external parties, for

RISK DOMAINS			Impact, consequence score (severity levels) and examples.				
			1 NEGLIGIBLE	**2** MINOR	**3** MODERATE	**4** MAJOR	**5** CATASTROPHIC
			has occurred in a Research Study that is not a Clinical Trial of an Investigation Medicinal Product.	Procedural requirements, and/or Good Clinical Practice (GCP) has occurred in a Clinical Trial of an Investigational Medicinal Product (CTIMP) but it is neither "critical" nor "major".	Request for provision of corrective action & preventive action plan (CAPA) updates at periodic intervals	Early re-inspection to determine adequate progress is observed in implementing a corrective action & preventive action (CAPA) plan Request for provision of corrective action & preventive action (CAPA) plan updates at periodic intervals For actions in relation to pending or future clinical trials (for example, suspension or revocation)	example, other competent authorities, other government departments or UK NHS Research Ethics Committees Meetings with senior representatives from the inspected organisations to review the implications of the critical findings, the organisation's proposed actions and the actions Infringement Notice Referral to the MHRA Enforcement Group for investigation with a view to criminal prosecution
10	Safety *Impact on safety of patients, staff or public (physical or psychological harm)*	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients or donors	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days RIDDOR/agency reportable incident Mismanagement of patient or donor care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects RIDDOR/agency reportable incident An event which has an effect on a large number of patients or donors
11	Workforce and OD *Human resources/ organisational development/ staffing/ competence*	Short term low staffing level that temporarily reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff. Very low staff morale Very poor staff attendance mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff Very poor staff attending mandatory training /key training on an ongoing basis

DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / OPERATIONAL

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic	Evidence of delivery of the majority or all of the agreed actions, with

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	SUMMARY
7	Improvements sustained over time - BAU
6	Outcomes realised in full

Level 6	specific performance concerns AND recognition of systemic causes/reasons for performance variation.	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

Trust Board

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

Date of meeting	30/01/24

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, Head of Operational Services and Delivery, Sarah Richards, Interim General Services Manager
PRESENTED BY	Cath O'Brien, Chief Operating Officer, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

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

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1.8   Velindre Cancer Service

- Radiotherapy performance remains consistent against RT treatment targets, despite challenges of fragility associated with aging equipment and recruitment challenges. There will continue to be improvements in the performance as we move through the IRS implementation.
- SACT performance for non-emergency target has reduced as anticipated as a result of challenges with pharmacy capacity to support provision of chemotherapy treatment. The demand planning group within VCS is identifying opportunities to increase capacity across the service and concerted action is underway.
- Work is in progress over the next few weeks looking at the demand forecast for SACT between now and year end, identifying the activity required to meet the demand and the capacity gap.

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

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
WBS SMT / Performance Review	**15 December 2023**
VCS SLT / Performance Review	**20 December 2023**
Executive Management Board – Run	**2 January 2024**
Quality Safety and Performance Committee	**16 January 2024**

Summary and outcome of previous governance discussions
The report has been considered and endorsed at the VCS and WBS Performance Review meetings, EMB, QSP Committee and is presented to the Trust Board for information and noting.

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

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

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

2. SITUATION AND BACKGROUND
VELINDRE NHST PERFORMANCE REPORT FOR NOVEMBER 2023

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

2.1   Cancer Centre Services Overview

88% of patients referred for scheduled radiotherapy treatments began treatment within the 21-day target in November. This marks an improvement relative to performance in October (72% compliance). This is against the mandated target of 100% patients beginning treatment within 21 days. There is a stretch target of 80% within 14 days, which has not seen correlating improvement. Compliance with the 7-day time-to-treatment target for urgent symptom control radiotherapy treatment was 93%. 90% of patients requiring emergency radiotherapy treatment began treatment within the 2-day target and 86% within the 1-day stretch target. The sustained improvement in performance remains encouraging and can be attributed, in part, to detailed work to rationalise and shorten treatment pathways which has been undertaken throughout 2023 and targeted training delivered to clinical teams. Additionally, a new radiotherapy workflow system trialled in May 2023 has now been rolled out to all treatment sites. This new system has supported the delivery of marked efficiencies.

It should be noted that the number of patients referred for radiotherapy treatment and those actually beginning treatment in November were lower than anticipated based on historical patterns of demand. Relatively depressed demand for radiotherapy treatment has likely been a contributing factor in the improved performance reported since August 2023. Dialogue with health board operational teams has confirmed that the number of referrals for radiotherapy treatment during quarter 3 have been lower than anticipated. This pattern does not appear to have been replicated elsewhere in Wales, Other Welsh cancer centres have acknowledged receiving the normal, anticipated increase in demand following summer period. We are continuing to explore these trends with Health Boards.

SACT

Forecast demand modelling for SACT for the financial year 2023/24, anticipated a 8% growth in referrals based on outturn March 2023. The actual referral rate is currently showing approximately 6.8% above the forecast. During the month of November SACT performance for 5-day for the emergency time to treatment target was 100%. Delivery of 21day non-emergency SACT time to treatment target is a challenge for the service. The anticipated drop in performance for November has been realised with 85% (329) patients being treated within target date (target 98%). 57 non-emergency patients waited over 21 days. The majority of these patients (50 patients) were treated WITHIN 28 days, with 6 patients waiting more than 28 days, further 2 patients waiting more than 36 days. All patients within a trial were booked within Trial timeframes.

It is anticipated that there will be a further drop in performance against the non-emergency treatment target in December. At present the anticipated performance at the end of December is unknown. There is significant work taking place within the Division in order to develop a comprehensive plan to improve overall performance.

A working group has been established and a number of options identified to increase activity. The key barrier to implementation of these measures is availability of pharmacy provision to meet the increase in Chemotherapy treatment for the patients. An external audit has identified that in order to increase production within pharmacy, requires additional asceptic provision and supporting workforce. Capital funding was approved in December 2024, which will facilitate an expansion of asceptic dispensing capacity. Supporting reconfiguration of work plans will be completed by end March 2024 and the recruitment of staff to support professional and regulatory compliance is expected to be approved in January 2024. This will provide capacity initially but further work is also ongoing to plan for the interim period before the regional provision through TrAMS programme is delivered.

The longer term solution was previously identified as TrAMS, but due to the delay at a regional level, it is now a requirement of the Division to look at an alternative means of meeting the additional demand for pharmacy between now and the 'go live' date for TrAMS. The working group is also undertaking an extensive piece of forecast modelling to understand the demand on the service between now and year end (March 2024) and the activity required to meet the demand.

All services undertook extensive planning to prepare for the additional capacity challenges over the Christmas and New Year period and forward into January through any periods of Industrial Action.

2.2   Welsh Blood Service Overview

Clinical demand was met throughout November despite it being a challenging month. There was a significant reduction in collection capacity following clinic cancellations beyond the control of the service (4 donor sessions were cancelled/replaced at short notice due to leaks in Mobile Donation Clinics (MDC) where air vents were fitted for Infection Prevention Control (IPC) requirements & a further 3 donor sessions were reduced due to I.T. issues affecting on session connectivity). A total of 441 appointments were lost that could not be recovered during November. This resulted in 2 days where stock for blood groups O, A and B+ fell below 3 days.

To address this, a Blue Alert was issued 7th November for OD- and OD+ which ended on the 9th November 2023, and on the 20th November for OD- & AD- ending on the 27th November. This impacted blood stocks in December, which resulted in the requirement for mutual aid to cover the Christmas period.

January continues to look challenging for WBS, and the following recovery plan is currently being implemented:

- An additional 3 overtime clinics secured and further work continuing to secure more.
- Requests made to WBS departments for release of seconded RNs to support on specific days when Collection RNs resources are insufficient.
- Donor education plan to commence to reduce deferrals.
- Additional appointment slots made available to mitigate Did Not Attends (DNAs).
- Refresher training plan developed for Registered Nurses (RNs) outside of Collection Services to allow supporting activity.
- Completion of initial training for existing cohort of trainee RNs and Clinic Collection Assistants (CCAs).

These mitigating actions are predicted to maintain existing stock levels in January if demand remains consistent against forecast. Further mitigation in underway for the medium term to support re-building stock levels. This includes:

- Continuation of scheduling additional clinics.
- New cohort of 11 staff starting training in January.
- Recruitment to all vacancies.
- Consideration of recalling Collection team staff on secondment.
- Commencement of workforce review under WBS Futures.
- Introduction of tours to improve North West Wales efficiency.
- Introduction of West Nile Virus testing.

Quality incident investigations closed within 30 days remains well above target (90%) and increased to 97% in November. There were 4 reportable events submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in November. All relate to donor eligibility assessment of malaria risk, or supplementary questions appearing under the incorrect primary question. Root Cause Analysis investigations are in progress for all events. Findings will be presented to the Trust Integrated Quality & Safety Hub and Quality Safety & Performance Committee.

Donor satisfaction met target for November at 95%. 7,553 donors were registered at donation clinics 5 informal concerns raised (0.07% of all donors registered). All 5 informal concerns have been managed within the 'Putting Things Right' 2-day timescale. No formal concerns were raised in November.

Reference Serology performance remained slightly below target (80%) at 70% for November, however sustained improvement can be observed throughout 2023. Training and development of junior members of staff will be completed between December 2023 and April 2024 and performance levels are expected to improve during this period.

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

At 1.22 collection productivity performance just missed the target of 1.25 in November. Contributory factors influencing performance include operational issues beyond the control of the service that resulted in 5 donor sessions being either cancelled or delayed leading to a reduction in donation capacity. However, there has been an improving trend evidenced over the last 15 months and WBS are now approaching the productivity target of 1.25.

The number of stem cell collections just failed to meet the target (7) in November. The total cell provision for the service was 6 (3 collected and 3 imported for a Welsh patients). The service is seeing a gradual increase in activity for this year with a current projected outturn of 50-55 at year end (against a target of 80). The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment and will be managed under WBS Futures.

2.3   Workforce and Wellbeing

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

Trust wide sickness absence data continues to remain high month on month with the current rolling absence of 5.63% to November 2023 which is still above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%. Trust wide PADRs this month remains at 72% lower than the 85% target, whereas Statutory and Mandatory training remains above target at 86% and has been consecutively on target for the whole year to date. Details of interventions can be found in the SPC's for these metrics and corresponding action plans.

Additional Equity measures have been added at the Trust-wide level for Welsh Language declaration, Gender Pay Gap and Workforce Diversity.

2.4   Nursing and Quality

The Trust's Quality & Safety Framework continues to be developed by the Integrated Quality & Safety Governance Group at its monthly meetings. The Divisions are also developing a range of Service level Quality and Safety metrics to be included within the Performance Management Framework and these potential measures are given in Appendix 4

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

2.5 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys: 'Would you recommend us?' (94%) and 'Your Velindre experience?' (87%) both set against a 95% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 95% for November which continues to meet the target.

2.6 Digital Services

Performance largely stable.

Following a number of incidents in August and November 2023, the rolling 12-month position for the number of significant IT business has increased slightly to 12 in November 2023. However, service stability through most of 2023 should result in a significant improvement in performance from February 2024. Work remains ongoing to remove / replace legacy IT infrastructure and improve the resilience across both the WBS and VCC sites.

3 significant incidents occurred in November 2023 – these related to the expiration of digital certificates used to authenticate devices and users across a number of key IT systems – namely, Prometheus (Welsh Bone Marrow Donor Registry), ePROGESA (WBS Blood Collections) and the VCC Wi-Fi service. Root cause investigations for each incident have been completed and action plans agreed to mitigate the risk of re-occurrence. Two incidents related to certificates managed by DHCW – a digital certificate register is to be developed by Digital Services, to enable the team to proactively manage and, where required, renew certificates due to expire.

Resolution timescales for service requests and incidents remains between 80-85% for both measures, although there was a significant increase in performance (84%) in respect of the number of service requests resolved within the agreed timescale – a reflection of recent work to ensure the Digital Service Desk is fully staff and ongoing work to improve the efficiency of the service desk. However, both metrics measuring performance of the Digital Service Desk remain under the 85% performance – the aim is to achieve 85% performance by the end of the financial year. A new IT Service Management Tool is due to be deployed in Q4, which should significantly improve service desk efficiency, including the introduction of more automated call responses.

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

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

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

- % of outpatient consultations performed virtually
- % of donors booking online
- % compliance with cyber security statutory & mandatory training
- % of Trust expenditure in digital
- Hours saved through digitisation / automation of paper-based manual processes.

2.7   Estates Infrastructure and Sustainability

The period through to November has seen consolidation of levels of compliance for PPM and reactive tasks which are currently listed as green. Recruitment complete within the Estates Team. Two H&S posts are progressing through the recruitment process Head of H&S at interview and the H&S Technician being uploaded to Trac.

The Trust has appointed a bureau 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 month has seen similar issues and data will be uploaded once available.

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

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

2.8   Finance

Key Financial targets / KPIs
- The Trust is currently reporting a small underspend on revenue and is forecasting to achieve an outturn position of Breakeven.
- The Trust is currently overachieving and expected to meet PSPP target of paying 95% of Non-NHS invoices within 30 days for 2023-24.
- At this stage the Trust is expecting to achieve the Capital CEL, however an unlikely risk remains around securing funding for additional nVCC project management costs, with a request having now been submitted to the Minister by WG officials seeking funding approval.

LTA Income & Covid Recovery / Planned Care Capacity

- The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to cover the costs of the investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Nov '23 is that income will cover the cost of the additional capacity.

NHS Wales Financial Pressures

- In response to the letter received from the Health Minister which detailed the financial pressures that was being faced by NHS Wales, the Trust identified costs savings proposals to the sum of c£2m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit.

  In addition, the reserves position continues to be under review with the option that if not fully required during the remainder of 2023-24 then it could be offered to support the NHS Wales position on a non-recurrent basis.

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

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

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

Trust Board Scorecard as at November (Month 08) 2023/24

QSF Domain	Key Performance Indicator (KPI)	Target	Reported	Performance as at Month 08 (November 2023)			Compliance against Target or Standard		Data Link
	Trust Board Performance Scorecard			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	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	→	KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	99%	✓	→	KPV.08
	Number of National VCS Serious Untoward Incidents recorded with Welsh Government	National	Monthly	0	0	0	✓	→	KPV.60
	Number of WBS Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	4	✗	↓	KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	11	✗	↑↓	H&S.55
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	102.7 C/m3 Sep	85.36 C/m3 Sep	✓	→	EST.06

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QSF Domain	Trust Board Performance Scorecard			Performance as at Month 08 (November 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	Number of Pathway of Care Delays	National	Monthly	1	0	3	✗	↓	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	107%	✓	↑	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0.00%	✓	→	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	115%	✓	↓	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	6	✗	↓	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.63%	✗	↓	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%	94%	✓	→	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	95%	✓	↑	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	→	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	100%	✓	→	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	18% 88%	✗	↓	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	13% 93%	✗	→	KPV.15
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	86% 90%	✗	↓	KPV.16

PMF Performance Report November 2023/24

QSF Domain	Trust Board Performance Scorecard				Performance as at Month 08 (November 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days	National	Monthly	27% 32%	80% 100%	83% 97%	✗	↓	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	98%	98%	85%	✓	↑↓	KPV.20
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	100%	✓	↑	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	92%	✓	↓	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	99%	✓	↑	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.017m)	✓	→	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£19.331m	£19.331m	✓	→	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.535m	£0.732m	✗	↓	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.106m	£1.106m	✓	→	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	→	FIN.60
Equitable	Mean Gender Pay Gap – Annual	Local	Annually	13.45%	TBA	TBA	✓	→	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	TBA	5.45%	✓	→	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	TBA	4.90%	✓	→	WOD.80
	% of Workforce not declared Welsh Language Listening/Speaking capability	National	Quarterly	11.63%	0%	9.81%	✓	→	WOD.81

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

PMF Performance Report November 2023/24

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below

If yes - please select all relevant goals:

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ⊠ Timely ⊠ Effective ⊠ Equitable ⊠ Efficient ⊠ Patient Centred ⊠

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

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

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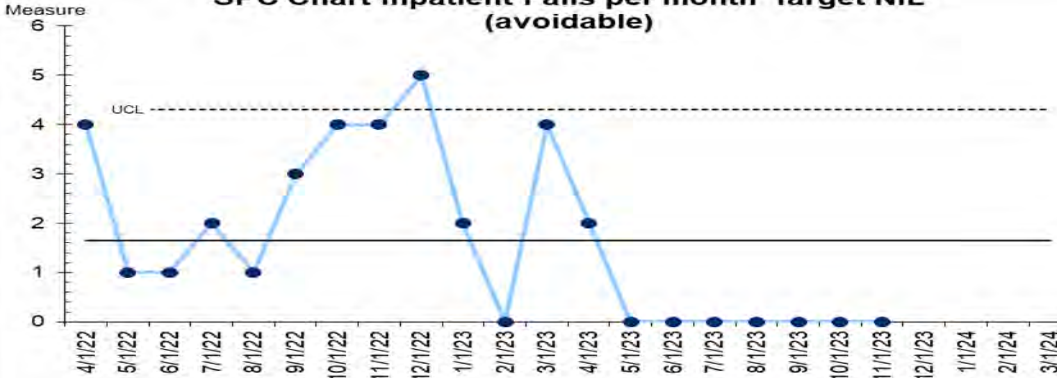
5. RISKS

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

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

Number of VCC Inpatient Falls per month		
Target: 0 Avoidable		**SLT Lead: Head of Nursing**

Current Performance against Target or Standard		Performance

VCC	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul2 3	Aug 23	Sep 23	Oct 23	Nov 23
Actual Number	3	4	4	5	2	0	4	2	0	3	5	5	3	5	3
Avoidable Falls	1	2	2	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

Performance

No avoidable falls in November 2023

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
-

SPC Chart Inpatient Falls per month Target NIL (avoidable)

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.

Number of VCC Acquired Pressure Ulcers per month (Inpatients)

| **Target: 0 Avoidable** | **SLT Lead: Head of Nursing** |

Current Performance against Target or Standard

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

No avoidable pressure ulcers in November 2023

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

Statutory and Mandatory (S and M) Training Compliance														

Target: 85%   **SLT Lead: WOD Business Partner**

Current Performance against Target or Standard   **Performance**

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

Assessment of current performance, set out key points:
- Compliance target is being met

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

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

Risks to future performance

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

SPC Chart Statutory & Mandatory Training Target 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.

Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)																
Target: NIL															**SLT Lead: Clinical Director**	
Current Performance against Target or Standard															**Performance**	

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

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

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

Healthcare Acquired Infections (Inpatients)

Target: NIL	SLT Lead: Head of Nursing

Current Performance against Target or Standard	Performance

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

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

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by (VCS WBS) Department															
Target: 100%															**SLT Lead: Clinical Director**
Current Performance against Target or Standard															**Performance**

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
VCS Hand Hygiene										100%	100%	99%	99.6%	100%	99%
WBS Hand Hygiene										100%	99.2%	99%			
Trust Hand Hygiene										100%	100%	99%			
IPC Validation										100%	100%	100%	99.4%	100%	96%
Target I00%	0	0	0	0	0	0	0	0	0	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

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: IPC
• Weekly validation audit by IPCT		

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
-

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

Target: NIL	**SLT Lead:**

Current Performance against Target or Standard	**Performance**

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

Assessment of current performance, set out key points:

[SUI data to be input]

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

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 |

Assessment of current performance, set out key points:

4 events were submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in November. All relate to donor eligibility assessment of malaria risk, or supplementary questions appearing under the incorrect primary question. Root Cause Analysis investigations are in progress for all events. Findings will be presented to the Trust Integrated Quality & Safety Hub and Quality Safety & Performance Committee.

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

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Lead:
Daily 100% review of relevant donor screening questionnaires. A Task and finish group is being set up to fully review the screening process at WBS. The findings will also be fed back to the Standing Advisory Committee on the Care and Selection of Donors to inform a review of the national guidance on travel-related screening. 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	Peter Richardson **Timescale:** Progress is reported Monthly into the WBS Integrated Quality & Safety Hub.

Expected Performance gain – immediate - N/A

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term - N/A

Risks to future performance

N/A

Incidents Reported to Regulator/Licensing

Bar chart values (Jan-23 to Dec-23):
- Jan-23: 0
- Feb-23: 2
- Mar-23: 0
- Apr-23: 0
- May-23: 2
- Jun-23: 0
- Jul-23: 1
- Aug-23: 2
- Sep-23: 1
- Oct-23: 0
- Nov-23: 4
- Dec-23: (none)

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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**

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

Service Improvement Actions – Immediate (0 to 3 months)

Actions	Timescale
All incident investigation have been assigned and are currently ongoing	

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

Total Number of Incidents by Division

Legend: VCC — WBS — Corporate/TCS/RD&A

% 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	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23
Actual Number	102.66	122.08	172.82	155.55	212.01	179.31	187.06	130.20	111.83	86.13	85.33	86.37	85.36		
Target (-3% from previous year emissions)	104.8802	133.9711	190.288	201.7611	217.2733	189.9079	194.9325	160.9681	130.2845	95.03259	99.91858	95.86	102.66		

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.

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.

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

Number of Pathway of Care Delays	
Target: NIL	**SLT Lead: Head of Nursing**
Current Performance against Target or Standard	**Performance**

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

Assessment of current performance, set out key points:
There was 1 Pathway of Care delay reported in November 2023

Patient 1: The patient had complex care needs and required support at home on discharge. A social work referral was submitted to support discharge planning. The total discharge delay was 25 days.

There were 2 Repatriation delays reported in November 2023

Patient 1: Awaiting repatriation to local hospital with a delay of 21 days.

Patient 1: Awaiting repatriation to local hospital with a delay of 4 days.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Number of Pathways of Care Delays Target NIL

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

Risks to future performance

Set out risks which could affect future performance

% 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	**Performance**

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

Performance

Performance on this metric has met target.

The average weekly demand in November was slightly lower at 1374 compared to October at 1417 units per week.
There were 2 days in November where stock for blood groups O, A and B+ fell below 3 days. A Blue Alert was issued 7th November for OD- and OD+ which ended on the 9th November 2023, and on the 20th November for OD- & AD- ending on the 27th November.

% Red Cell Demand Met

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:
N/A	Business As Usual **Lead:** Jayne Davey / Georgia Stephens

Expected Performance gain – longer-term   N/A

Risks to future performance

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

SPC Chart Red Blood Cell Demand Target 100%

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. Performance has fluctuated in the previous three months, but has improved and exceeded target in November.

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 — **Performance**

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

Performance

Assessment of current performance, set out key points:
Performance of this metric has met target in November 2023, with no Red Cell wastage 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.	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.

Time Expired Red Cell

0.2% 0.1% 0.0% 0.1% 0.7% 0.4% 0.0% 0.0% 0.0% 0.0% 0.0%

(Jan-23, Feb-23, Mar-23, Apr-23, May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23)

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SPC Chart Time Expired Red Blood Cells Target 1%
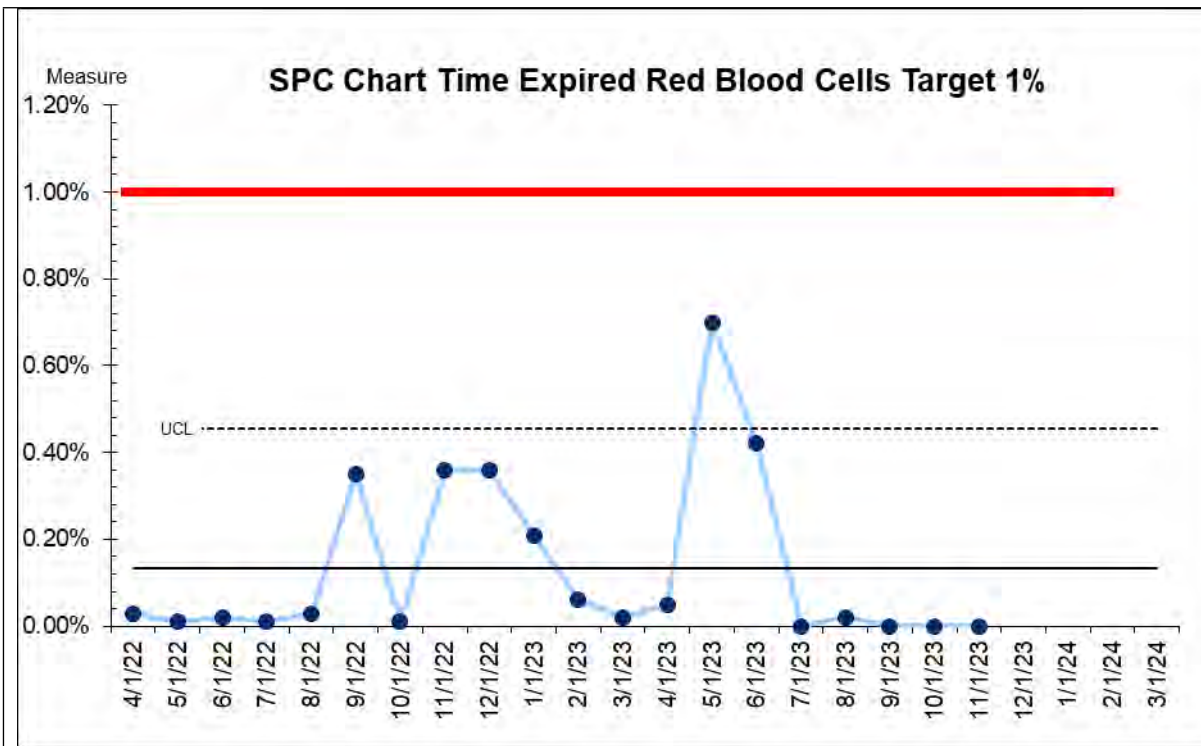
SPC Chart Analysis

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%

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	**Performance**

	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23
Actual %	132	126	139	145	141	168	133	127	117	114	120	125	121	122	115
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

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

Service Improvement Actions – Immediate (0 to 3 months)

	Lead: Georgia Stephens **Timescale:** Ongoing – Business As Usual
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.	

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve A focus on balance of apheresis versus pooled platelets and timing of apheresis clinics will be conducted as part of the WBS futures programme under the Laboratory Modernisation work workstream for Platelet Strategy. Consideration of a digital tool to enable prediction/requirement for platelet production will also be included. The workstream meetings have been initiated and the revised platelet strategy is expected to be completed by the end of March 2024.	**Timescale:** March 2024 **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).
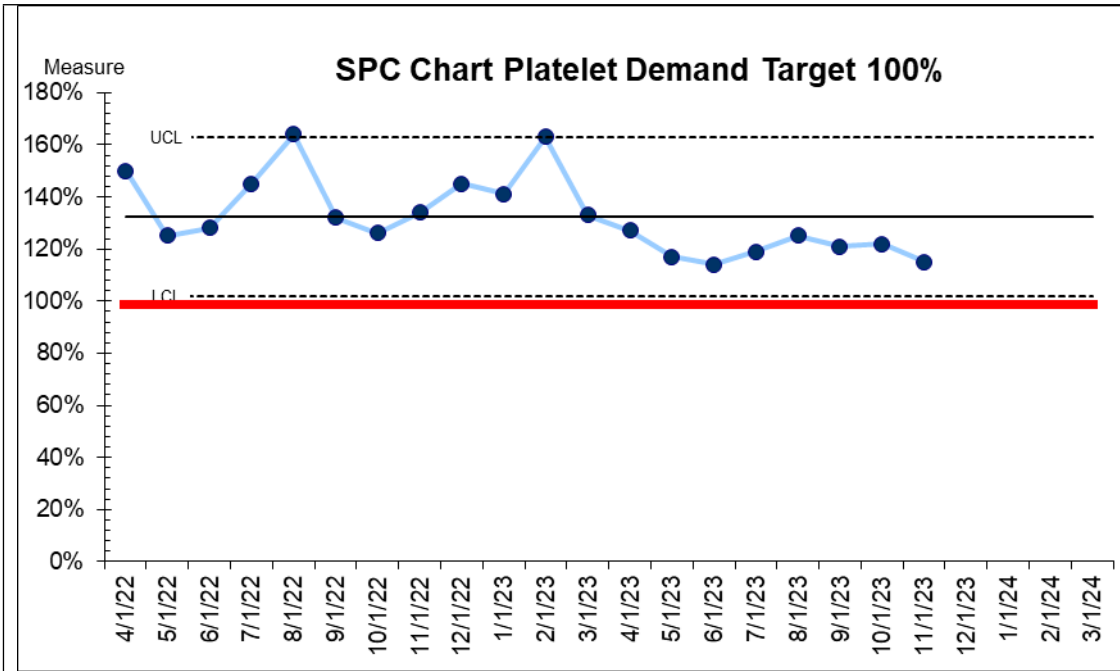
% Platelets Demand Met

141%, 163%, 133%, 127%, 117%, 114%, 119%, 125%, 121%, 122%, 115%

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.

PMF Performance Report November 2023/24

SPC Chart Platelet Demand Target 100%

SPC Chart Analysis

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

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

Target: Maximum Wastage 10%	SLT Lead: Georgia Stephens

Current Performance against Target or Standard	Performance

	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23
Actual %	25	14	15	27	23	25	20	10	8	9	12	12	11	11	10
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

Performance

Assessment of current performance, set out key points:
At 10%, performance met target for November.

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

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
A focus on balance of apheresis versus pooled platelets and timing of apheresis clinics will be conducted as part of the WBS futures programme under the Laboratory Modernisation work workstream for Platelet Strategy. Consideration of a digital tool to enable prediction/requirement for platelet production will also be included. The workstream meetings have been initiated	Mar 2024 **Lead:** Jayne Davey/Georgia Stephens

Time Expired Platelets

Values: Jan-23 23.00%, Feb-23 26.00%, Mar-23 20.00%, Apr-23 10.00%, May-23 7.72%, Jun-23 9.00%, Jul-23 12.00%, Aug-23 12.00%, Sep-23 11.00%, Oct-23 11.00%, Nov-23 10.00%

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

	and the revised platelet strategy is expected to be completed by the end of March 2024.	
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.		

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 fluctuating special cause variation for this metric. Whilst the average performance of 18% remains above the maximum wastage limit of 10%, it is clear that there is a significantly improved performance, sustained since Apr. 2023.

SPC Chart Time Expired Platelets Target Max Wasteage 10%
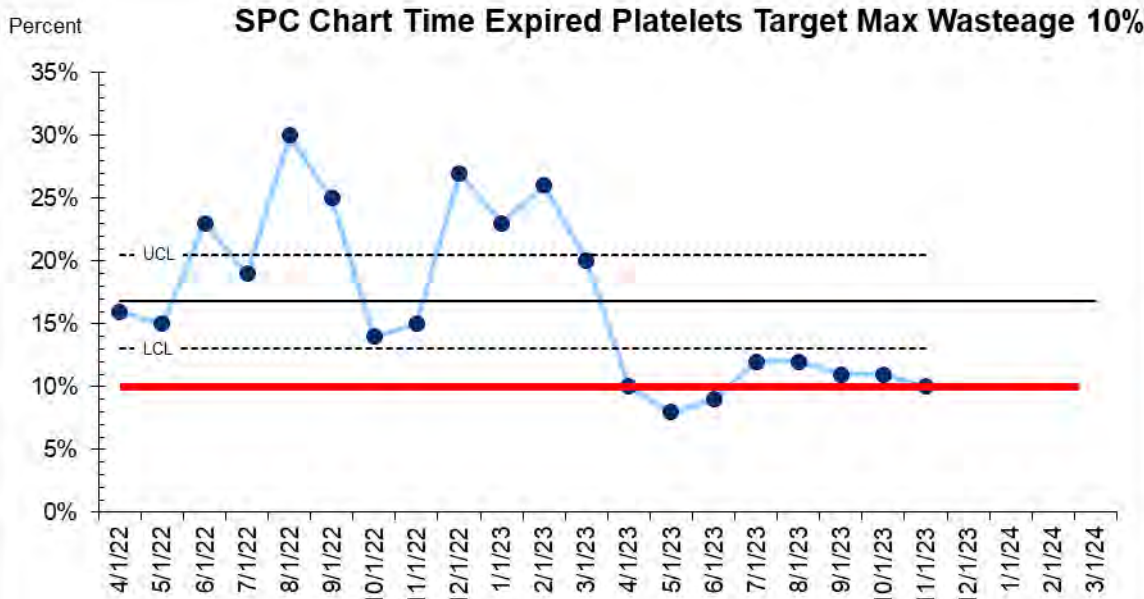
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target															
Target: 80 per annum									**SLT Lead: Deborah Pritchard**						

Current Performance against Target or Standard

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

Performance

At 6 total cell provision for the service just failed to meet the monthly target (7) in November. Provision was compiled of 2 Peripheral Blood Stem Cell, 1 Peripheral Blood Lymphocytes and 3 imports for a Welsh patient.

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

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

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

Stem Cell Collections

Bar values (Stem Cell Collection in Wales): Apr-23: 3, May-23: 6, Jun-23: 12, Jul-23: 18, Aug-23: 21, Sep-23: 26, Oct-23: 33, Nov-23: 35

Projected Forecast line values: 7, 14, 20, 27, 34, 40, 47, 54, 60, 67, 73, 80

Legend: Stem Cell Collection in Wales | Stem Cell Projected Forecast FinYear 23/24

Service Improvement Actions – Immediate (0 to 3 months)

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

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Staff Sickness levels against Target															
Target: National 3.54% Local Stretch Target 4.70%												**SLT Lead: WOD Director**			
Current Performance against Target or Standard												**Performance**			

Trust Position	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23
Actual %	6.36	6.30	6.19	6.19	6.24	6.36	6.22	6.06	5.99	5.84	5.71	5.70	5.75	5.70	5.63
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

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

Short-term absence remains relatively low across the Trust.

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

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

SPC Staff Sicknesss National Target 3.54% Local 4.7%

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

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

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• Launch benefit platforms (Health Shield, Wage stream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation	Ongoing	Head of OD and Trust Board

Expected Performance gain – longer-term
The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.

Risks to future performance

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

Performance and Development Reviews (PADR) % Compliance															
Target: 85%															

SLT Lead: WOD Director

Current Performance against Target or Standard															
Trust Position	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23
Actual %	71	75	76	77	77	74	73	73	72	73	74	74	74	71	72
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:
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.

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.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term
As regular monitoring and reviews of compliance is undertaken in the divisional operational meetings the Trust's compliance will improve.

Risks to future performance

Set out risks which could affect future performance
- People have lack of clarity and objectives casing them to be less engaged and motivated in the workplace
- Higher turnover rates due to lack of engagement and motivation

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PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

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% of Patients that Rate Experience at Velindre at 9/10 or above	
Target: 85%	**SLT Lead: Head of Nursing**
Current Performance against Target or Standard	**Performance**

VCC	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
Would you recommend us? %	89	88	nda	nda	93	96	95	95	98	96	97	97	95	95	94
Your Velindre Experience? %			nda	nda	84	86	82	82	68	71	91	94	63	83	87
Target 85%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Assessment of current performance, set out key points:
There are two surveys used in VCC – 'Would you recommend us?' and 'Your Velindre Experience'.
The 'Would you recommend us?' survey uses categories such as Very good, good etc
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	33	86.84%
Good	2	5.26%
Neither good nor poor	0	0.00%
Poor	2	5.26%
Very poor	1	2.63%
Don't know	0	0.00%
Total	38	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	47	77.05%
9	6	9.84%
8	4	6.56%
7	1	1.64%
6	3	4.92%
5	0	0.00%
4	0	0.00%
3	0	0.00%
2	0	0.00%
1	0	0.00%
0	0	0.00%
Total	61	100%

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Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
Outcomes from CIVICA are reviewed monthly and form part of SLT Q&S highlight report and the QSP report	Ongoing	Head of Nursing/SLT
Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback	Ongoing	SLT/Directorate Managers
Directorates to develop plans to increase response rate.	Ongoing	
Q+S team to work with each directorate to provide further analysis on responses		SLT/Directorate Managers
CIVICA working group established with attendees from each directorate		Q+S manager
Q+S team to review the difference in positive percentages for both surveys		
Expected Performance gain – immediate		
A new Patient Experience and Concerns manager has been in post since June 2023 who is engaging with staff across teams to encourage patient feedback and the recording of compliments.		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
Patient Engagement Hub to work with Q&S team to continue to find new/different ways of engaging patients and seeking feedback.	December 2023	Head of Patient Engagement
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance • insert text		

% 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	**Performance**

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

Assessment of current performance, set out key points:
At 95.1%, donor satisfaction is above target for November. In total there were 1,193 respondents to the donor survey, 221 from North Wales (scoring satisfaction at 97.6%), and 961 from South or West Wales (scoring satisfaction at 94.5%).

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

Donor Satisfaction

Chart values (combined label above bars): 98%, 98%, 96%, 99%, 97%, 98%, 97%, 96%, 98%, 97%, 95%

Legend: ■ Scored 5_6 out of 6 SW   ■ Scored 5_6 out of 6 NW

Months: Jan-23, Feb-23, Mar-23, Apr-23, May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23

<mark>KPI Indicator KPV.12</mark>

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

Performance

Assessment of current performance, set out key points:
- Target deadline has consistently been achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

% 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	Performance

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

Performance

Assessment of current performance, set out key points:

Performance for November 2023 met target with the 1 formal concern received in October 2023 closed in November ahead of 30-day timeline.

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.

% Responses to Concerns within 30 Working Days

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.

TIMELINESS

KPI Indicator KPV.14   Return to Top

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	**Performance**

<table>
<tr>
<td rowspan="2" valign="top">

Scheduled Elective RT COSC within 14 & 21 days

12% of RT patients (Nov) (27) breached the 100% referral to treatment within 21 days target

88% of RT patients (Nov) 40 + 159 =199) met the 100% referral to treatment within

Only 18% of RT patients (Nov) (40) met the 80% referral to treatment within 14 days target

Patients <14 days   Patients <21 days   Patients >21 days

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.

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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	226	
treated within 14 days of referral (80% target)	40	18%
treated within 21 days of referral (100% target)	199	88%

Service Improvement Actions – Immediate (0 to 3 months)

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

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: October 2023	Lead: Tom Rackley
Pathway change group in place to address changes in process to meet revised patient journey timings with SST leads.		

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

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

Scheduled Urgent RT COSC within 2 & 7 days

17% of RT patients (Nov) (3) breached the 100% referral to treatment

93% of RT patients (Nov) (6 + 36 = 42) met the 100% referral to treatment within 7 days target

13% of RT patients (Nov) (6) met the 80% referral to treatment within 2 days target

Legend: Patients <2 days | Patients <7 days | Patients >7 days

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

Number of referrals		45
treated within 2 days of referral (80% target)	6	13%
treated within 7 days of referral (100% target)	42	93%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
-

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.

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

Current Performance against Target or Standard

Emergency RT COSC within 1 day

14% (3) RT patient (Nov) treated over 48 hours

86% of RT patients (Nov) (18) met the 100% referral to treatment within 1 day target

Performance

Assessment of current performance, set out key points:

Target Achieved

Number of referrals		21
80% treated within 1 day of referral	18	86%
100% treated within 2 days of referral	19	90%

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

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.

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

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

Elective Delay RT Treated COSC within 7 Days and 14 days

3% of RT patients (Nov) (1) breached the 100% Elective Delay within 14 days target

97% of RT patients (Nov) (30 + 5 = 35) met the 100% Elective Delay within 14 days target

83% of RT patients (Nov) (30) met the 80% Elective Delay within 7 days target

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.

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

Number of referrals		36
treated within 7 days of referral (80% target)	30	83%
treated within 14 days of referral (100% target)	35	97%

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
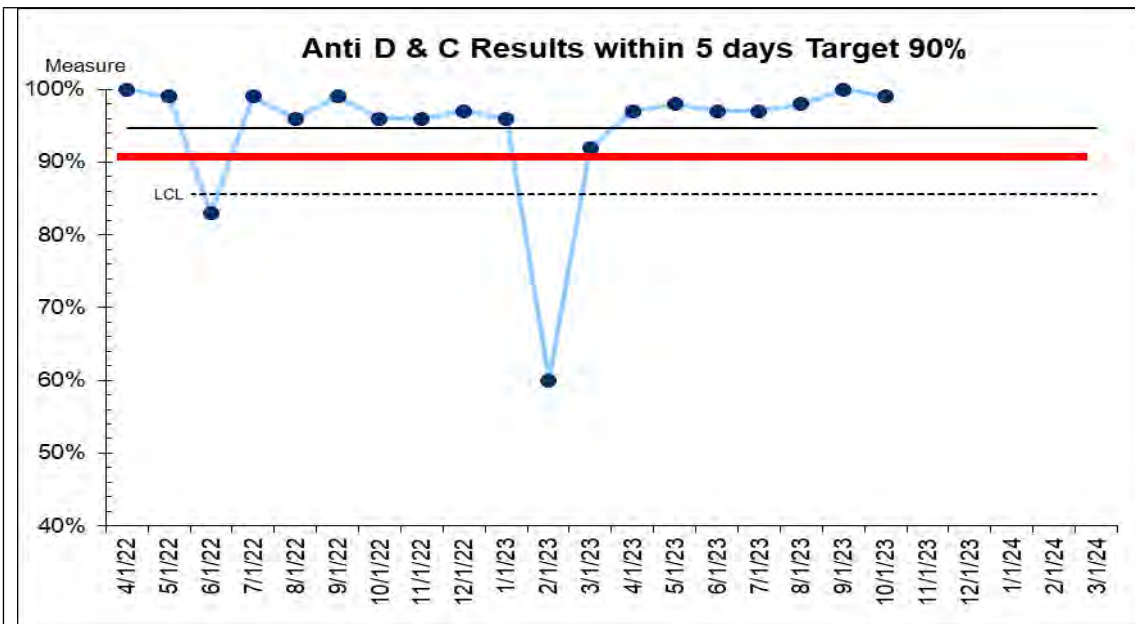
Set out risks which could affect future performance
•

Non-Emergency SACT Patients Treated Within 21-Days															
Target: 98%															

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23
Actual %	89	96	98	96	97	98	98	93	90	90	94	92	90	98	85
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days		14	6	12	9	9	8	26	40	40	25	32	35	10	57
Within 21 days		341	354	322	336	388	409	343	354	378	370	380	323	414	329

The number of patients scheduled to begin non-emergency SACT treatment in Oct 2023 was 424.

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

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,186	2,105	2,242	2,270	2,269	2,101	2,392
2022/23 Attendances	2,297	2,297	2,336	2,302	2,558	2486	2463	2572	2297	2455	2162	2557
2023/24 Attendances	2,220	2,545	2,622	2,483	2,679	2,453	2824					

Performance

November 23 data and narrative:

Intent /Days -	22-28	29-35	36-42	43 da1ys +
Non-emergency (21-day target)	50	5	1	1

All patients within a Trial are booked within Trial timeframes. Pharmacy capacity remains a challenge to delivering required activity levels.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead
Data model to be developed to understand demand and capacity required to meet demand	31/01/2024	WJ
Reconfiguration of accommodation to deliver increased asepctic capacity following capital received December 2024	31/01/2024 31/01/2024	BT BT
Recruitment of additional staff to support additional aseptic capacity		
Appointment of SACT service Delivery manager	March 2024	VC

SPC Chart Non Emergency SACT within 21 days Target 98%
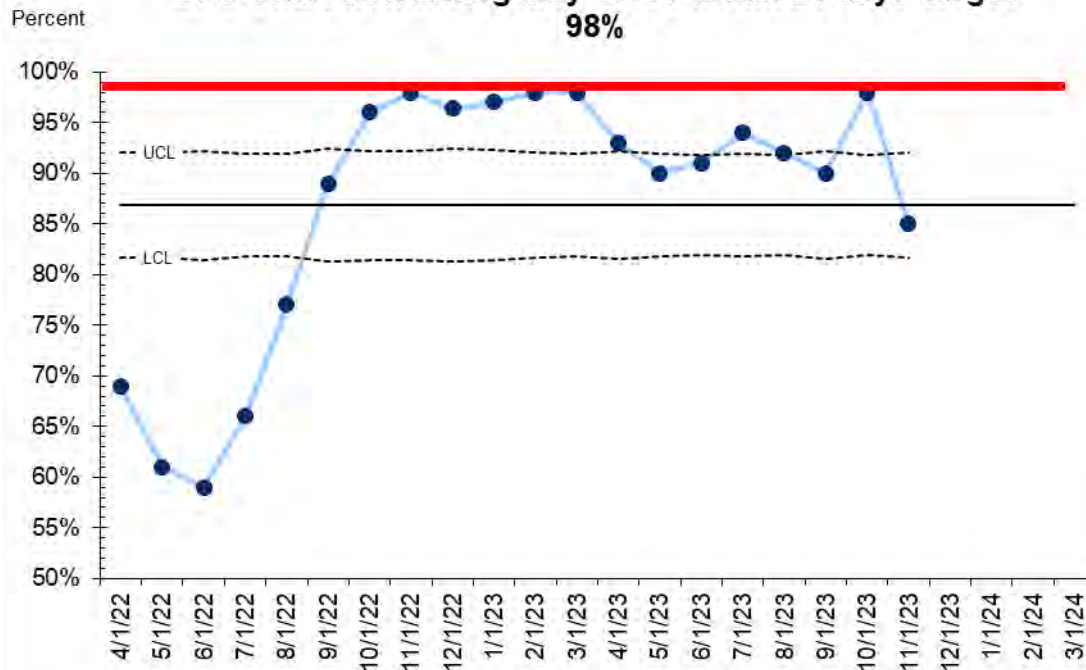
SPC Chart Analysis

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

Expected Performance gain – immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Review of SACT service delivery model		Planning
• Re-determine the impact of continued growth in demand across SACT teams	**01/04/24**	BW
• Nursing: international nurse recruitment and preceptorship recruitment	01/05/ 2024	BT
		RM Outreach board
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance		
• Pharmacy capacity		
• Requirement for additional aseptic capacity to support preparation of additional chemo (including 'buy-in)		
• Vacancies within SACT booking team		
• Recent increase and complexity of in-patient SACT demand has impacted on pharmacy capacity to support day case workload		

Emergency SACT Patients Treated Within 5 Days

| Target: 100% | | | | | | | | | | | | | | | SLT Lead: Head of Medicines Management and SACT |

Current Performance against Target or Standard

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

Performance

Target achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

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
  •

SPC Chart Emergenct SACT within 5 days Target 100%

SPC Chart Analysis

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

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															**Performance**	

	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23
Actual %	97	98	96	87	97	96	96	96	95	98	97	96	96	96	92
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 92% the turnaround time performance for routine Antenatal tests continued to exceed target in November 2023.

Antenatal Turnaround Times

97% 96% 96% 96% 95% 98% 97% 96% 96% 96% 92%

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	Ongoing **Lead:** Georgia Stephens

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance

SPC Chart Antenatal Turnround Time 3 days Target 90%

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, with the average performance continues to exceed the 90% target.

% 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										**Performance**				

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

Performance

There was excellent performance during Quarter 2 for Antenatal -D & -c quantitation Turnaround Times within 5 working days. At 99% in October, performance averaged 99% for the quarter, meeting target and showing continuous performance improvement.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.

Anti D & C Results within 5 days Target 90%

SPC Chart Analysis

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

EFFICIENT

<mark>KPI Indicator FIN.71</mark>

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				
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at November 23

	YTD Budget £000	YTD Actual £000	YTD Variance £000		Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(28,365)	(28,366)	0		(41,288)	(41,288)	(0)
RD&I	(399)	(397)	(1)		91	91	0
WBS	(14,726)	(14,725)	(0)		(21,666)	(21,666)	0
Sub-Total Divisions	**(43,490)**	**(43,488)**	**(1)**		**(62,862)**	**(62,862)**	**(0)**
Corporate Services Directorates	(8,895)	(8,897)	2		(13,188)	(13,188)	(0)
Delegated Budget Position	**(52,385)**	**(52,386)**	**1**		**(76,050)**	**(76,050)**	**(0)**
TCS	(501)	(484)	(17)		(744)	(744)	0
Health Technology Wales	(62)	(61)	0		(117)	(117)	0
Trust Income / Reserves	52,948	52,948	0		76,911	76,911	0
Trust Position	**(0)**	**17**	**(17)**		**(0)**	**(0)**	**(0)**

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

Performance

The overall position against the profiled revenue budget to the end of November 2023 is an underspend of £0.017m and is currently expecting to achieve an outturn forecast of Breakeven.

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

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

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve Actions addressed through Divisional Action Plans	**Timescale:**	**Lead:** M Bunce
Expected Performance gain - immediate		

Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve •	**Timescale:**	**Lead:**
Expected Performance gain – longer-term		

Risks to future performance
Set out risks which could affect future performance • Further Non Delivery of recurrent savings plans

PMF Performance Report November 2023/24

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

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				
Target £24.416m CEL		1.389m	1.637m	5.646m	10.333m	8.683m	11.326m	14.277m	19.331m				

Capital Position as at November 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M8 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	8.690	0.000	2.206	10.896	0.000
nVCC - Project costs	0.000	2.308	0.000	(2.308)	3.141	(3.141)
nVCC - Advanced Works	3.882	3.171	0.000	0.711	4.631	(0.749)
nVCC - Whitchurch Hospital Site	0.000	0.018	0.000	0.000	0.018	(0.018)
Integrated Radiotherapy Solutions (IRS)	7.826	4.712	0.000	3.114	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.000	0.000	0.147	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Cyber Security	0.051	0.000	0.000	0.000	0.051	0.000
Total All Wales Capital Programme	22.966	18.899	0.000	4.034	26.874	(3.908)
Discretionary Capital	1.683	0.432	0.000	1.251	1.683	0.000
Total	24.649	19.331	0.000	5.285	28.557	(3.908)

The approved Capital Expenditure Limit (CEL) as at November 2023 is **£24.649m**. This represents all Wales Capital funding of **£22.966m**, and Discretionary funding of **£1.683m.** During September the Trust was awarded £3.882m in respect of advanced design works in nVCC.

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

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

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

Within the discretionary programme £0.340m had been ring fenced to support the nVCC enabling works and project costs. Following slippage in expenditure against the enabling works budget this funding has now been re-provided to the discretionary programme and will be re-allocated based on Divisional priorities.

NHS – All Wales Capital Prioritisation

The Trust received notification from WG in November 2023 that the NHS Infrastructure Investment Board (IIB) have now 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 to ensure alignment with the Duty of Quality which came into force in April 2023. Consequently, the Trust needs to complete a prioritisation form by 14th February 2024 for ALL unapproved business cases irrelevant of status, where Full Business Case / Business Justification approval has not been received.

Performance to date

The actual expenditure to November 2023 on the All-Wales Capital Programme schemes was £18.899m, this is broken down between spend on the nVCC enabling works £8.690, nVCC Project Costs £2.308m, nVCC Advanced works £3.171m, nVCC Whitchurch Hospital Site £0.018m and IRS £4.712m.

Spend to date on Discretionary Capital is currently £0.432m.

Year-end Forecast Spend

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding to support the Project with latest forecast being c£3.1m as at the end of October.

In addition, Capital colleagues within WG are aware that investigation and due diligence costs of c£0.018m have already been incurred on the Whitchurch Hospital site which is associated with the nVCC.

Furthermore, due to the delay additional costs are expected to be incurred on the nVCC advances design agreement which is highlighted within the table above.

Indication from WG colleagues is that funding will be provided to cover the additional costs. We understand that delay in approval of this funding is linked to the nVCC FBC approval and understanding the full cost requirement, which is anticipated to increase following the revised MIM Financial Close. The nVCC FBC is due to be submitted to WG in January '24.

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

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

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance • NVCC not securing the additional funding request from WG of c£4m for further advanced works and project costs.		

Usage of Overtime Bank and Agency Staff within Budget	
Target: Spending within budget	**SLT Lead: Finance Director**
Current Performance against Target or Standard	**Performance**

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

The spend on agency for Nov'23 was **£0.095m,** which gives a cumulative year to date spend of £0.732m and a current forecast outturn spend of circa **£0.987m** (£1.323m 2022/23).

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Agency actual / f'cast Spend 23/24 and Average actual 22/23 & 21/22

Legend: Spend & F'cast 23-24 — Av. Spend 22-23 — Av. Spend 21-22

Cost Improvement Programme delivery against plan														

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

Current Performance against Target or Standard	Performance

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.300	0.084m	0.108m	0.087m	**0.132m**	0.137m	0.137m	0.254m	0.169m				
Target £1.8M Forecast		0.084M	0.084m	0.084m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	1.8M

Overall VUNHST Cost Improvement Programme £1.8M

Cummulative monthly savings achieved compared to target

[Bar chart: Cumulative Achieved Savings (blue) vs Cumulative Target Savings (orange), months April through Mar, values £0 to £1,200,000]

■ Cumulative Achieved Savings   ■ Cumulative Target 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 £0.391m of underlying surplus which had been carried forward from 2022/23.

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

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

Public Sector Payment Performance Target Non NHS Invoices paid within 30 days													
Target: 95%													

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

SLT Lead: Finance Director

Performance

During November '23 the Trust (core) achieved a compliance level of **97.6%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.6%** as at the end of month 8, and a Trust position (including hosted) also of **97.6%** 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 Work between Finance, NWSSP and the service will continue throughout 2023-24 in order to maintain performance.	**Timescale:** 31/03/2024	**Lead:** M Bunce

Expected Performance gain – longer-term.
Ensured compliance

Risks to future performance

Set out risks which could affect future performance

PMF Performance Report November 2023/24

EQUITABLE

<mark>KPI Indicator WOD.81</mark>   [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	**Performance**

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

Performance

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

Trust
Welsh Language (Listening/Speaking)
30th Sept 2023

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1042	1652	63.08%
1 - Entry/ Mynediad	235	1652	14.23%
2 - Foundation / Sylfaen	66	1652	4.00%
3 - Intermediate / Canolradd	40	1652	2.42%
4 - Higher / Uwch	46	1652	2.78%
5 - Proficiency / Hyfedredd	61	1652	3.69%
Not Stated	162	1652	9.81%
Grand Total	**1652**	**1652**	**100%**

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

Mean Gender Pay Gap – Annual															
Target: TBA%															

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Performance

Trust Position	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23
Actual %	-	-	-	-	-	-	13.45	-	-	-	-	-	-	-	
Target TBA%	-	-	-	-	-	-	TBA	-	-	-	-	-	-	-	

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

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%

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
-

Diversity of Workforce – % Black, Asian and Minority Ethnic people														
Target: TBA%														
Current Performance against Target or Standard														

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

SLT Lead: Director of Workforce and OD

Performance

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

Trust

Ethnic Origin

30th Sept 2023

Ethnic Origin	Headcount	%	BAME %
Asian	51	3.09%	**5.45%**
Black	14	0.85%	
Chinese	10	0.61%	
Mixed	15	0.91%	
Not Stated or Unspecified	90	5.45%	
Other	8	0.48%	
White	1464	88.62%	
Grand Total	**1652**	**100%**	

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

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

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

Performance

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

Trust		
Disability		
30th Sept 2023		
Disability	**Headcount**	**%**
No	1354	81.96%
Not Declared	46	2.78%
Prefer Not To Answer	9	0.54%
Unspecified	162	9.81%
Yes	81	4.90%
Grand Total	**1652**	**100%**

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

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

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST NOVEMBER (M8)

DATE OF MEETING	30/01/2024

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 November 2023. The three main issues are highlighted below: 1. **Key Financial targets / KPIs** • The Trust is currently reporting a small underspend on revenue and is forecasting to achieve an outturn position of Breakeven.

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

	TRUST BOARD is asked to:
RECOMMENDATION / ACTIONS	**NOTE** the contents of the November 2023 financial report and in particular the expectation that the Trust will deliver against its 3 statutory Financial Targets at year end, subject to WG Capital funding being approved.
	ENDORSE for Board **APPROVAL** the option that any reserves not required to deliver the Trust revenue breakeven position may be offered to support the NHS Wales position on a non-recurrent basis.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	02/01/2023
Quality, Safety & Performance Committee	16/01/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
EMB endorsed for approval the option that any reserves not required to deliver the Trust revenue breakeven position may be offered to support the NHS Wales position on a non-recurrent basis.	

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 - November 2023
Appendix 2	TCS Finance Report – November 2023

1. SITUATION/ BACKGROUND

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

1.2 The key financial targets information included within this report relates to the Core Trust (Including Health Technology Wales (HTW)). The financial position reported does not include NHS Wales Shared Services Partnership (NWSSP) as it is directly accountable to Welsh Government (WG) for its financial performance. The Balance Sheet / Statement of Financial Position (SoFP) and cash flow provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.011	0.017	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	5.054	19.331	28.557
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.6%	97.6%	95.0%

2.2   Revenue Budget

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

The overall position against the profiled revenue budget to the end of November'23 is an underspend of **£0.017m**, with an outturn forecast of **Breakeven** expected.

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

Long Term Agreement (LTA) Contract Performance

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

NHS Wales Financial Pressures

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

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

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

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

2.3 Savings

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

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

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

2.4 PSPP Performance

PSPP performance for the whole Trust is currently 97.6% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently also achieving a target of 97.6% as at the end of October.

2.5 Covid Expenditure

Covid Programme Costs

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

Covid Recovery and Planned Care Capacity

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

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

2.6 Reserves

The financial strategy for 2023-24 enabled the establishment of recurrent and non-recurrent reserve to support the Trust transformation and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. These assumptions have largely held, apart from the non-delivery of £305k of planned recurrent savings which have been replaced by non-recurrent schemes and removal of the planned c/fwd of a recurrent surplus into 2024-25. In addition, the Trust holds an emergency reserve of £0.522m which has been unused.

Work to review the third year of investment commitments in corporate infrastructure to support delivery of front-line services has been completed. This has not identified any significant funding release that can contribute to the All Wales position. It is important that the Trust keeps its reserve for emergency costs which may arise over the remainder of the year, however, if this reserve and other reserves are not utilised the Trust may be in a position later in the year to release this funding on a non-recurrent basis to contribute to the All Wales position.

2.7 **Financial Risks**

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

There are still several risks that may impact from 2024/25 with the material risks being SDEC Funding uncertainty, Whitchurch site security costs and operational cost pressures 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.

Capital funding has not been allocated for the additional nVCC Project costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding, with the latest forecast being c£3.1m as at the end of October.

In addition, Capital colleagues within WG are aware that investigation and due diligence costs of c£0.018m have already been incurred on the Whitchurch Hospital site which is associated with the nVCC.

Additional costs of c0.750m are also now expected to be incurred on the nVCC advanced design works following the delay to the nVCC.

WG officials have informed the Trust that a request has been submitted to the minister seeking funding approval to cover these additional costs.

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

Discretionary Programme

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

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

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

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

2.9   Cash

In order to support a cash flow pressure during October the Trust drew down £8.881m of Public Dividend Capital (PDC) from WG. The cash position has been further escalated recently as the Trust is yet to receive funding for the 2023-24 AfC or Medical pay awards which led to a net cash outflow directly in relation to the unfunded pay awards of c£13m as at the October pay date.

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 **£0.017m** for November'23 which is in line with the IMTP financial plan. The capital position is forecast overspend as the Trust is awaiting confirmation that additional nVCC Project costs

	and additional advanced design work costs will be funded by WG.
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	

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED NOVEMBER 2023/24

TRUST BOARD
30/01/2024

1

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.**

IMTP Underlying Revenue Position +'ve Surplus / -'ve Deficit Velindre Trust £Ms
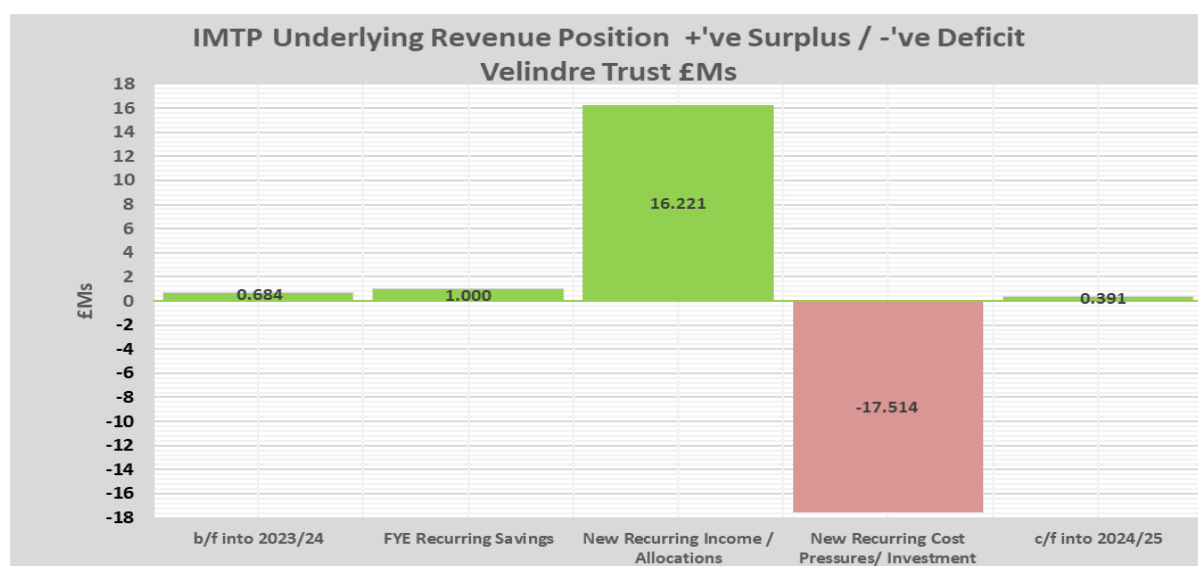
Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2023/24	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.684	1000	16.221	-17.514	0.391

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.011	0.017	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	5.054	19.331	28.557
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.6%	97.6%	95.0%

Performance against Planned Savings Target

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

Revenue

The Trust has reported a **£0.011m** underspend on the in-month position for November in '23, which gives a year to date cumulative underspend of **£0.017m** and an outturn forecast of **Breakeven**.

Capital

The latest approved Capital Expenditure Limit (CEL) as of November 2023 is **£26.649m**. This represents all Wales Capital funding of **£22.966m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to Novemberr'23 of £19.331m and is currently forecasting to remain within the CEL of £26.469m, however is reliant on the Trust receiving funding from WG to support the nVCC project costs and additional costs advanced design works following the delay of Financial close.

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

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	£m Opening	£m Movement	£m Current
Discretionary Capital	**1.683**	**-**	**1.683**
All Wales Capital:			
nVCC - Enabling Works	10.896	-	10.896
nVCC - Advanced Works		3.882	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
Cyber Security		0.051	0.051
Total All Wales Capital	**22.733**	**0.233**	**22.966**
Total CEL	**24.416**		**24.649**

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

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

PSPP

During November '23 the Trust (core) achieved a compliance level of **97.6%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.6%** as at the end of month 8, and a Trust position (including hosted) also of **97.6%** compared to the target of 95%.

Efficiency / Savings

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

Revenue Position

Cumulative				Forecast			
£0.017m Underspent				Breakeven			
Type	**YTD Budget (£m)**	**YTD Actual (£m)**	**YTD Variance (£m)**	**Full Year Budget (£m)**	**Full Year Forecast (£m)**	**Forecast Variance (£m)**
Income	(129.557)	(131.308)	1.751	(198.253)	(200.006)	1.753
Pay	57.280	57.049	0.231	85.218	85.009	0.209
Non Pay	72.277	74.241	(1.964)	113.035	114.997	(1.962)
Total	**0.000**	**(0.017)**	**0.017**	**0.000**	**(0.000)**	**0.000**

The overall position against the profiled revenue budget to the end of November 2023 is an underspend of **£0.017m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

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

4.1 Revenue Position Highlights / Key Issues

4

NHS Wales Financial Pressures

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

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

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

Underlying Position

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

The expected underlying surplus to be carried into 2024-25 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

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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

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24. The Trust's Medium-Term Financial Plan assumed that activity levels may not be high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The latest position (Nov'23 M8) is that the contract performance has recovered to a level that sufficiently funds the capacity investments made to date.

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

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Projected Outturn Variance £m	Projected Outturn £m	Projected Variance (%)
Hywel Dda (7A2)	0.283	-0.039	0.244	-14%
Swansea Bay (7A3)	0.294	-0.007	0.287	-2%
Cardiff & Vale (7A4)	15.036	1.485	16.522	10%
Cwm Taf Morgannwg (7A5)	13.221	1.146	14.367	9%
Aneurin Bevan (7A6)	17.344	1.442	18.786	8%
Powys (7A7)	0.758	0.179	0.938	24%
WHSSC	2.633	-0.314	2.319	-12%
Total	**49.569**	**3.893**	**53.463**	**8%**

Financial Performance Per Contract Currency	Base Contract Value £m	Projected Outturn Variance £m	Projected Outturn £m	Projected Variance (%)
Radiotherapy	17.929	-0.162	17.766	-1%
Nuclear Medicine	0.923	-0.043	0.880	-5%
Radiology Imaging	2.840	0.540	3.381	19%
Preparation for Systemic Anti-Cancer Therapy	2.594	0.155	2.749	6%
Delivery of Systemic Anti-Cancer Therapy	5.935	0.953	6.888	16%
Ambulatory Care Services	1.235	0.251	1.486	20%
Outpatient Services		2.241	11.470	24%
Inpatient Admitted Care	9.229	-0.041	8.843	0%
Total	**49.569**	**3.893**	**53.463**	**8%**

6

VCS Contract income has recovered to a level that sufficiently funds the capacity investments made to date (£3.5m). However, there remains a small risk that planned growth for the remainder of the year may not transpire at the projected levels.

Pay Highlights / Key Issue

At this stage the Trust is expecting to receive full funding from WG for the recurrent impact of the 1.5% (c£1.2m), 5% (c£3.5m) AFC consolidated pay award which was processed in July and the Medical Pay award which was processed in October (c£0.7m). Pay award budget has been allocated to Divisions on assumption of WG matched funding.

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

A number of posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work is continuing in VCS and with Health Board partners through the operational groups to update the likely cancer activity demand forecasts and associated income to help mitigate the financial risk exposure.

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

Non-Pay Key Issues

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

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

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

4.2 Pay Spend Trends (Run Rate)

As of November 2023, the current staff in post is 1,524 WTE. The number of vacancies is 98 WTE, which represents a vacancy rate of 6.04% against the budget of 1622 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 the Trust is reducing, however remains relatively high particularly in Nursing, last year significant improvement was made through targeted recruitment interventions in SACT (in VCC and outreach), reducing the Nursing and HCSW vacancies. Ongoing recruitment interventions are being assessed for SACT nursing with the Trust exploring the international recruitment scheme. During October'23 VCS filled 10 vacancies across various departments including outpatients, Complementary Therapies, SACT day care and 3 posts within Radiotherapy.

7

The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to November 2023:
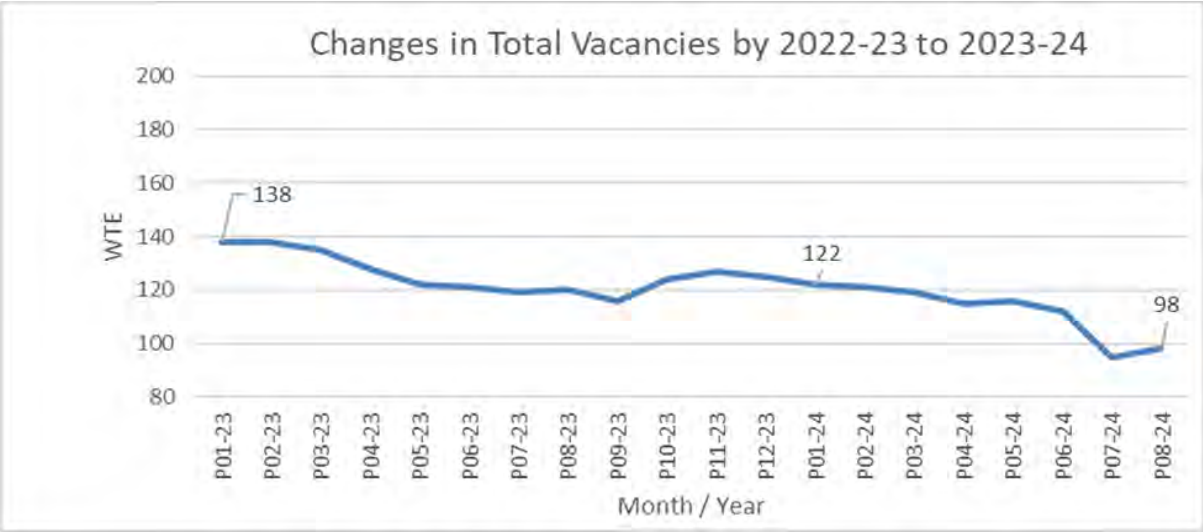
The total Trust vacancies as of November 2023 is 98wte (October 95wte), VCC (54wte), WBS (30wte), Corporate (7wte), R&D (3wte), TCS (2wte) and HTW (2wte).
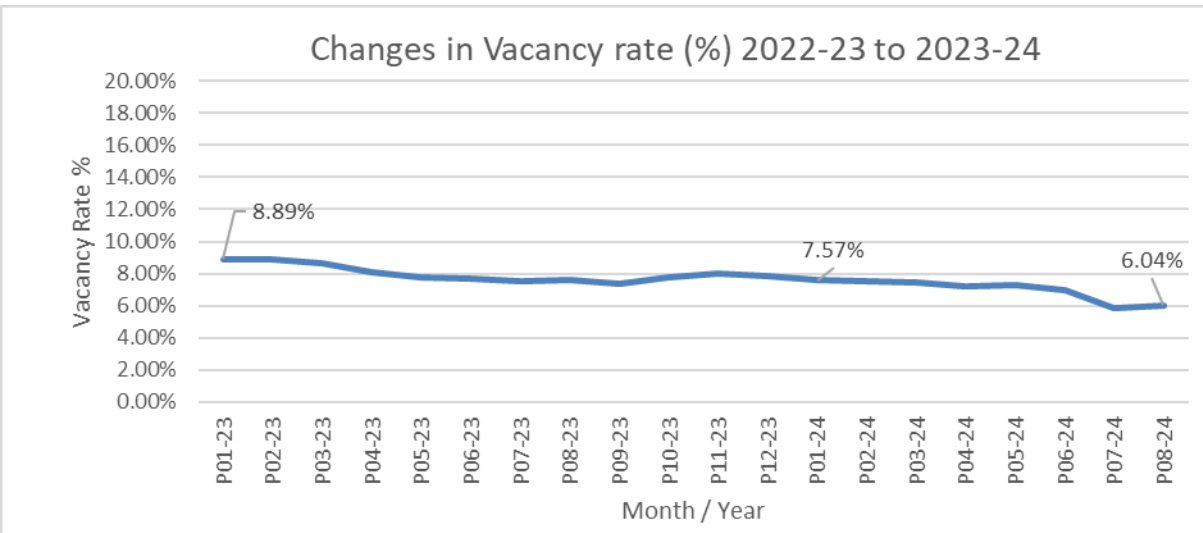
Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions in 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.

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Actual / F'cast Pay Spend 23/24 and Average actual 22/23 & 21/22
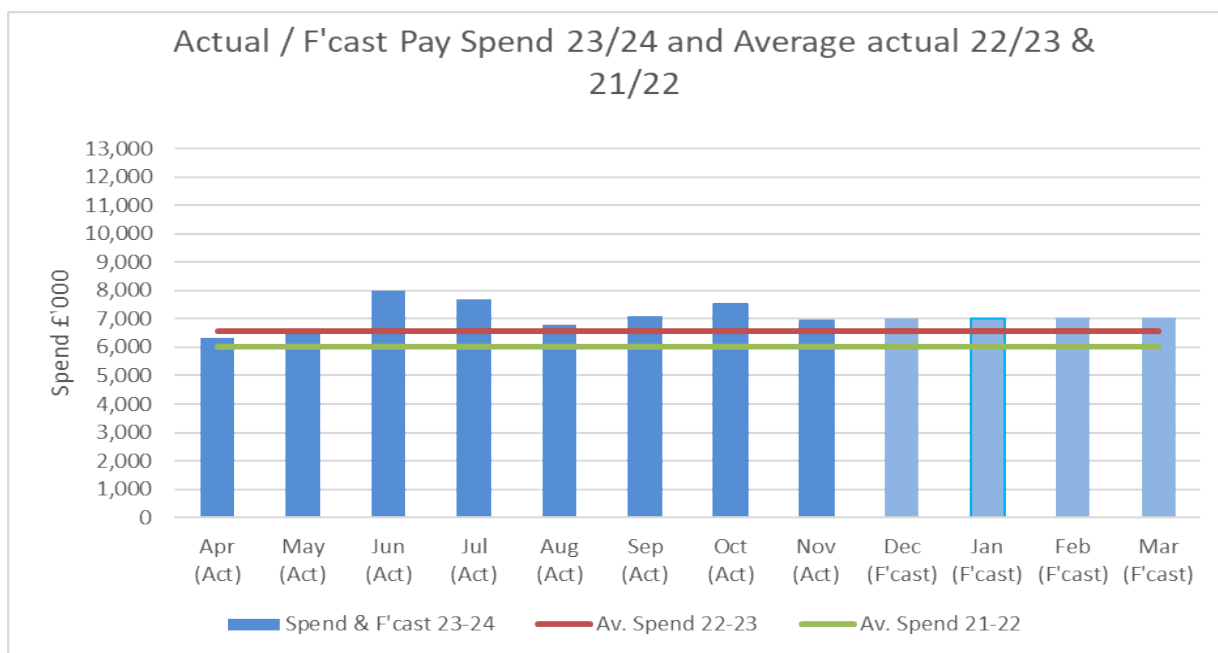
*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% AFC consolidated pay award backdated to April 2023.
*The Spike in pay during October relates to the 5% Medical consolidated pay award backdated to April 2023.

Agency actual / f'cast Spend 23/24 and Average actual 22/23 & 21/22
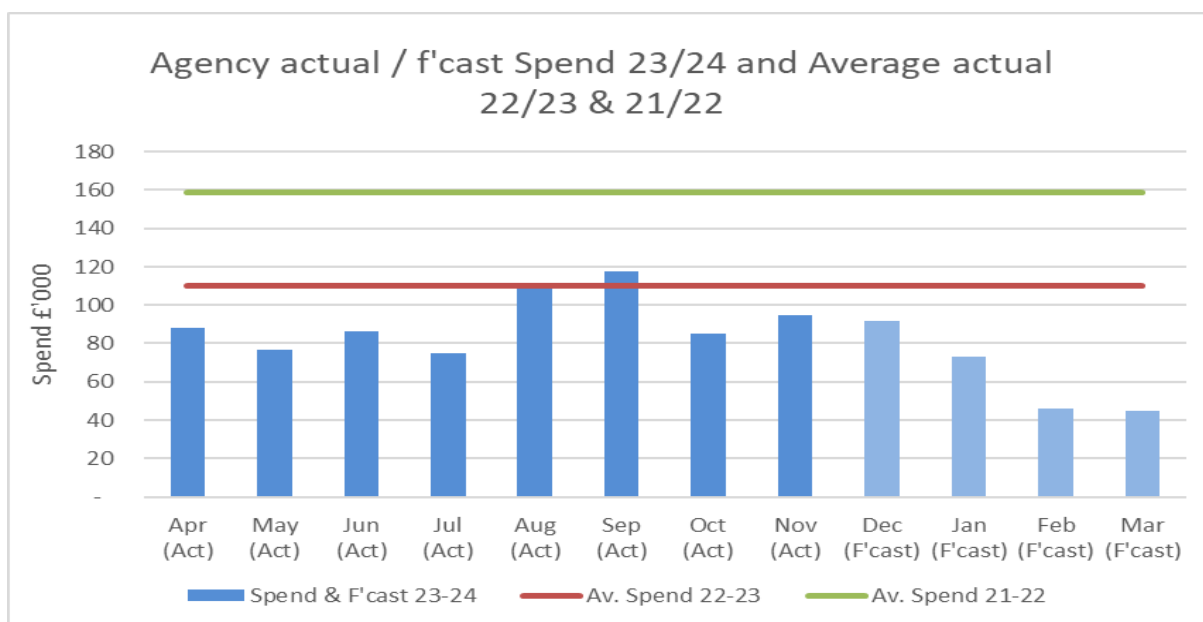
The spend on agency for Nov'23 was **£0.095m** (Oct £0.085m), which gives a cumulative year to date spend of £0.732m and a current forecast outturn spend of circa **£0.987m** (£1.323m 2022/23).

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Changes in Total WTE 2022-23 to 2023-24

Changes in Actual WTE 2022-23 to 2023-24 By Division
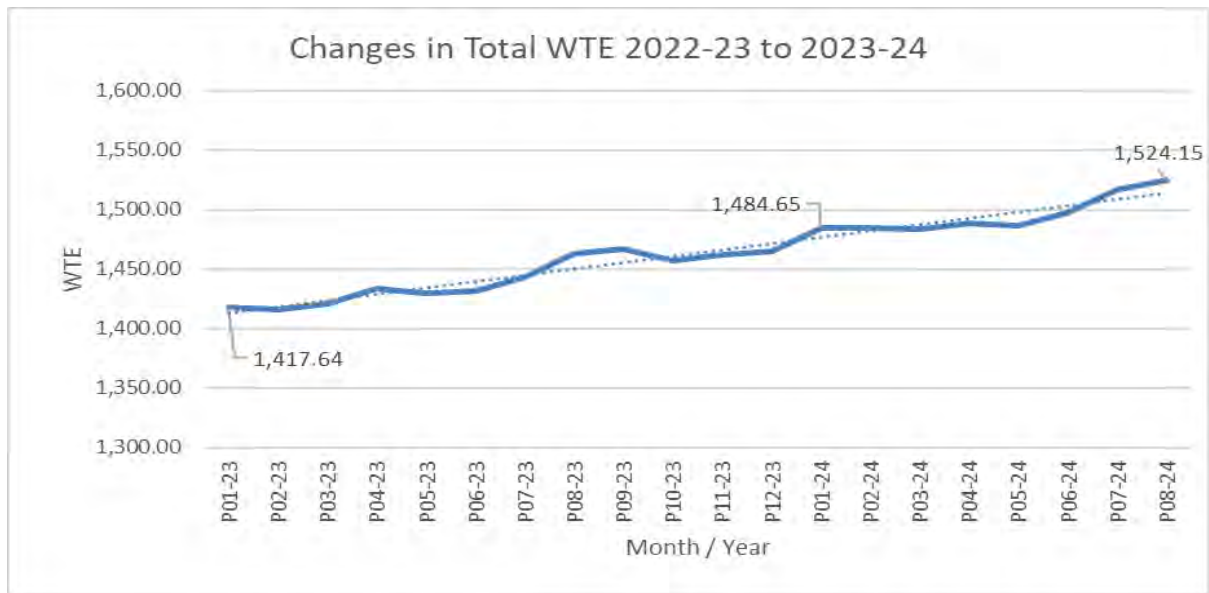
4.3 Non-Pay

The average monthly spend for 2022-23 was £8.5m which was £0.5m higher than the reported monthly average spend for 2021-22. Most of the monthly average increase related to the WBS wholesaling costs, along with the growth in energy costs and general inflation. Average non-pay spend so far for 2023/24 is £9.2m per month which is a £0.7m increase from the previous whole year average. Largest movement is in drug spend which has increased by £4.2m ytd, or £0.7m average per month when compared with the previous year's spend for the same period.

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Monthly Non Pay Spend 2023-24 compared to Average 22-23 & 21-22
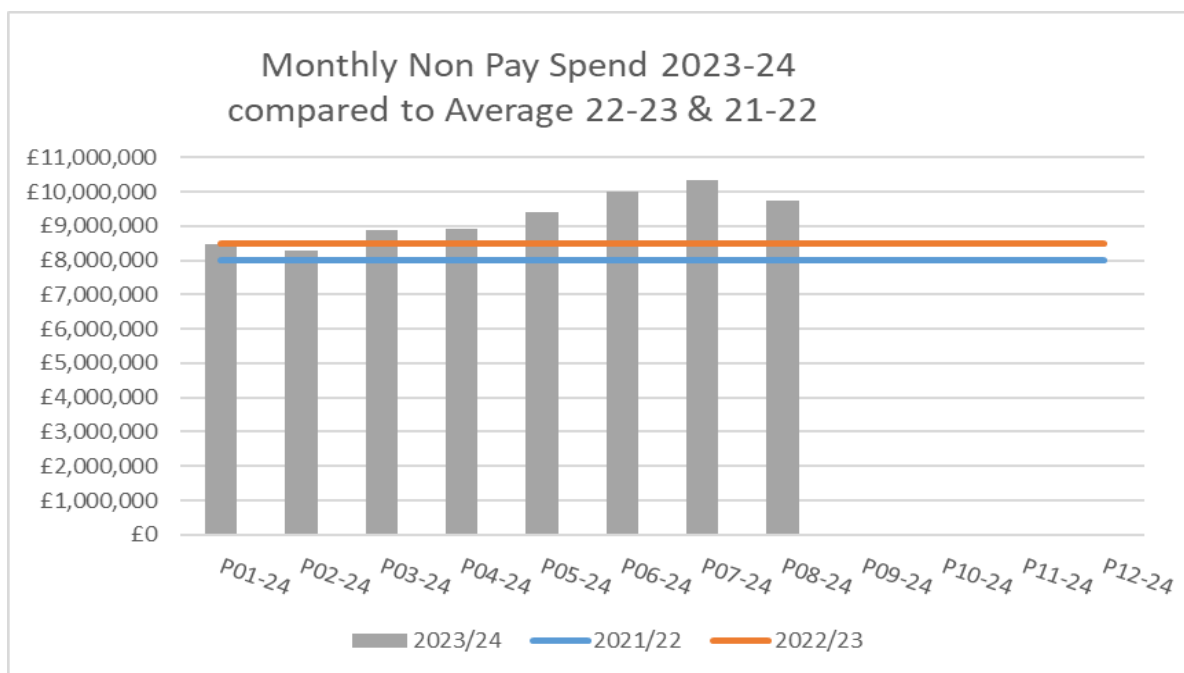
4.4 Covid-19

Covid Programme Costs

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

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

Covid Recovery and Planned Care Capacity

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

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners. The Trust's Medium-Term Financial Plan

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assumed that the growth in activity levels may not be sufficient to recover the costs of investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Nov '23 is that income will cover the cost of the additional capacity.

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

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

4. Savings

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

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

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

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

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

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

It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented, or mitigations put in place to ensure that the Savings target is met for 2023-24.

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ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	950	488	488	0	950	0
			100%		100%	
WBS TOTAL SAVINGS	700	364	364	0	700	0
			100%		100%	
CORPORATE TOTAL SAVINGS	150	88	88	0	150	0
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	1,800	939	939	0	1,800	0
			100%		100%	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes							
Establishment Control (N/R) (Corporate)	Green	75	44	44	0	75	0
Procurement Supply Chain (R) (WBS)	Red	100	44	0	(44)	0	(100)
Collection Team Costs Reduction (R) (WBS)	Green	10	6	6	0	10	0
Collection Team Costs Reduction (NR) (WBS)	Green	8	5	5	0	8	0
Establishment Control (R) (WBS)	Green	60	35	35	0	60	0
Reduced use of Nitrogen (R) (WBS)	Red	55	24	0	(24)	0	(55)
Reduced Research Investment (R) (WBS)	Green	25	15	0	(15)	25	0
Stock Management (NR) (WBS)	Green	125	73	125	52	125	0
Reduced Transport Maintenance (NR) (WBS)	Green	30	13	0	(13)	30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	Green	137	61	23	(38)	137	0
Service Workforce Re-design (R) (VCS)	Red	50	22	0	(22)	0	(50)
Establishment Control (NR) (VCS)	Green	175	78	78	0	175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	Green	150	67	67	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	73	73	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	29	29	0	50	0
Procurement Supply Chain (R) (VCS)	Red	100	44	0	(44)	0	(100)
Total Saving Schemes		1,275	633	484	(149)	970	(305)

	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Income Generation							
Bank Interest (R) (Corporate)	Green	75	44	44	0	75	0
Sale of Plasma (R) (WBS)	Green	150	88	88	0	150	0
Expand SACT Delivery (R) (VCS)	Green	200	117	117	0	200	0
Private Patient Income (R) (VCS)	Green	50	29	29	0	50	0
Private Patient Income (N/R) (VCS)	Green	50	29	29	0	50	0
NEW Medicines at Home (N/R) (VCS)	Green		0	67	67	150	150
NEW Sale of Plasma (NR) (WBS)	Green		0	83	83	155	155
Total Income Generation		525	306	456	150	830	305

TRUST TOTAL SAVINGS	1,800	939	940	0	1,800	0
			100%		100%	

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Cummulative monthly savings achieved compared to target

Legend: ■ Cumulative Achieved Savings ■ Cumulative Target Savings
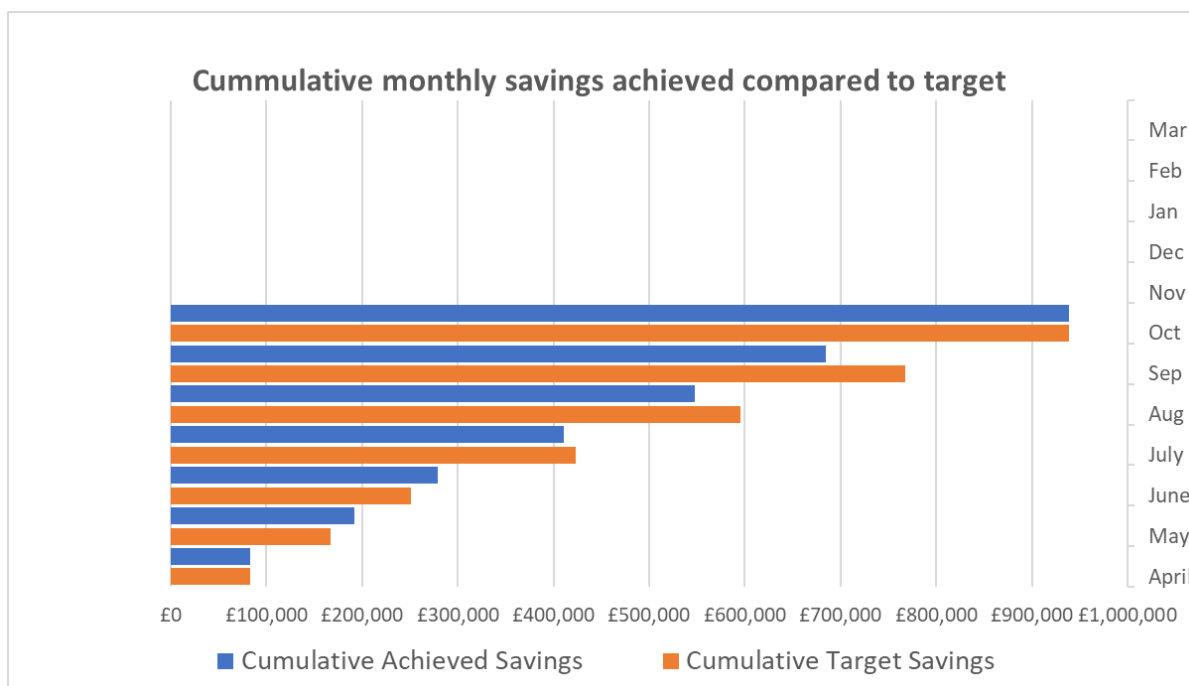
5. Reserves

The financial strategy for 2023-24 enabled the establishment of a recurrent and non-recurrent reserve to support the Trust transformation and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. These assumptions have largely held, apart from the non-delivery of £305k of planned recurrent savings which have been replaced by non-recurrent schemes and removal of the planned c/fwd of a recurrent surplus into 2024-25.

As well as the planned reserves further, un-planned non-recurrent reserves have arisen during the first 6 months of the year as financial pressures built into the IMTP financial plan have reduced (e.g. energy costs) or been mitigated and income levels improved above the plan, including Bank Interest, cancer services activity recovery above plan, balance sheet provisions not required, Plasma Sale income (commercial) and Private Patient Income (Commercial) above plan.

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

Work to review the third year of investment commitments in corporate infrastructure to support delivery of front-line services has been completed. This has not identified any significant funding release that can contribute to the All Wales position. It is important that the Trust keeps its reserve for emergency costs which may arise over the remainder of the year, however, if this reserve and other reserves are not utilised the Trust may be in a position later in the year to release this funding on a non-recurrent basis to contribute to the All Wales position.

6. End of Year Forecast / Risk & Opportunities Assessment

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

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

Risks

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

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

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

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

VCS - SDEC Funding 2024/25 – *Risk 2024/25. £0.935m*

At time of submission of its Business Cases the Trust received assurance from WG Officers that the SDEC funding was recurrent in nature, however the Trust is yet to receive written confirmation to confirm the recurrent funding. Whilst the funding has been confirmed for the current financial year, if this is not secured recurrently it would impact the Trust's underlying position to be carried into 2024/25.

Opportunities

The majority of opportunities have now been accounted for into the overall financial position. The remaining opportunities which have been reported to WG which are in addition to those contributions that have been identified to support the delivery of a reduction in the NHS Wales deficit include:

VCS - Recovery and Planned Care Capacity- *Opportunity / Likelihood - Medium*

The current forecast activity and income to the end of the financial year would lead to £0.300m income opportunity. This income needs to be prioritised for investment against significant service capacity increases required and statutory / mandatory compliance cost pressures in the VCS. The ability to implement these investment priorities in 2023-24 may lead to further non-recurrent reserves being generated.

7. CAPITAL EXPENDITURE

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

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M8 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	8.690	0.000	2.206	10.896	0.000
nVCC - Project costs	0.000	2.308	0.000	(2.308)	3.141	(3.141)
nVCC - Advanced Works	3.882	3.171	0.000	0.711	4.631	(0.749)
nVCC - Whitchurch Hospital Site	0.000	0.018	0.000	0.000	0.018	(0.018)
Integrated Radiotherapy Solutions (IRS)	7.826	4.712	0.000	3.114	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.000	0.000	0.147	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Cyber Security	0.051	0.000	0.000	0.000	0.051	0.000
Total All Wales Capital Programme	22.966	18.899	0.000	4.034	26.874	(3.908)
Discretionary Capital	1.683	0.432	0.000	1.251	1.683	0.000
Total	24.649	19.331	0.000	5.285	28.557	(3.908)

The approved Capital Expenditure Limit (CEL) as at November 2023 is **£24.649m**. This represents all Wales Capital funding of **£22.966m**, and Discretionary funding of **£1.683m.**

During September the Trust was awarded £3.882m in respect of advanced design works in 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 represents an increase of 16% on the £1.454m provided during 2022/23.

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

Within the discretionary programme £0.340m had been ring fenced to support the nVCC enabling works and project costs. Following slippage in expenditure against the enabling works budget this

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funding has now been re-provided to the discretionary programme and will be re-allocated based on Divisional priorities.

NHS – All Wales Capital Prioritisation

The Trust received notification from WG in November 2023 that the NHS Infrastructure Investment Board (IIB) have agreed a framework for investment decision making that will provide a common basis for prioritisation of capital schemes. The review and prioritisation for 2023/24 is required due to the challenging financial climate, an oversubscribed capital backlog and need to ensure alignment with the Duty of Quality which came into force in April 2023. Consequently, the Trust needs to complete a prioritisation form by 14th February 2024 for all unapproved business cases irrelevant of status, where Full Business Case / Business Justification approval has not been received.

Performance to date

The actual expenditure to November 2023 on the All-Wales Capital Programme schemes was £18.899m, this is broken down between spend on the nVCC enabling works £8.690, nVCC Project Costs £2.308m, nVCC Advanced works £3.171m, nVCC Whitchurch Hospital Site £0.018m and IRS £4.712m.

Spend to date on Discretionary Capital is currently £0.432m.

Year-end Forecast Spend

Capital funding has not been allocated for the additional nVCC Project costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding, with the latest forecast being c£3.1m as at the end of October.

In addition, Capital colleagues within WG are aware that investigation and due diligence costs of c£0.018m have already been incurred on the Whitchurch Hospital site which is associated with the nVCC.

Additional costs of c0.750m are also now expected to be incurred on the nVCC advanced design works following the delay to the nVCC.

WG officials have informed the Trust that a request has been submitted to the minister seeking funding approval to cover these additional costs.

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

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

Major Schemes in Development

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

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

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund. The financial year cash flows for many of these schemes including the IRS and IRS Satellite projects require further re-profiling due to delays in the nVCC project and RSC project. This is currently being worked on. The TCS nVCC cash flows will be revised due to the VCC project delays for inclusion in the final FBC. The Digital and Digital scanning infrastructure schemes are also being revised with expectation that costs will now land in future years. All schemes will be reviewed and updated as part of the IMTP process which is underway, and the first draft will be presented on the 16th January.

The schemes that were included within the IMTP for 2023-24 are provided below:

All Wales Approved and Unapproved Capital Schemes	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works	10.896	0.000	1.547			12.443
Integrated Radiotherapy Solution (IRS)	10.326	14.697	6.150			31.173
IRS Satellite Centre	1.347	10.065				11.412
Digital Priority Fund - WHIAS Project	0.167					0.167
Total Approved Capital Schemes	**22.736**	**24.762**	**7.697**	**0.000**	**0.000**	**55.195**
All Wales Unapproved Schemes						
TCS nVCC	7.168	34.132	7.147			48.447
TCS nVCC Enabling works	1.000					1.000
WBS HQ	0.120	1.016	12.808	9.996	10.961	34.901
Plasma Fractionation (under development)						0.000
WBS Fleet Replacement		1.400				1.400
WTAIL Lims Case	0.826	0.066				0.892
WBS Blood Establishment Computer System (BECS) (under development)						0.000
WBS Blood Group Analyser Replacement		0.480				0.480
WBS Asset Replacement		0.300	0.400	0.500		1.200
VCC Replacement Brachytherapy Applicators			0.300			0.300
Digital Services	0.650	0.400	0.400	0.400		1.850
Digital Scannning infrastructure	2.536	0.536				3.072
Total Unapproved Capital Schemes	**12.300**	**38.330**	**21.055**	**10.896**	**10.961**	**93.542**
Total All Wales Capital Plans	**35.036**	**63.092**	**28.752**	**10.896**	**10.961**	**148.737**

8. BALANCE SHEET / 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.

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	Opening Balance Beginning of Apr 23	Closing Balance End of Nov-23	Movement from 1st April Nov-23	Forecast Closing Balance End of Mar 24
Non-Current Assets	£'m	£'m	£'m	£'m
Property, plant and equipment	170.418	181.802	11.384	181.802
Intangible assets	11.194	10.712	(0.482)	10.712
Trade and other receivables	1,107.047	1,111.837	4.790	1,111.837
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,288.659	1,304.351	15.692	1,304.351
Current Assets				
Inventories	34.070	30.950	(3.120)	30.950
Trade and other receivables	565.742	557.500	(8.242)	570.588
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	31.136	23.488	(7.648)	10.400
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	630.948	611.938	(19.010)	611.938
TOTAL ASSETS	1,919.607	1,916.289	(3.318)	1,916.289
Current Liabilities				
Trade and other payables	(226.254)	(218.423)	7.831	(218.423)
Borrowings	(1.123)	0.00	1.123	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(392.525)	(431.449)	(38.924)	(431.449)
Current Liabilities sub total	(619.902)	(649.872)	(29.970)	(649.872)
NET ASSETS LESS CURRENT LIABILITIES	1,299.705	1,266.417	(33.288)	1,266.417
Non-Current Liabilities				
Trade and other payables	(3.092)	(3.092)	0.000	(3.092)
Borrowings	(2.421)	0.00	2.421	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,108.919)	(1,069.028)	39.891	(1,069.028)
Non-Current Liabilities sub total	(1,114.432)	(1,072.120)	42.31	(1,072.120)
TOTAL ASSETS EMPLOYED	185.273	194.297	9.024	194.297
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	34.708	34.833	0.125	34.833
PDC	131.461	139.928	8.467	139.928
Retained earnings	19.104	19.536	0.432	19.536
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	185.273	194.297	9.024	194.297

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. The cash position has been further escalated recently as the Trust is yet to receive funding for the 2023-24 AfC or Medical pay awards which has left a net cash outflow directly in relation to the unfunded pay awards of c£13m.

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

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	Income from other Welsh NHS	37.581	38.378	41.097	40.905	41.581	41.028	45.508	50.729	45.997	45.302	46.530	47.662	522.297
2	WG Income	14.460	18.799	9.707	42.966	22.143	2.138	9.901	40.339	30.778	24.722	27.378	25.053	268.384
3	Short Term Loans													0.000
4	PDC							8.881					12.199	21.080
5	Interest Receivable	0.149	0.162	0.143	0.126	0.106	0.117	0.140	0.107	0.100	0.100	0.100	0.100	1.450
6	Sale of Assets													0.000
7	Other	6.156	3.753	2.953	5.651	5.886	12.689	4.605	9.557	4.550	5.350	6.250	7.325	74.724
8	TOTAL RECEIPTS	58.346	61.092	53.900	89.648	69.716	55.971	69.035	100.732	81.425	75.474	80.258	92.339	887.935
	PAYMENTS													
9	Salaries and Wages	31.801	34.720	38.993	34.802	34.922	34.500	37.556	39.292	35.906	35.917	35.941	35.875	430.226
10	Non pay items	28.883	34.362	26.186	46.813	35.820	9.253	33.404	49.863	43.300	47.602	46.650	44.473	446.609
11	Short Term Loan Repayment											0.000		0.000
12	PDC Repayment		0.000											0.000
14	Capital Payment	1.122	0.394	2.160	1.949	0.824	1.094	2.297	5.077	4.500	2.162	3.482	6.776	31.837
15	Other items													0.000
16	TOTAL PAYMENTS	61.807	69.477	67.339	83.564	71.566	44.847	73.257	94.232	83.706	85.681	86.073	87.124	908.672
17	Net cash inflow/outflow	(3.461)	(8.385)	(13.438)	6.085	(1.850)	11.124	(4.222)	6.500	(2.281)	(10.207)	(5.816)	5.215	
18	Balance b/f	31.136	27.675	19.290	5.851	11.936	10.086	21.210	16.988	23.488	21.207	11.000	5.185	
19	Balance c/f	27.675	19.290	5.851	11.936	10.086	21.210	16.988	23.488	21.207	11.000	5.185	10.400	

Monthly Cash Flow Forecast

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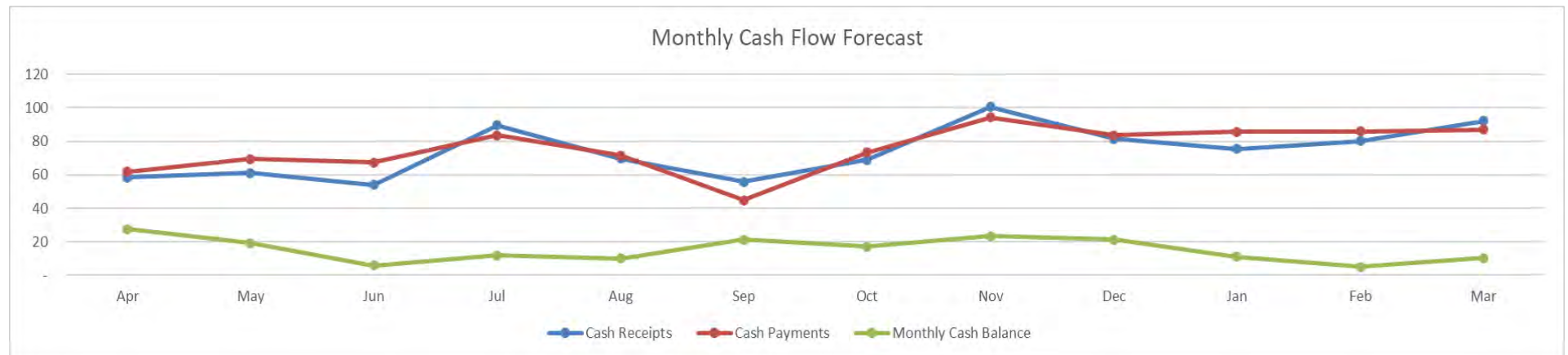
DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(28,365)	(28,366)	0	(41,288)	(41,288)	(0)
RD&I	(399)	(397)	(1)	91	91	0
WBS	(14,726)	(14,725)	(0)	(21,666)	(21,666)	0
Sub-Total Divisions	**(43,490)**	**(43,488)**	**(1)**	**(62,862)**	**(62,862)**	**(0)**
Corporate Services Directorates	(8,895)	(8,897)	2	(13,188)	(13,188)	(0)
Delegated Budget Position	**(52,385)**	**(52,386)**	**1**	**(76,050)**	**(76,050)**	**(0)**
TCS	(501)	(484)	(17)	(744)	(744)	0
Health Technology Wales	(62)	(61)	0	(117)	(117)	0
Trust Income / Reserves	52,948	52,948	0	76,911	76,911	0
Trust Position	**(0)**	**17**	**(17)**	**(0)**	**(0)**	**(0)**

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**48.770**	**49.692**	**0.922**	**75.632**	**76.554**	**0.922**
Expenditure						
Staff	**33.361**	**33.470**	**(0.109)**	**49.589**	**49.698**	**(0.109)**
Non Staff	**43.775**	**44.588**	**(0.813)**	**67.331**	**68.144**	**(0.813)**
Sub Total	**77.136**	**78.057**	**(0.922)**	**116.920**	**117.842**	**(0.922)**
Total	**(28.365)**	**(28.366)**	**0.000**	**(41.288)**	**(41.288)**	**(0.000)**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of November 2023 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 8 represents a surplus of **£0.920m**. 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 small income overachievements in areas such as Catering and project income which are offset with non-pay costs.

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VCS have reported a year to date overspend of **£(0.109)m** against staff. The division continues to have reasonably high levels of vacancies although reducing with VCS filing 10 vacancies in October across various departments including outpatients, Complementary Therapies, SACT day care and 3 posts within Radiotherapy. Vacancies sickness, and maternity leave still remain relatively high across several services and particularly across Nursing budgets, this along with recruitment challenges, is largely offsetting both the vacancy savings target and the requirement to support posts appointed into without funding agreement i.e. Advanced recruitment and Capacity investments. The international recruitment scheme is being explored within Nursing to help fill current vacancies with posts expected to commence from December.

Non-Staff Expenditure at Month 8 was **£(0.813)m** overspent which is a result of the divisional management savings target, along with increased activity pressures which can be linked to contract performance and in areas such as PICC and SACT following treatment returning to Nevill Hall.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**18.783**	**19.019**	**0.237**	**28.181**	**28.417**	**0.237**
Expenditure						
Staff	**12.307**	**12.271**	**0.036**	**18.442**	**18.407**	**0.036**
Non Staff	**21.201**	**21.473**	**(0.272)**	**31.404**	**31.676**	**(0.272)**
Sub Total	**33.508**	**33.745**	**(0.236)**	**49.846**	**50.083**	**(0.236)**
Total	**(14.726)**	**(14.725)**	0.000	**(21.666)**	**(21.665)**	0.000

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of November 2023 was **Breakeven** with an outturn forecast position of **Breakeven** currently expected.

Income overachievement of **£0.237m** to month 8. Targeted income generation on plasma sales through increased activity which is exceeding planned expectations and creating opportunities to support divisional investment. Temporary drop in plasma sales during November primarily due to staffing issues and temperature control of external freezer, issue has been reported and is being reviewed within the Service. 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 have previously run campaigns to try and grow the panel in sites such as schools and universities, however the year to date target is currently underachieving by c40%.

Staff reported a **£0.036m** underspend to November. Vacancies are helping to offset the overspend from posts supported without identified funding source. This includes advanced recruitment and

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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 **£(0.272)m** to November. YTD energy price rises have been funded centrally by the Trust as agreed at the IMTP planning stage along with venue hire costs pressures c£10-£15k per month previously funded by WHSSC, are being partly offset by reduced spend from lower activity releasing non-recurrent benefits linked to reduced production volumes. Trust and Divisional savings plans are phased into the position and contributing to the overspend.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	1.755	2.289	0.534	2.583	3.117	0.534
Expenditure						
Staff	8.195	7.907	0.288	12.206	11.918	0.288
Non Staff	2.456	3.279	(0.824)	3.566	4.388	(0.822)
Sub Total	10.651	11.186	(0.536)	15.772	16.305	(0.534)
Total	(8.895)	(8.897)	(0.002)	(13.188)	(13.188)	(0.000)

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of November 2023 was a small overspend of **£0.002m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

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

For staff several vacancies have been carried throughout the year across the division particularly within finance which is offsetting the cost of agency and the divisional savings target within non pay and reflecting and underspend of £0.288m as at month 8.

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

RD&I

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	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	1.661	1.723	0.063	3.330	3.392	0.062
Expenditure						
Staff	1.901	1.906	(0.006)	2.956	2.962	(0.006)
Non Staff	0.159	0.214	(0.055)	0.283	0.338	(0.055)
Sub Total	2.059	2.120	(0.061)	3.239	3.300	(0.061)
Total	(0.399)	(0.397)	(0.001)	0.091	0.092	0.000

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of November 2023 was **breakeven** with a current forecast outturn position of **breakeven**.

Trials Income fluctuations expected throughout the year.

TCS – (Revenue)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	0	0	0	0	0	0
Expenditure						
Staff	491	473	17	730	730	0
Non Staff	10	11	(0)	15	15	0
Sub Total	501	484	17	744	744	0
Total	(501)	(484)	17	(744)	(744)	0

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of November 2023 is **£(0.017)m** overspent with a forecasted outturn position of **Breakeven.**

Interest received from the Escrow account is expected to be used to mitigate the current overspend which is reflected in the TCS report where the expenditure budgets have been inflated to match actual spend.

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	1.050	1.047	(0.003)	1.677	1.677	0.000
Expenditure						
Staff	1.026	1.022	0.004	1.545	1.545	0.000
Non Staff	0.086	0.086	0.000	0.248	0.248	0.000
Sub Total	1.112	1.108	0.004	1.794	1.794	0.000
Total	(0.062)	(0.061)	(0.000)	(0.117)	(0.117)	0.000

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of November 2023 was **breakeven,** with a forecasted outturn position of **breakeven.**

HTW programme costs are funded directly by WG.

The pay award is to be funded via the Trust allocation for 2023/24 and going forward.
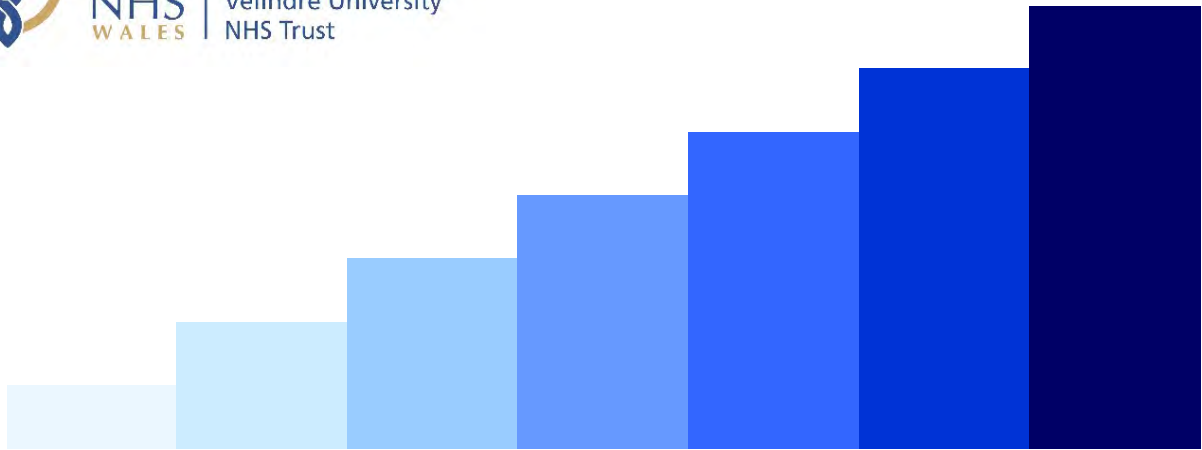
TCS PROGRAMME
FINANCE REPORT 2023-24

Period Ending 30th November 2023

**Presented to EMB Shape on
18th December 2023**

Contents   **Page**

1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2023-24, outlining spend against budget as at 30th September 2023 and the current year-end forecast.

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

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2023-24 as at 30th November 2023 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Capital	£14.189m	£14.778m	£18.685m	-£3.907m
Revenue	£0.513m	£0.785m	£0.785m	£0
Total	**£14.702m**	**£15.564m**	**£19.470m**	**-£3.907m**

2.2 The overall forecast outturn for the Programme is an overspend of £3.907m for the financial year 2023-24 against a budget of £15.564m.

2.3 Capital funding has not been allocated for the FBC phase of the nVCC Project for this financial year. The funding request for c£2.800m made to WG will be increased to £3.140m.

2.4 Capital funding of £3.882m has been allocated to the nVCC Project by WG for advanced works for the FBC stage, confirmed in October 2023.

2.5 No revenue funding has been allocated for Project Delivery and Judicial Review elements of the nVCC project for this financial year. These costs will be funded from the interest gained from the Escrow account for ASDA.

2.6 The current financial risks associated with TCS are:

- The Enabling Works Project may be required to provide financial support to the nVCC Project due the current lack of funding for 2023-24 for the latter. This risk is being mitigated as previously noted.

- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.300m. Ministerial approval will be sought for this additional funding.

- The current risk to the nVCC Project is the lack of funding, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of c£3.140m.

- There is a risk of a lack of funding for the Advanced Works Agreement element of the ADDA. This is being mitigated by A funding request is being submitted to WG, who have agreed to underwrite these costs.

- There is also the risk of a lack of funding for these costs, which is being mitigated by securing additional funding from WG as part of the Enabling Works FBC Addendum.

3.   BACKGROUND

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

3.2   By 31st March 2023, the Welsh Government (WG) had provided a total of £42.377m funding (£40.084m capital, £2,293m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.380m non-recurrent revenue funding.

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

3.4   The current funding provided to support the TCS Programme in 2023-24 is £10.896m capital and £0.785m 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	-£0.230m	-£0.230m
nVCC Project	£0	£0
ADDA	£3.882m	£3.882m
Whitchurch Hospital Site	£0	£0
Total	**-£0.230m**	**-£0.230m**

Current Allocation (as at 30th November 2023)

Project	WG Capital	Total Funding
Enabling Works Project	£10.667m	£10.667m
nVCC Project	£0	£0
ADDA	£3.882m	£3.882m
Whitchurch Hospital Site	£0	£0
Total	**£10.667m**	**£10.667m**

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**

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   £0
- ADDA   £3.882m
- Whitchurch Hospital Site   £0
  Total   **£14.778m**

4.2   The capital position as at 30th November 2023 is outlined below, with a forecast overspend of £18.685.150m for 2023-24 against a budget of £14.778m. This is due to the lack of capital funding being allocated to the nVCC Project for this financial year.

Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£8.691m	£10.896m	£10.896m	£0.001m
nVCC Project	£2.309m	£0	£3.141m	-£3.141m
ADDA	£3.172m	£3.882m	£4.631m	-£0.749m
Whitchurch Hospital Site	£0.018m	£0	£0.018m	-£0.018m
Total	**£14.189m**	**£14.778m**	**£18.685m**	**-£3.907m**

4.3   A funding request has been made to WG for c£2.800m for the nVCC Project, which will be amended to reflect the increased overspend of £3.140m.

4.4   There are three new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.300m. This additional capital funding will require Ministerial approval.

5.   REVENUE POSITION

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

- PMO   £0.328m
- nVCC Project   £0.137m
- SDT Project   £0.320m
  Total   **£0.785m**

5.2   The revenue position as at 30th November 2023 is outlined below, with a forecast break even position for the financial year for 2023-24 against a budget of £0.785m. This is due to the lack of funding for the nVCC revenue non-pay costs for this financial year.

Revenue Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
PMO	£0.215m	£0.328m	£0.328m	£0
nVCC Project	£0.100m	£0.137m	£0.137m	£0
SDT Project	£0.198m	£0.320m	£0.320m	£0
Total	**£0.513m**	**£0.785m**	**£0.785m**	**£0**

5.3   Revenue funding of £0.041m will be provided to the nVCC Project for Project Delivery and Judicial Review costs.

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 will have been incurred within the first half of the financial year.

EW Project Cash Flow 2023-24
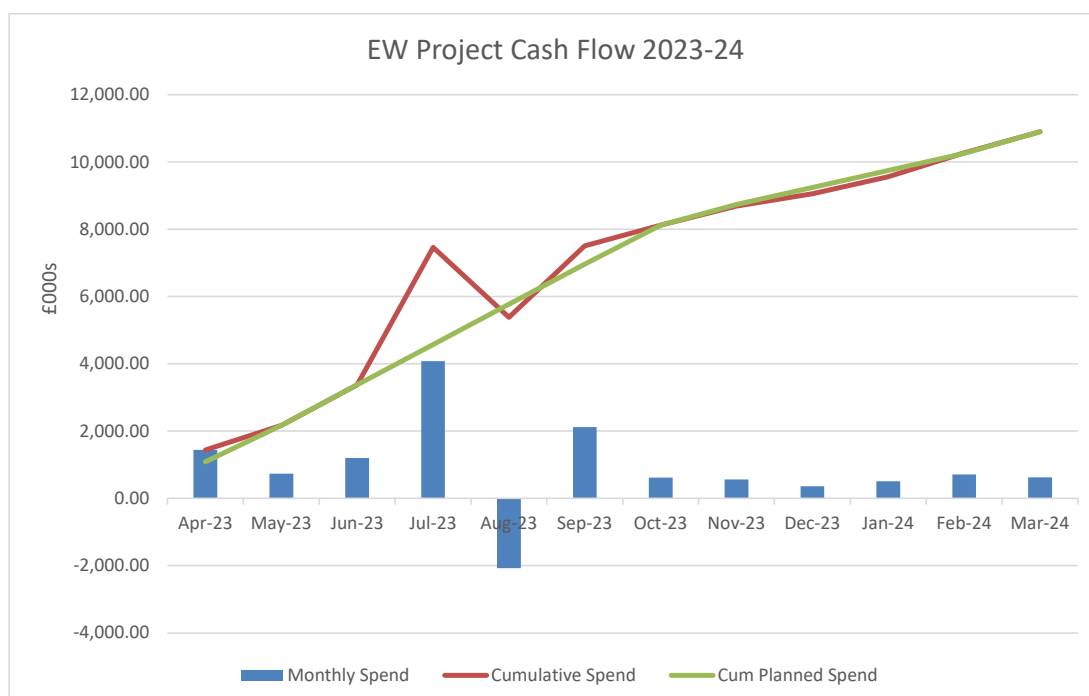
6.2   The capital cash flow for the **nVCC Project** is outlined below. Actual spend is higher than planned spend due to the increased costs associated with the delay in financial close.

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nVCC Project Cash Flow 2023-24
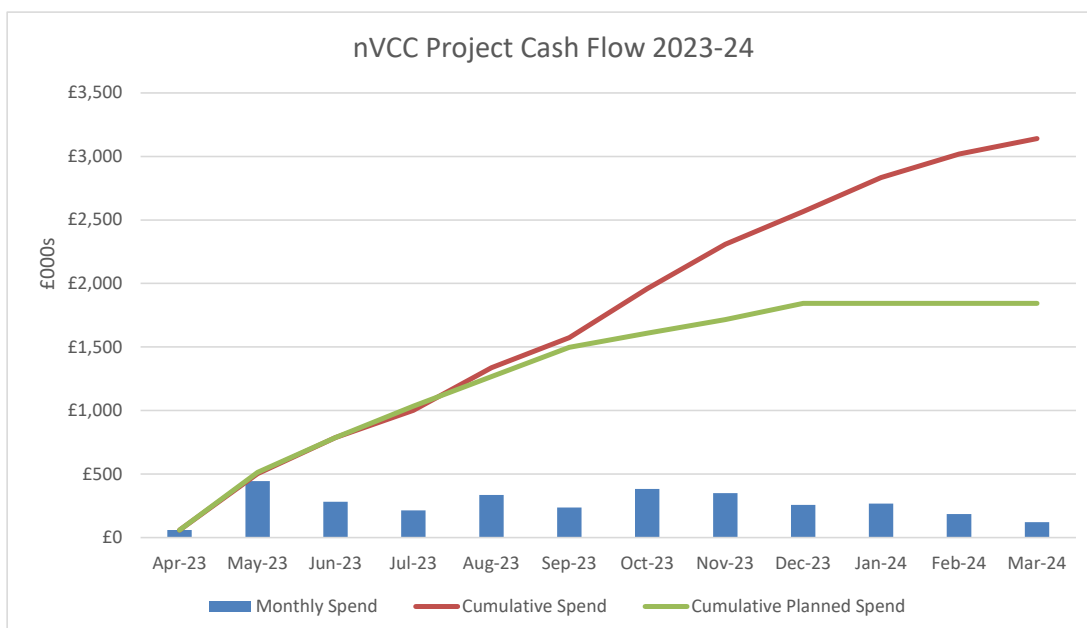
6.3   The cash flow for the remainder of the Programme is not reported as it is not of a material nature.

7.   PROJECT FINANCE UPDATES

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

Programme Management Office

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

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

7.4   The revenue position for the PMO as at 30th November 2023 is shown below, showing a forecast breakeven positon for the year against a budget of £0.328m.

PMO Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.212m	£0.327m	£0.327m	£0
Non-Pay	£0.003m	£0.001m	£0.001m	£0
Total	**£0.215m**	**£0.328m**	**£0.328m**	**£0**

7.5   There are currently no financial risks associated with the PMO for 2023-24.

Enabling Works Project

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

7.7   The Project's financial position for 30th November 2023 is shown below. The forecast position reflects an expected underspend of £0.001m for this financial year.

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Enabling Works Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.213m	£0.230m	£0.297m	-£0.067m
Non-Pay	£8.478m	£10.667m	£10.599m	£0.068m
Total	**£8.691m**	**£10.896m**	**£10.896m**	**£0.001m**

7.8   There are three new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.300m. This additional capital funding will require Ministerial approval. The elements are:

- Water Main Diversion   £0.850m inc VAT
- S278 Works – Longwood Drive   £1.200m inc VAT
- Off Site Habitat Creation   £0.250m inc VAT
  Total   **£2.300m inc VAT**

7.9   The Project spend relates to the following activities:

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

Description	Budget Nov-23 £	Year to Date Spend Nov-23 £	Variance Nov-23 £	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY						
Project 1b - Enabling Works FBC	171,227	212,987	-41,759	229,841	297,155	-67,314
Pay Capital Total	**171,227**	**212,987**	**-41,759**	**229,841**	**297,155**	**-67,314**
NON-PAY						
EF02 Utility Costs	2,134,351	1,491,385	642,967	2,873,927	2,491,385	382,542
EF03 Supply Chain Fees	233,333	306,688	-73,355	375,000	413,688	-38,688
EF04 Non Works Costs	208,337	83,100	125,236	312,505	173,000	139,505
EF05 ASDA Works	2,951,946	2,366,836	585,110	3,813,893	2,712,235	1,101,658
EF06 Walters D&B	3,033,982	4,229,954	-1,195,973	3,033,982	4,354,954	-1,320,973
EF07 Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	0	0	0
EF08 Section 278	0	0	0	0	500,000	-500,000
EFQR Quantified Risk	6,247	512	5,735	257,245	512	256,733
EFQS QRA - SCP	0	0	0	0	0	0
EFRS Enabling Works FBC Reserves	0	-549	549	0	-47,049	47,049
Enabling Works FBC Project Capital Total	**8,568,196**	**8,477,928**	**90,269**	**10,666,552**	**10,598,726**	**67,825**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE	**8,739,424**	**8,690,914**	**48,510**	**10,896,393**	**10,895,881**	**512**

7.10   There are currently two financial risks associated with the Enabling Works Project:

- The Enabling Works Project may be required to provide financial support to the nVCC Project due the current lack of funding for 2023-24 for the latter. This risk is being mitigated as previously noted.

- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.300m. Ministerial approval will be sought for this additional funding.

New Velindre Cancer Centre Project
Capital

7.11   The nVCC Project has not been allocated capital funding for this financial year. A funding request has been made to WG for c£2.800m, which will be updated to £3.140m.

7.12   The capital financial position for the nVCC Project for 30th November 2023 is shown below, with a forecast overspend of £3.141m. This is due to the delay of the nVCC Financial Close into 2023-24 with no funding for the Project at this stage.

nVCC Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.761m	£0	£1.175m	-£1.175m
Non-Pay	£1.548m	£0	£1.966m	-£1.966m
Total	**£2.309m**	**£0**	**£3.141m**	**-£3.141m**

7.13   The spend relates to the following activities:

nVCC OBC Project Capital Budget & Spend Summary 2023-24

Description	Budget Nov-23 £	Year to Date Spend Nov-23 £	Variance Nov-23 £	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY						
Project Leadership nVCC OBC	0	142,394	-142,394	0	215,952	-215,952
Project 2a - New Velindre Cancer Centre OBC	0	618,501	-618,501	0	959,028	-959,028
Pay Capital Total	**0**	**760,895**	**-760,895**	**0**	**1,174,980**	**-1,174,980**
NON-PAY						
nVCC OBC Project Delivery	**0**	**35,516**	**-35,516**	**0**	**63,000**	**-63,000**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	0	1,349,159	-1,349,159	0	1,727,159	-1,727,159
VC10 Legal Advice	0	9,398	-9,398	0	11,898	-11,898
VC11 S73 Planning	0	14,437	-14,437	0	14,437	-14,437
VC12 nVCC FBC	0	118,254	-118,254	0	118,254	-118,254
VCRS nVCC OBC Reserves	0	20,945	-20,945	0	30,945	-30,945
nVCC Project Capital Total	**0**	**1,512,193**	**-1,512,193**	**0**	**1,902,693**	**-1,902,693**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**2,308,604**	**-2,308,604**	**0**	**3,140,673**	**-3,140,673**

7.14   The current risk to the Project is the lack of funding, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of c£3.140m.

Revenue

7.15   The current 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 has superceded 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 30th November 2023 is shown below, reflecting a forecast break even position for the year against budget of £0.137m.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.070m	£0.096m	£0.096m	£0
Project Delivery	£0.019m	£0.030m	£0.030m	£0
Judicial Review	£0.011m	£0.011m	£0.011m	£0
Total	**£0.100m**	**£0.137m**	**£0.137m**	**£0**

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) up to a value of £3.882m (excl. VAT).

7.20   The capital financial position for this Project for 30th November 2023 is shown below, with a forecast spend of £4.631m against a current budget £3.882m for the year.

ADDA Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Non-Pay	£3.172m	£3.882m	£4.631m	-£0.749m
Total	**£3.172m**	**£3.882m**	**£4.631m**	**-£0.749m**

7.21   The spend relates to the following activities:

Advanced Design Development Agreement Capital Budget & Spend Summary 2023-24						
Description	Budget Nov-23 £	Year to Date Spend Nov-23 £	Variance Nov-23 £	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY						
Project 2b - Advanced Design Development Agreement	0	0	0	0	0	0
Pay Capital Total	0	0	0	0	0	0
NON-PAY						
Work Packages						
AD01 Advanced Design Development Agreement	2,422,896	2,422,896	1	3,881,995	3,881,994	1
AD02 Advanced Works Agreement	0	748,715	-748,715	0	748,715	-748,715
AD03 Advanced Works Deed of Variation	0	0	0	0	0	0
AD04 Advisory Services	0	0	0	0	0	0
ADRS ADDA Reserves	0	0	0	0	0	0
nVCC Project Capital Total	2,422,896	3,171,611	-748,714	3,881,995	4,630,709	-748,714
TOTAL nVCC OBC CAPITAL EXPENDITURE	2,422,896	3,171,611	-748,714	3,881,995	4,630,709	-748,714

7.22   There is an increase of £0.750m in the forecast spend for the year due to the Advance Works Agreement. A funding request is being submitted to WG, who have agreed to underwrite these costs.

7.23   There is a risk of a lack of funding for these costs, which is being mitigated as noted above.

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 nVCC Project for 30th November 2023 is shown below, with a forecast overspend of £0.018m.

Whitchurch Hospital Site Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0.018m	£0	£0.018m	-£0.018m
Total	**£0.018m**	**£0**	**£0.018m**	**-£0.018m**

Whitchurch Hospital Site Capital Budget & Spend Summary 2023-24

Description	Year to Date			Financial Year		
	Budget Nov-23 £	Spend Nov-23 £	Variance Nov-23 £	Annual Budget £	Annual Forecast £	Annual Variance £
PAY						
Project 2c - Whitchurch Hospital Site	0	0	0	0	0	0
Pay Capital Total	0	0	0	0	0	0
NON-PAY						
Work Packages						
WS01 Advisory Services	0	11,232	-11,232	0	11,232	-11,232
WS02 Prelimiary Works	0	6,495	-6,495	0	6,495	-6,495
WSRS Whitchurch Hospital Site Reserves	0	0	0	0	0	0
nVCC Project Capital Total	0	17,727	-17,727	0	17,727	-17,727
TOTAL nVCC OBC CAPITAL EXPENDITURE	0	17,727	-17,727	0	17,727	-17,727

7.26 There is a risk of a lack of funding for these costs, which is being mitigated by securing additional funding from WG as part of the Enabling Works FBC Addendum.

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

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

7.29 The SDT Project revenue position for 30th November 2023-24 is shown below, showing a forecast breakeven positon for the year against a budget of £0.320m.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.190m	£0.306m	£0.306m	£0
Non-Pay	£0.008m	£0.013m	£0.013m	£0
Total	**£0.198m**	**£0.320m**	**£0.320m**	**£0**

7.30 There are currently no financial risks associated with the Project for 2023-24.

8.   KEY RISKS AND MITIGATING ACTIONS

8.1   The current three financial risks associated with TCS are outlined below:

- The Enabling Works Project may be required to provide financial support to the nVCC Project due the current lack of funding for 2023-24 for the latter. This risk is being mitigated as previously noted.

- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.300m. Ministerial approval will be sought for this additional funding.

- The current risk to the nVCC Project is the lack of funding, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of c£3.140m.

- There is a risk of a lack of funding for the AWA element of the ADDA. This is being mitigated by A funding request is being submitted to WG, who have agreed to underwrite these costs.

- There is also the risk of a lack of funding for these costs, which is being mitigated by securing additional funding from WG as part of the Enabling Works FBC Addendum.

9.   TCS SPEND REPORT SUMMARY

9.1   At the end of 2019, a financial model was developed by the TCS Finance Team to provide a spend profile for the TCS Programme. The model allocates reported spend by year to defined deliverables and outputs within each project within the Programme. It also allocates spend to the various resources need to deliver the Programme, such as pay, advisors, suppliers, etc. The output for the model itself is an in-year report providing spend details on a quarterly basis. A cumulative report is also produced for the Programme for its inception to the end of the latest quarter.

9.2   Appendix 3 provides cumulative report to 31st March 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 October 2023

TCS Programme Budget & Spend 2023-24

CAPITAL	Year to Date			Financial Year		
	Budget Nov-23	Spend Nov-23	Variance Nov-23	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership nVCC OBC	0	142,394	-142,394	0	215,952	-215,952
Project 1b - Enabling Works FBC	171,227	212,987	-41,759	229,841	297,155	-67,314
Project 2a - New Velindre Cancer Centre OBC	0	618,501	-618,501	0	959,028	-959,028
Capital Pay Total	**171,227**	**973,882**	**-802,654**	**229,841**	**1,472,135**	**-1,242,294**
NON-PAY						
nVCC OBC Project Delivery	0	35,516	-35,516	0	63,000	-63,000
Project 1b - Enabling Works FBC	8,568,196	8,477,928	90,269	10,666,552	10,598,726	67,825
Project 2a - New Velindre Cancer Centre OBC	0	1,512,193	-1,512,193	0	1,902,693	-1,902,693
Project 2b - Advanced Design Development Agreement	2,422,896	3,171,611	-748,714	3,881,995	4,630,709	-748,714
Project 2c - Whitchurch Hospital Site	0	17,727	-17,727	0	17,727	-17,727
Capital Non-Pay Total	**10,991,093**	**13,214,974**	**-2,223,881**	**14,548,546**	**17,212,855**	**-2,664,309**
CAPITAL TOTAL	**11,162,320**	**14,188,856**	**-3,026,536**	**14,778,387**	**18,684,990**	**-3,906,603**

REVENUE	Year to Date			Financial Year		
	Budget Nov-23	Spend Nov-23	Variance Nov-23	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
nVCC Pay Award	70,418	70,418	0	96,408	96,408	0
Programme Management Office	215,627	211,576	4,051	326,890	326,890	0
Project 6 - Service Change Team	204,752	190,389	14,363	306,290	306,290	0
Revenue Pay Total	**490,798**	**472,384**	**18,414**	**729,589**	**729,589**	**0**
NON-PAY						
nVCC OBC Project Delivery	2,394	18,933	-16,539	30,000	30,000	0
nVCC OBC Judicial Review	11,000	11,000	0	11,000	11,000	0
Programme Management Office	1,410	3,174	-1,764	1,410	1,410	0
Project 6 - Service Change Team	9,000	7,542	1,458	13,340	13,340	0
Revenue Non-Pay Total	**23,805**	**40,650**	**-16,845**	**55,750**	**55,750**	**0**
REVENUE TOTAL	**514,602**	**513,033**	**1,569**	**785,339**	**785,339**	**0**

APPENDIX 2:   TCS Programme Funding for 2022-23

Description	Funding Type	
	Capital	**Revenue**
Programme Management Office	**£0**	**£0.328m**
Commissioner's Funding		£0.240m
Trust Revenue Funding		£0.060m
WG One Off Pay Award 2022/23 Funding		£0.006m
WG Recurrent Pay Award Funding		£0.022m
Enabling Works FBC	**£10.896m**	**£0**
2023-24 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£10.896m	
New Velindre Cancer Centre OBC	**£0**	**£0.137m**
WG One Off Pay Award 2022/23 Funding		£0.019m
WG Recurrent Pay Award Funding		£0.077m
Escrow Interest		£0.041m
Advanced Design Development Agreement	**£3.882m**	**£0**
2023-24 CEL from Welsh Government funding for ADDA approved October 2023	£3.882m	
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	**£14.778m**	**£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

Years (horizontal axis £0m–£7m): 2014-15, 2015-16, 2016-17, 2017-18, 2018-19, 2019-20, 2020-21, 2021-22, 2022-23, 2023-24, 2024-25, 2025-26

Legend:
- Programme Management Office
- Project 1 - Enabling Works
- Project 2 - nVCC
- Project 3a - Integrarted Radiotherapy Solutions
- Project 3b - Digital Strategy
- Project 4 - RT Satellite
- Project 5 - Outreach Centres
- Project 6 - Service Delivery, Transformation and Transition
- Project 7 - Decommissioning

SPEND FOR EACH PROJECT ACROSS ALL YEARS

Legend:
- Programme Management Office
- Project 1 - Enabling Works
- Project 2 - nVCC
- Project 3a - Integrarted Radiotherapy Solutions
- Project 3b - Digital Strategy
- Project 4 - RT Satellite
- Project 5 - Outreach Centres
- Project 6 - Service Delivery, Transformation and Transition
- Project 7 - Decommissioning

SPEND FOR EACH YEAR ACROSS ALL PROJECTS

£328,459 £2,398,448
£6,428,671
£6,167,590
£3,924,181
£2,928,426
£4,267,262
£3,909,063

Legend:
- 2014-15
- 2015-16
- 2016-17
- 2017-18
- 2018-19
- 2019-20
- 2020-21
- 2021-22
- 2022-23
- 2023-24
- 2024-25
- 2025-26

TOTAL SPEND BY PROJECT TO DATE — £30,352,092

Project	Amount
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

	Supplier	Amount
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

Project Control, Feasibility Studies, Construction Costs, Planning and Design, Procurement Strategy, Outline Business Case including revisions and approval, Asda, Project Agreement, Procurement Documents, Programme Control, Governance and Assurance, Planning and Surveys, Equipment, Schedule of Accommod..., Competitive Dialogue, Integrated Activity & Workforce Modelling, Refere... Design Develo..., Cardiff City Council - Land..., Planning excluding Asda, Procu... Activi..., Design exclu... Asda, Ad hoc, Comms, Land..., Cli... Ou..., Site..., Im..., Facili... Man..., Ri..., F..., B..., Dig..., Pr..., S...

TRUST BOARD

Development of New Trust Values

DATE OF MEETING	30 January 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	Claire Budgen, Head of Organisational Development
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

| EXECUTIVE SUMMARY | A refreshed set of organisational values is proposed which have been developed over the past two years with feedback from staff members and from patients and donors. These values have then been refined with input from Board members and then a recommendation from Executive Management Board.

Once approved, a programme of work will commence to communicate and embed the values in day-to-day working life. |
|---|---|

RECOMMENDATION / ACTIONS	Approve the proposed values for the Trust

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	02/01/2024
Strategic Development Committee	18/01/2024

Summary and outcome of previous governance discussions

Whilst outside the formal Governance route for this paper, the proposals have been drafted with input from the Trust Board at the Board Development Session of 14 December 2023.

A further set of feedback was requested from Board members following this session and this feedback was considered at Executive Management Board on the 2nd January 2024. Further to this a revised proposal was developed as a result of that discussion which is described in the paper below.

This proposal was discussed at a Board Briefing session on the 11th January 2024 at which the final proposal was decided on which was taken to the Strategic Development Committee on 18 January 2024.

7 LEVELS OF ASSURANCE

Not applicable.

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES

Page 2 of 8

1.   SITUATION

1.1   After a period of engagement and dialogue a refreshed set of organisational values is proposed to complement Destination 2033. Once adopted, these will shape how people act in the course of their work and be the foundation for people policies and practices.

2.   BACKGROUND

2.1   A detailed programme of organisational development was undertaken from 2015 to 2017 called Building Excellence. It produced the organisational values which are in use today: Accountable, Bold, Caring, Dynamic. These have been threaded through processes such as recruitment, appraisal (PADR), induction and management development. They are evident in service plans and strategies. They are visible in the Trust environment.

2.2   Around these values sit the NHS Wales Values and Standards of Behaviour Framework which gives a broader ethical context for NHS work with these core values:

1.   Putting quality and safety above all else: providing high value, evidence-based care for our patients at all times.
2.   Integrating improvements into everyday working and eliminating harm, variation and waste.
3.   Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of Welsh people.
4.   Working in true partnership with partners and organisations and with our staff.
5.   Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools systems and environment to work safely and effectively.

2.3   In March 2022, Executive Management Board requested that the Trust values be reviewed in order to build an effective and compassionate culture. This was subsequently included under the Building Our Future Together organisational design and development portfolio with the following objectives:

a. Review and refine the values of the organisation

b. Have a picture of how people feel about the organisation which will be utilised by other elements of our Building Our Future Together work programme
c. Develop a Behaviours Framework
d. Embed Values and Behaviours Framework within Trust process such as recruitment, appraisal and team working.

This paper proposes a response to objectives a and b above; objectives c and d will be implemented once the values are agreed.

3.   ASSESSMENT

3.1   A structured programme of engagement with stakeholders took place in two phases, July to October 2022 and August to November 2023 leading to a discussion at a Board Development Session in December 2023 (Appendix 1).

Method	Participants
Board Interviews 2022	13
Staff Survey 2022	275
Focus Group for Patients and Donors 2023	9
Focus Group for Staff 2023	19
Team meeting structured discussions 2023	193
Stakeholder Survey 2023	3
TOTAL	**509**

3.2   Conclusions from the first phase of engagement were used as a basis for the second phase so that the picture of what people felt was important grew with time. The feedback was logged so that common themes could be distilled as a basis for the final set of values.

3.3   Taking account of the feelings and ideas gathered during engagement including the views of the Trust Board, the proposed values were refined as below:

Caring	Professional	Respectful
We are kind, supportive, approachable and show compassion to all	*We deliver on our commitments and drive for improvement and excellence, listening in order to learn*	*We seek to understand other people's perspectives, we build relationships with partners and we share information openly and transparently*

3.4 The captions beneath the core values are offered to enable a shared understanding of what the single word means in the context of Velindre University NHS Trust. These sentences draw upon the words surfaced during the engagement exercise in order to make a clear connection between what stakeholders told us and what has been agreed.

3.5 A fundamental component in embedding the values will be the use of a Behavioural Framework. This will be developed from examples of positive behaviour gathered during the engagement exercise.

3.6 This proposal was circulated to members of the Board for further comment on the 20th December 2023. Feedback received from six Board Members was then considered at Executive Management Board on the 2nd January 2024

3.7 Following the discussion at EMB a further Board Briefing Session was held on the 11th January 2024 during which Board Members agreed on the following values and supporting statements:

Caring	Respectful	Accountable
We are always kind, supportive, approachable and show compassion to all.	*We seek to understand other people's perspectives. We are always open and transparent.*	*We always take personal responsibility for what we do and how we do it.*

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The proposed values fit with the Trust Purpose and Vision as set out in Destination 2033. Together, they provide the starting point for everything that the Trust wishes to achieve.

4.2 The review of the Trust values is a foundation stone within the Building Our Future Together portfolio. Once adopted, the refreshed values will be used in a wide variety of different contexts such as our approach to Speaking Up Safely, leadership development, recruitment and personal development reviews. They will be used proactively to help shape a constructive and supportive working environment to enable staff to flourish in their roles.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ☐ areas of priority • An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future ☒ for people across the globe	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 - Organisational Culture	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe ☐ Timely ☐ Effective ☒ Equitable ☐ Efficient ☐ Patient Centred ☐	
	A relevant code of values plays an important role in building an effective working environment where staff can flourish and thereby deliver excellent services.	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Yes	

For more information: https://www.gov.wales/socio-economic-duty-overview	Completed as part of the EQIA. This change will create benefits for all by setting out a clear set of organisational values and examples of how to put them into practice.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Click or tap here to enter text
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
	We have 1. involved Welsh speakers in refining the options for Trust Board and 2. presented the values in both languages in the final draft. In future, we will 1. design the branding as a bilingual package and 2. once the values are agreed, we will develop a multi-faceted communications campaign that meets the needs of people with different needs.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5.1 RISKS

6.1 There are no significant risks associated with implementing this code of values as it has been developed with input from staff to reflect what is important to them at work.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

255/597

WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	
All risks must be evidenced and consistent with those recorded in Datix	

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD
30 November 2023 to 30 January 2024

DATE OF MEETING	30 January 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	• **Appendices 1 and 2** Cath O'Brien, Chief Operating Officer • **Appendix 3** Neil Frow, NWSSP Managing Director • **Appendix 4** Jonathan Irvine, NWSSP Director of Procurement Services • **Appendix 5** Andy Butler, NWSSP Director of Finance & Corporate Services

EXECUTIVE SUMMARY	This report details the Trust Board decisions required for Commitment of Expenditure exceeding the Chief Executive's Limit (£100k), for the period **30/11/2023 – 30/01/2024**.

	There are five (5) items of expenditure are required for the Trust Board Approval during this period: • **APPENDIX 1** – Funding of Wig Vouchers provided to VCC patients affected by hair loss. • **APPENDIX 2** – Replacement of Third Linac. • **APPENDIX 3** – Provision of Clean Room Design, Build & Validation Services. • **APPENDIX 4** – Provision of Medical Consumables Commercial Storage Facilities & Distribution Services • **APPENDIX 5** – Renewal of Mamhilad House Lease

RECOMMENDATION / ACTIONS	The Trust Board is requested to: • **AUTHORISE** the Chief Executive to **APPROVE** the award of contracts summarised within this report and supporting appendices • **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

GOVERNANCE ROUTE	
Appendix 1	
• VCC Senior Management Team	22/03/2023
• Executive Management Board	02/01/2024
Appendix 2	
• Executive Management Board	22/01/2024
Appendices 3 to 5	
NWSSP/NHS Wales Shared Services Partnership Committee	18/01/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board **APPROVED** the following:
• **Appendix 1** – Funding of Wig Vouchers provided to VCC patients affected by hair loss
• **Appendix 2** – Replacement of Third Linac.

NWSSP/NHS Wales Shared Services Partnership Committee **APPROVED** the following:
• **Appendix 3** – Provision of Clean Room Design, Build & Validation Services.
• **Appendix 4** – Provision of Medical Consumables Commercial Storage Facilities & Distribution Services
• **Appendix 5** – Renewal of Mamhilad House Lease

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7 LEVELS OF ASSURANCE – N/A

APPENDICES
Appendix 1 - Funding of Wig Vouchers provided to VCC patients affected by hair loss
Appendix 2 – Replacement of Third Linac
Appendix 3 - Provision of Clean Room Design, Build & Validation Services
Appendix 4 – Provision of Medical Consumables Commercial Storage Facilities & Distribution Services
Appendix 5 – Renewal of Mamhilad House Lease

1.   SITUATION/ BACKGROUND

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

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

1.3   The decisions expected during the period **30/11/2023** – **30/01/2024** are highlighted in this report.

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

2.0   ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1   Please refer to **Appendices 1 to 5** for the detailed appraisals undertaken of the expenditure proposal that the Trust Board is asked to **APPROVE**.

2.2   The table overleaf provides a summary of the decisions sought from the January 2024 meeting of the VUNHST Board:

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Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £
Appendix 1	Velindre Cancer Service	Funding of Wig Vouchers provided to VCC patients affected by hair loss	Start: 01/02/2024 End: 31/01/2028 Option to Extend: The Working Group will decide on whether the contract should run to 31.1.2027 with an option to extend for a further 12 months or whether to utilise the full contract duration (4 years) from the offset.	£120,000 (inc VAT)
Appendix 2	Velindre Cancer Service	Replacement of 3rd Linac at VCC and Associated Bunker Refurbishment Works	Start: 08/11/2022 End: 07/11/2035	£3,970, 208.40 (inc VAT)
Appendix 3	NWSSP	Provision of Clean Room Design, Build & Validation Services.	Start: 01/02/2024 End: 30/06/2024 Option to Extend: The contract also contains options for the build, but we are not committed at this stage to carry them out, pending the main investment decision on the project. If the options are taken up the maximum duration could extend out to March 2029 (60 months)	£6,845,670 (inc VAT)
Appendix 4	NWSSP	Provision of Medical Consumables Commercial Storage Facilities & Distribution Services	Start: 01/12/2023 End: 30/11/2024 Option to Extend: Contract can be extended by a further 12 months in two six-month blocks.	£1,128,000 (inc VAT)
Appendix 5	NWSSP	Renewal of Mamhilad House Lease	Start: 08/10/2023 End: 07/10/2033 Option to Extend: Lease has a five (5) year break clause.	£259,000 (incVAT)

3   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	

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

RELATED STRATEGIC RISK - **TRUST ASSURANCE** **FRAMEWORK (TAF)** *For more information:* _STRATEGIC_ _RISK DESCRIPTIONS_	06 - Quality and Safety

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
	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	

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

SCHEME TITLE	FUNDING OF WIG VOUCHERS PROVIDED TO VCC PATIENTS AFFECTED BY HAIR LOSS
DIVISION / HOST ORGANISATION	Velindre Cancer Centre (VCC)
DATE PREPARED	
PREPARED BY	Michele Pengelly and Melanie Foote-Jones
SCHEME SPONSOR	

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

This proposal is to support the provision of funding for WIG vouchers towards the cost of wigs for VCC patients who experience hair loss as a result of their cancer treatment. A Charitable Funds business case has been completed for the next 3 years funding of this service through Velindre Charitable Funds and has already been presented to the SLT.

This service is available to any VCC patient who is likely to lose their hair through treatment for cancer and the aim is to provide options and choices for patients. For the patients who elect to have a wig, they are eligible to receive a subsidy of £100 inclusive of VAT towards the purchase from a framework of suppliers. In line with other Health Boards, provision is restricted to one wig for those who will have a temporary hair loss i.e., those on chemotherapy and a maximum of two per year for those who may have a permanent hair loss as a result of chronic alopecia or through cranial radiotherapy.

This service lead is the patient and carer information and support services manager as part of the supportive care team`

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

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/02/2024
Expected End Date of Contract	31/01/2028
Contract Extension Options **(E.g. maximum term in months)**	The Working Group will decide on whether the contract should run to 31.1.2027 with an option to extend for a further 12 months or whether to utilise the full contract duration (4 years) from the offset.

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. The scheme is not specifically referenced in the Trust's IMTP, but is considered an important means of continuing to provide holistic, supportive care to patients undergoing treatment at VCC.		

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

If this service is not supported there is a risk that VCC patients in financial hardship will be disadvantaged and a potential inequality will develop. Cancer patients throughout Wales have access to free wig vouchers

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

The provision of funding of this invaluable service of VCC patients demonstrates how we continue to put patient-centred care at the heart of care by helping support patients with their dignity and self-esteem.

Illness can affect how patients feel about themselves and influences their self-confidence. Cancer treatment may often leave them with reminders of what they have been through and hair loss is one such reminder. The provision of a wig, hair piece or scarf can in many instances be an invaluable aid to combating such feelings. Hair loss as result of systemic anti-cancer treatment and cranial radiotherapy is sadly an all-too-common side effect. Some may not lose their hair at all, whilst others will notice their hair becoming thinner and fall out, for those who do lose their hair, the psychological and emotional impact can be enormous.

Many people see their hair as an important part of their personality and identity. Loss of hair can affect their relationships with those around them and may lead to lack of confidence and inhibit their ability and desire to socialise.

Moreover, it can act as a visible reminder of having cancer. This leaves them feeling vulnerable and exposed. Whilst many patients cope with the loss, some consider it to be the 'final straw'. Therefore, VCC has always provided funds to cover the costs of buying a wig. VCC use the following organisations to provide help and support:

- Inspirations, Bridgend

- Salon Wills, Cardiff

- Peruke, Newport

- Fich and Ramous, Cowbridge

Clearly, this is an important service to offer patients who are facing a life changing event. The impact on self-esteem and confidence cannot be underestimated. Headstrong work hard with the patients establishing a positive body image and wearing a wig doesn't suit all patients, but the choice and financial support is greatly appreciated by those that opt for a wig.

There is currently a national working group in development which will review both the procurement process of wig services, the quality, accessibility and patient experience of these services and a potential increase in the voucher amount.

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
Patients in financial hardship will be disadvantaged and a potential inequality will develop if this service were not supported.	Redirect eligible patients to charitable provision.

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		
Following review of wig provision across NHS Wales, NHS Wales Procurement Services (NWSSP ProcServ) have determined an all Wales Procurement exercise be conducted. Engagement has been undertaken with Clinical leads across Wales to scope current practice and identify feasibility of implementing an all Wales approach. A Working Group comprising of clinical and admin leads from services providing wigs is currently being formed. Scoping engagement has identified the need for patient choice in respect of wig salon, therefore a non-ranked multi-supplier Framework Agreement will be proposed. Patient feedback will support the alignment of wig provision with Patient Reported Experience Measures (PREMS) as part of the tender process and throughout the life of the contract. There is a need for pre-tender engagement with salons, many of which are known to be Welsh SME's and may have limited experience of bidding for formal tenders. This will also support Welsh Government		

directives in respect of the Foundational Economy. Support may also be sought from relevant 3rd sector Organisations who engage with patients regarding hair loss and wigs.

6.3 What is the approximate time line for procurement?

BCUHB have a formal contract in place. This has been extended at risk until 31.1.24 to facilitate the award of an all Wales Framework Agreement. The new Framework Agreement will therefore need to start by 1.2.2024. Scoping engagement has already been undertaken with a view to holding the first Working Group Meeting during February 2024.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Emma Lane
Signature:	
Date:	28/12/2023

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£100,000**	**Including VAT (£k)** **£120,000**
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:

Via charitable funds business case.

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
Revenue	33.3	33.3	33.3	100	100	120
Overall Total	33.3	33.3	33.3	100	100	120

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	

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:	Rachel Hennessy

Signature:	![signature]
Service Area:	Velindre Cancer Services
Date:	28/12/2023

10. APPROVALS RECEIVED

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

Divisions	Date of Approval:
Business Planning Group or local equivalent	
Divisional Senior Management Team	22/03/2023
Executive Management Board	02/01/2024

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

NWSSP PROCUREMENT SERVICES
CONTRACT RATIFICATION BRIEFING

Contract:	CLI-OJEU-52728 Provision and Fitting of Wigs
Contract period (dates):	01/02/2024 to 31/01/2028
No of tenders issued:	N/A Open Procedure
No of tenders received:	14
Value of current contract:	£173,300.15 per annum £693,200.60 total
Proposed value of new contract:	£184,300 per annum £737,200 total

Executive Summary

The key objectives for the NHS Wales Provision and Fitting of Wigs Framework Agreement are:

- Facilitate the first All Wales Framework Agreement for the provision of Wigs.
- To implement a non-ranked multi supplier Framework Agreement which supports patient choice through a wider supply base with the ability for patients to use *any* framework provider regardless the geographical location of their preferred salon and regardless of which Health Board/Trust is providing treatment (e.g. a patient receiving care in HDUHB can use a salon in Cardiff city centre)
- Establish clear protocols with regards to standards for Wig provision across all Salons which are patient centric and support alignment with PREMS (Patient Recordable Experience Measures)
- Ensure Framework Agreement suppliers are compliant with industry standards and are therefore safe to contract with.
- Develop sustainable partnerships between NHS Wales and the supply market that will support the Foundational Economy within Wales

Product/Market Overview

Wigs are provided to patients who temporarily lose their hair through oncology or haematology treatments and to patients who suffer ongoing hair loss through dermatological conditions such as alopecia. All Health Boards/Trusts offer one wig to oncology/haematology patients per course of treatment with dermatology patients receiving two wigs per year (their NHS Wales financial contribution can be combined for the purchase of a single higher quality wig or used separately). The impact on patient wellbeing as a result of hair loss is well documented, with support and guidance being provided by third party organisations such as MacMillan Cancer Care and Alopecia UK. Wigs therefore offer both practical and emotional support to patients.

The scope of this Framework Agreement is specific to modacrylic (synthetic) wigs. Patients are able to personally "top up" their NHS Wales financial contribution to purchase a higher quality wig of their choice. This Framework Agreement will supersede local arrangements for wig provision at ABUHB, CAVUHB, CTMUHB, HDUHB, SBUHB and VELCC, and BCUHB Framework T.0861 which expires 31/01/2024.

Contract Process

A Contract Briefing paper outlining the extent of internal and external stakeholder engagement and outlining the process to be undertaken was approved by all principal procurement contacts in May 2023. A Working Group was formed as detailed in Appendix A. Whereas the Working Group initially looked to include hair loss headwear within the scope of the tender, upon review, it was decided that the scope should be specific to wigs.

The Framework Agreement was tendered in accordance with Public Contract Regulations (2015) using the Open Procedure. The Invitation to Tender (ITT) was advertised via Sell2Wales and published on eTender Wales on 04/07/2023, with a closing date of 31/08/2023. Bidders were required to operate their wig provision from a salon premises in Wales or within twenty miles of the Welsh border.

In recognition of the need to inform and support the supply base (primarily SME hair salons with little or no previous experience of bidding for a public sector tender), supplier engagement formed a key part of the planning process. This initially involved making direct contact with all nineteen salons who had provided wig provision to NHS Wales in the past 18 months. A PIN was used to advertise the opportunity to participate in an online supplier engagement session. The team worked closely with salons and with Business Wales during pre-tender engagement to ensure salons were sufficiently informed and confident to submit a bid. Business Wales continued to support Bidders with constructing their bid and with clarification queries during the live tender.

In total, fourteen Bidders submitted bids, offering wig provision from seventeen salon premises. Aderans (Wiggins) and Daxbourne (operating from Salon Wills in Cardiff) provide wig fitting UK wide. The wording of each question in the tender was reviewed to ensure it would be clear for the Bidders to understand.

Round 1 – An assessment of the Qualification Envelope was undertaken. This included ESPD selection questions (as relevant). This stage was evaluated on a Pass/Fail basis with only those Suppliers whose responses met the acceptable capability levels progressing on to Round 2 of the evaluation. All bidders passed Round 1.

Round 2 – This round comprised a number of Pass/Fail questions including evidencing stipulated insurance levels and a number of sections carrying a weighted score. The scored sections included questions specific to Welsh Government objectives including the Wellbeing and Future Generations Act (2015), supporting Foundational Economy, and Sustainability. Scores were also assigned to questions relating to how wig consultations and fitting appointments are conducted (higher scores being awarded here to responses where patient focus was evidenced), whether wigs styles for people of colour are offered, relationship with relevant third sector organisations and the stocking of wigs. Scores could also be achieved for Bidders able to attend the patient at home or on the hospital ward (at the specific request of the Clinician). An in-person audit (scored) of each salon premises against set criteria was also conducted. This section accounted for 60% of the overall weighting with a focus on patient experience, covering areas such as ambience, environment, cleanliness, facilities, and privacy. All Bidders passed Round 2.

Round 3 – Commercial evaluation comprised of three sections and accounted for 40% of the overall score. In section 1, Bidders were required to specify how many wig styles they could supply against the listed wig types within the NHS Wales financial contribution. The Bidder offering the highest number of wig styles within the NHS Wales financial contribution secured the highest score. 27% of the commercial score was applicable to Section 1. In section 2, Bidders were required to provide pricing for the complete range of listed wig types (some of these could be within the NHS Wales financial contribution and some could be priced higher and available to patients wanting to "top-up"). The Bidder with the lowest overall price for this "basket" of wigs secured the maximum 10% score. Bidders were asked to offer capped pricing, a maximum of 3% being available in respect of this.

Route of Supply

Within the tender, Bidders were required to provide information relating to their supply chain. All Bidders stock wigs in a range of styles and colours with the majority of clients wishing to have a wig which looks the same as their own hair. Some Bidders such as Aderans (Wiggins) and Morgans offer a more extensive range of wigs with both of these Bidders also offering an online wig shop. A number of Bidders advised they would look to increase their wig range should they be successfully awarded on to the Framework Agreement. Wigs are fitted, cut, and styled to the client's requirement. Bidders such as Aderans (Wiggins), Morgans and Phoenix offer a bespoke/custom made wig services.

Financial Implications

In recognition of the NHS Wales financial contribution not having been increased for a number of years and escalating wig costs meaning the choice of wigs available within the NHS Wales financial contribution, the Working Group agreed to review their financial contribution as follows:

HB/TRUST	Previous £ Contribution	New £ Contribution
ABUHB	100	100
BCUHB	90	100
CTMUHB Haem	83.33	100
CTMUHB Orthotics	83.33	83.33
CAVUHB	100	100
HDUHB	90	100
SBUHB	90	100
VEL	100	100

The table below shows the spend per annum for those Health Boards having increased their financial contribution.

HB/TRUST	Current Spend £ per annum	Spend at Increased Contribution £ per annum
BCUHB	22,410	24,900
CTMUHB (Haematology only)	917.45	1100
HDUHB	13,260	15,650
SBUHB	37,419.00	42,388.99

Environmental Information

Within the tender, Bidders were advised that they must be willing to support NWSSP-ProcS and NHS Wales Bodies to deliver against Welsh Government objectives including Well-Being Future Generations (Wales) Act (2015), building our Foundational Economy, and the Green Growth Pledge. Bidders were asked to explain how they would be able to achieve this alignment during the life of the Framework Agreement. Fifteen of the seventeen salons operated by Bidders are within Wales with two situated in England but within the twenty mile radius stipulated. Twelve of the fourteen Bidders are SMEs.

Well-Being of Future Generations (Wales) Act 2015

With regards to the "Prosperous Wales" well-being goal, all fourteen Bidders employ people who live in Wales with the majority of Bidders referring to investment in staff training in their response. Hair Clinical (Haverfordwest) have a local person on a work placement and have offered a placement to a local graduate. Aderans (Wiggins), Browns (More Hair Now), Hair Clinical, Michila Harris Wigs and Papa Salon all have bilingual members of staff working within their wig fitting service thus supporting the Welsh Language wellbeing goal.

A number of Bidders addressed social and economic resilience in their response recognising that offering a range of wigs within the NHS Wales financial contribution was important as many clients would not be able to afford to "top up" to purchase a higher quality wig. Natural Look Wigs, Morgans, Peruke, Hair Clinical and The Wig and Beauty Co. all offer a "wig bank" where wigs are recycled and made available to clients at significantly reduced prices. Scarlett Jack Hairtage and Peruke offer free haircuts to families on low income. All Bidders evidenced strong recognition of wellbeing and the impact of hair loss in their response thus supporting the "Healthier" wellbeing goal. Michila Harris Wigs focussed on the importance of supporting "The High Street" as this is pivotal to supporting a thriving community and reducing carbon footprint. All Bidders offer a wig range for people of colour. Papa Salon is a dementia friendly salon and offer specific appointments for clients with dementia.

Foundational Economy

The majority of Bidders provided specifics around their supply chains but overall, scores were lower than the WBFGA question. Inspirations listed seventeen local suppliers used. Papa Salon, Hair Clinical and Scarlett Jack Hairtage all scored highly on this section, demonstrating clear understanding of the importance of supporting the foundational economy and provided specifics around their localised supply chains covering a range of goods and services such as printing, accountancy, embroidery services, plumbing, catering and stationery. Since being awarded on the BCUHB Framework T.0861, Morgans Wigs, initially operating from one salon in Prestatyn have expanded to open three further salons.

Towards Zero Waste and Carbon Reduction

All Bidders have signed up to the Green Growth Pledge and provided examples of their approach to recycling. Responses to this question included actively using less electricity, using eco-friendly hair dyes, recycling cardboard, using recycled carrier bags, recycled loo roll, car sharing and recycling wigs into reusable polymers. Papa Salon have recently attended a workshop aimed at assisting SMES with better managing their carbon footprint and Scarlett Jack Hairtage are looking to Business Wales to assist them with further improving their approach to sustainability.

Bidders' progression in terms of sustainability will be monitored and driven through proactive supplier performance management during the life of the Framework Agreement.

Current Contractor Performance

BCUHB are the only Health Board with a compliant contract for wigs. Other HBs/Trusts have used local salons for wig provision for a number of years. Phoenix and Hair and More have not supplied wigs into NHS Wales historically. Working Group representatives identified the need to monitor "upselling" where clients are shown or signposted to higher priced wigs or products as historically there has been evidence of this. BCUHB utilise a patient feedback questionnaire however the questionnaires (paper) are at the salon and there has been feedback from patients that they are being asked to complete their feedback in the presence of the wig fitter and some patients felt they were not able to provide true feedback.

HDUHB have successfully introduced an online questionnaire and feedback from their Working Group Representatives is that this is working very well. During the planning process, the Working Group identified that PREMS are key to shaping this contract and to this end the Patient Experience Manager within NHS Wales Executive was contacted to take on the role of establishing a patient reference group to inform the tender processes. Due to personnel changes this still remain in process, however the NHS Executive have been approached to support with establishing a process to capture and monitor patient feedback for wigs on an All-Wales basis moving forward. HBs/Trusts have been asked to review how best to capture patient feedback in the interim. VCC Working Group representative was joined by a patient when conducting their allocated salon audit.

Contract Proposal

Having reviewed the geographical location of the salons, the HDUHB Working Group representatives felt that their HB was insufficiently covered for wig provision, having one salon (Hair Clinical) in Haverfordwest. This position was reviewed with the Working Group Representatives and the HDUHB Procurement Team wherein it was decided that the services of two previously used salons who had not bid for the tender would need to continue but this would be specific to patients who were not able to travel to Haverfordwest. Two Bidders identified within their tender submission that should they be successful; they would be looking to expand their wig service. To this end, following award, all Framework Suppliers will be asked if they have any plans to expand their wig provision in to HDUHB.

The Framework Agreement is a multi-supplier, non-ranked Framework Agreement. The table below shows the scores corresponding to the fourteen Bidders who passed the mandatory criteria and will be awarded onto the Framework Agreement.

BIDDER	60% TECHNICAL	40% COMMERCIAL	OVERALL %
SUPPLIER			
ADERANS (WIGGINS)	33.91	10.9	44.81
BROWNS MORE HAIR NOW	44.6	28.53	73.13
DAXBOURNE (Salon Wills)	29.78	7.08	36.86
HAIR AND MORE	28.78	3.57	32.35
HAIR CLINICAL	41.1	38.33	79.43
INSPIRATIONS	35.44	8.13	43.57

MICHILA HARRIS	34.96	8.92	43.88
MORGANS HAIR AND BEAUTY	40.07	20.55	60.62
NATURAL LOOK WIGS	31.72	4.12	35.84
PAPA SALON	37.12	2.81	39.93
PERUKE	39	11.21	50.21
PHOENIX	36.92	11.14	48.06
SCARLETT JACK HAIRTAGE	33.28	9.19	42.47
THE WIG AND BEAUTY CO	41.83	8.58	50.41

Recommendation

The Category Team recommends that the Framework Agreement is awarded for 3 years with the option to extend for a further year, from 1st February 2024.

Please confirm your agreement to this recommendation. Your prompt response to this document by the 27.11.23 is critical to maintain agreed timelines.

Further details or enquiries

Further details or enquiries, or if you wish to discuss the content of this document, please contact:

Email: Melanie.Foote-Jones@wales.nhs.uk
Telephone: 01745 366821

Appendix A below lists all members of the Stakeholder Group who have been presented with this Ratification Briefing Paper.

Appendix A

HB/Trust	REPRESENTATIVE	CLNICAL PATHWAY
ABUHB	Dave Gamble	Podiatry
	Carlie Griffiths	Family & Therapies
BCUHB	Mannon Williams	Oncology
	Bev Jones	Oncology
CTMUHB	Angharad Rich	Orthotics
	Denise Jenkins	Orthotics
	Sarah Norrish	Haematology
CVUHB	Annette Beasley	Cancer Services
	Cheryl Reed	Haematology
HDUHB	Gina Beard	Oncology

	Linsey Jones	Oncology
	Phillipa Krelle	Oncology - Haem
	Kathryn Mulroy	Orthotics
SBUHB	Allison Murray	Podiatry and Orthotics
	Briony Davies	Podiatry and Orthotics
	Martin Wright	Podiatry and Orthotics
VEL	Leigh Porter	Oncology (Patient Information & Support Services Manager)
	Michelle Pengelly	Oncology
	James Coliandri	Finance

TRUST BOARD

Approval for Replacing a 3rd Linac @VCC

DATE OF MEETING	30/01/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Angharad Boundford, Programme Manager
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	22/01/2024	ENDORSED FOR APPROVAL

APPENDICES
Appendix 1 – Halcyon Capacity analysis

ACRONYMS	
IRS	Integrated Radiotherapy Solution
VCC	Velindre Cancer Centre
WG	Welsh Government
LA3	Linac Treatment Machine 3
FBC	Full Business Case

1.   SITUATION

Since the initiation of the IRS Implementation Programme in June 2022, following successful award of the procurement process, a number of key milestones have now been achieved, these include:

- Establishment of IRS Board and Programme team
- Execution of contract
- Commencement and acceleration of initial Linac replacement (LA6) and planning and agreement of second linac replacement (LA5)
- Installation of the majority of software systems into the department with phased implementation for the first patient on LA6
- The commencement of the build Radiotherapy Satellite Centre (RSC) at Neville Hall hospital and the associate programme board, with an opening date of January 2025.

We continue to operate a mixed fleet from two suppliers, with ongoing fragility and complex configuration. We have also clarified the end-of-life notices for the Elekta fleet (LA1,3,7,8) which will remove LA1 and LA3 from use in May 2024 and LA7 and LA8 in 2025 and 2026 respectively. In the interim, the risk of running machines of this age brings additional maintenance and quality checks and potential breakdowns resulting in downtime and impact on capacity.

In addition, with the changes in the anticipated opening date of nVCC, we need to address a significant lack of treatment capacity from early 2025 until the opening of nVCC.

The detailed programme plan for phase 1 and phase 2 (implementation of the LINAC at RSC) indicates that there is a single time window between February 2024 and August 2024 during which an additional linac treatment machine may be installed and commissioned following minimal refurbishment of the bunker. This will provide resilience and alleviate the anticipated impact on capacity.

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As a result, this paper seeks to provide detail and rationale for the proposed replacement of a third Linac at VCC under the phase 1 of IRS Implementation and seek agreement to proceed.

2.   BACKGROUND

The IRS implementation programme is being delivered in 3 core phases and includes the realisation of:
- new capabilities
- expected deliverables / outcomes
- monitised and non-monitised benefits

The implementation consists of a complex Programme of work that spanned numerous departments, service users and the replacement of multiple systems and high value Radiotherapy Equipment over a 4-year phased implementation plan (consisting of 3 phases).

The Programme of work is the implementation of a long term 14-year partnership contract.   Initial scope as follows the replacement of two existing Treatment Machines in the existing Velindre Cancer Centre (Phase 1), a new Radiotherapy Satellite Centre (RSC) in 2024 and cumulating in the installation, and commissioning of the final phase in the nVCC in 2025 (Phase 3). Dates have now changed from these original planning assumptions.

Successful and timely implementation is key for maintaining existing levels of radiotherapy service at VCC, by mitigating the significant end of life service components, and providing the basis for an enhanced and more effective radiotherapy service and the slippage of phase 2 and 3 will impact which is discussed in further detail in this paper.

Phase 1 of the implementation initially set out the replacement and commissioning of two linear accelerators with associated construction phases for bunker refresh for each machine. This has now commenced and our aim following the successful acceleration the LA6 replacement is now to continue to meet the aims of programme with the replacement of the second linac to commence in July 2023.

The FBC for the IRS Implementation has been fully approved internally and by Welsh Government. The contract has been executed between the Trust and Varian so there is full approval in place to move forward phase 1 of the programme.

Review and analysis of all three phases of the implementation programme alongside demand and forecast demand coming into the radiotherapy service at VCC, shows that in consideration of the interdependent timescales of the RSC and nVCC there will be a capacity gap for patient treatment. Please reference appendix A for a breakdown.A

potential solution to meet the capacity gap would be to replace a third linac at VCC in 2024.

A full appraisal of this recommendation is detailed below.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

As previously documented and approved, the first machine for replacement was LA6, this was the oldest of the treatment machines and was no longer in clinical use. As service continuity is the next most important factor after age and function, the next machine to be replaced is LA5; commencing in July 2023.

Replacement of these machines will see an eventual efficiency in capacity but not to the levels to mitigate the risks of the ageing fragility of fleet and slippages in the timelines of RSC and nVCC

The Elekta element of the fleet is approaching end of life, which brings performance challenges and ultimately cessation of use. To illustrate the fleet status below is a summary of all fleet and age. The result of not increasing the capacity of the fleet by installing an additional new Linac treatment machine will require VCC to run very old machines without any manufacturer support and limited opportunity to obtain spare parts when faults develop.

Linac Identifier	Type	Age in 2023	Years over Recommended asset Life (current)	Absolute End of Support
LA1	Elekta Synergy	15	+5	01/05/2024
LA2	Varian Stereotactic	7	-3	-
LA3	Elekta Synergy	15	+5 (recommended 3rd replacement)	01/05/2024
LA4	Varian Stereotactic	9	-1	-
LA5	Will be replaced July 23 operational Dec 23			-
LA6	Replaced Jan 23 operational June 23			-
LA7	Elekta Synergy	13	+3	01/05/2026
LA8	Elekta Synergy	12	+2	01/05/2027[1]

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[1] From 01/05/2026 LA8 would be an unmatched machine with associated capacity issues

Initial phasing and alignment plans were based on RSC go live 2024 and nVCC 2025, since contract signature in November 2022 when initial planning for phase 1 linac replacements was developed there have been significant changes to go live; RSC to 2025 and nVCC to 2027. This movement has significant impact on the radiotherapy service resilience due to the ageing of the existing fleet of linac treatment machines in VCC. With the new dates provided for these major interdependent programmes the IRS implementation team have built a detailed progarmme and resource plan.

This in terms of a programme timeline shows that there is a potential to accommodate a replacement of a third linac between February 2024 and August 2024, this would account for the resource interdependencies required to commence clinical commissioning at RSC, at the end of August 2024.

The team required to take forward the commissioning of the equipment is highly skilled and lays with a limited number of staff. As such their time must be planned to undertake this activity sequentially, linac by linac. Failure to agree this replacement and implement within this time slot will result in an inability to replace a further linac before 2026, which then also impedes the installation in nVCC.

Additionally, this proposed replacement would have the potential to mitigate any risks associated with delays in the interdependent construction schemes of RSC and nVCC. It is to be noted this will not be an additional machine but would be the movement of a linac from phase 3 of the programme at nVCC to phase 1 at VCC, to maximise patient treatment capacity and resilience at VCC in the shorter term.

Contractual and financial arrangements.

The agreement with Welsh Government on the funding for the IRS programme is planned and agreed in line with the phases 1,2,and 3. This includes equipment purchase and the refurbishment of the bunkers required for the replacements. There is a separate but aligned budget for the RSC programme.

Phase 1 included the refurbishment of two bunkers, but also held a potential contingency that can, with the agreement of Welsh Government, be utilised for a third bunker. There is also proposed provision within the nVCC FBC for £1m funding for additional cost associated with extra linac bunker refurbishments at VCC. Early discussions have been undertaken with Welsh Government colleagues to assess this and additionally the revised financial forecast for 2024/25 to understand the movement of capital funding from 2025/26 to fund the 3rd linac replacement early and these are positive and will be confirmed post approval of the decision this paper is seeking.

Clearly the utilisation of a 3rd LINAC at the current VCC site will require its subsequent relocation to nVCC. The additional cost of this relocation and the move of the LINAC has also been included in the current FBC proposal.

The decision to replace a 3rd LINAC will requires a contractual change with Varian the provider and this is feasible and straightforward to execute as above this is not additional but a movement within the existing contract. The process is clearly laid out within the contract as change control notice and this can be implemented in a timely manner to meet required deadlines. Approaches have been made to Varian to explore this option and they have confirmed that they are able to accept such a change and deliver in line with our proposal.

Finally, it is important to note, work will be continued to be undertaken due to the delay of the nVCC from Summer of 2025 to 2027 to model capacity in 2025/26 and 2026/27 taking into account the aforementioned age of the Elekta machines; LA7 and LA8.

4. IMPACT ASSESSMENT
5.

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	IRS Requirements relate directly to the quality of service that will be capable of being delivered by the solution
RELATED HEALTHCARE STANDARD	Timely Care
	Safe care Effective care Staff and resources IRS Requirements relate directly to the quality of service that will be capable of being delivered by the solution
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	There will be one for the overall IRS implementation programme.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Requirements will link to the Contract

| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | As per the approved financial detail within the FBC and spend profile submitted to Welsh Government. |

6. RECOMMENDATION

The Trust Board is requested to approve the Commitment of Expenditure to replace a third linac at VCC.

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

SCHEME TITLE	REPLACEMENT OF 3RD LINAC AT VCC AND ASSOCIATED BUNKER REFURBISHMENT WORKS
DIVISION / HOST ORGANISATION	VCC
DATE PREPARED	17.01.2024
PREPARED BY	Angharad Boundford
SCHEME SPONSOR	Cath O'Brien/Matthew Bunce

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The Integrated Radiotherapy Solution (IRS) implementation programme is being delivered in 3 core phases and includes the realisation of

- New clinical and technological capabilities
- Expected deliverables / outcomes
- Monitised and non-monitised benefits

It consists of a complex programme of work that spans numerous departments, service users and the replacement of multiple systems and high value Radiotherapy Equipment over a 4-year phased implementation plan.

Phase 1 of the implementation of IRS involves the commissioning of two linear accelerators with associated construction phases for bunker refresh for each machine. This is now successfully underway with the second replacement machine being clinically live in February 2024.

The scope of phase 1 has been formally changed to include the replacement of a third linac treatment machine at VCC, this is due to movement within interdependent programme timescales, increased fragility of ageing machines, which will without the commissioning and availability of this third treatment machine create a capacity gap in patient treatment. Full details of approved rationale can be found in the below paper.

📄 **SBAR_IRS 3rd linac @ VCC_ final.docx**

The FBC for the IRS Implementation has been fully approved internally and by Welsh Government. The contract has been executed between the Trust and Varian, the purchase of the Linac is not additional funds but a movement of budget from phase 3 of the programme to phase 1. Funding of the bunker refurbishment has also been allocated and approved within our financial management process and with Welsh Government.

As previously approved the attached SBAR details the requirement and rationale for the 3rd treatment machine along with the associated benefits.

This paper now seeks authorization to raise the order for the 3rd linac and the necessary refurbishment works to the existing bunker.

Summary of Estimated Contract Charges (Excl. VAT)

The cost of the linac is £2,611,255.00 this includes removal and disposals costs, necessary upgrades and warranties.

The anticipated cost of the bunker refurb is £697, 252.00 we would seek to build in a 10% cost tolerance to this forecast.

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

1.2 Period of contract including extension options:	
Expected Start Date of Contract	08/11/2022
Expected End Date of Contract	07/11/2035
Contract Extension Options **(E.g. maximum term in months)**	n/a

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

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

2.2 INTEGRATED MEDIUM TERM PLAN		
	Yes	**No**
Is this scheme included in the Trust Integrated Medium Term Plan?	☒	☐
If not, please explain the reason for this in the space provided.		

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

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

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

Prevention	☐	Long Term	☒	Integration	☒	Collaboration	☒	Involvement	☐

3. OPTIONS CONSIDERED
Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Linac purchase and bunker refurbishment Option 1 - Do Nothing – this will constrain the progress of the programme and IRS contract implementation and result in the objectives and improvements for patients and staff being impacted and delayed. Additionally, without the extra capacity created this would have a negative impact on patient treatment times and outcomes. Option 2 – purchase the linac and commence the bunker refurbishment as per revised and approved programme plan – this will allow us to maintain the delivery of the programme and its objectives within the agreed and approved funding and associated budget, within the contract, and ensure required patient treatment capacity is maintained.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The benefits of the procurement will, • Support deliverability, affordability, and value for money of services as set out in the Full Business Case for the IRS programme.

- Support the rescaled completion of Phase 1 of the IRS implementation to plan to ensure required treatment capacity is maintained.
- Optimised patient treatment pathways.
- Supports the creation of increased capacity for treatment for Radiotherapy Patients.
- Support facilities of high-quality care, and in support of research, education and improved utilisation of technology advances.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
Not proceeding will severely affect the implementation timelines for the IRS programme, and have the potential to negatively impact on patient treatment capacity due to associated delays in the IRS Programme delivery. There is a reputational risk to Velindre that we will not deliver on the commitments made within the business case submitted to Welsh Government, resulting in negative impact on patient care, reputational damage and possible loss of access to funding.	There is no mitigation. If the contract is not in place in a timely manner the potential risks will be realised.

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

There is no formal procurement required this will be deployment as part of an agreed and awarded contract via an approved procurement route (Competitive Dialogue).

The formal procurement process for this requirement was concluded successfully and the IRS contract awarded in November 2022 and will be in place for 14 years in total with Varian (the successful bidder).

Therefore, there is already a contract in place and this purchase is within the agreed time and approved budget.

6.3 What is the approximate time line for procurement?

As procurement has concluded and a contract is in place, the only timelines will be pre-determined and agreed supplier lead times.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Claire Salisbury

Signature:	![signature]
Date:	19/01/2024

7. FINANCIAL ANALYSIS

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

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 2023 - 24 (exc. VAT) £	Total (exc. VAT) £	Total (inc. VAT) £
CAPITAL	£3, 308, 507.00	£3,308, 507.00	£3,970, 208.40
TOTAL	£3, 308, 507.00	£3,308, 507.00	£3,970, 208.40

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	There is a full programme structure in place for IRS implementation which will

	support delivery of this element of the IRS Programme.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Matthew Bunce
Signature:	MBunce
Service Area:	Finance
Date:	19.02.24

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	May 2023
Divisional Senior Management Team	June 2023
Executive Management Board	July 2023

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

Linac	2023/24												2024/25											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
La1	44	44	44	44	44	44	44	44	44	44	44	44	44	44										
La2	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38
La3	38	38	38	38	38	38	38	38	38	38	38	38	38	38										
La4	38	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44
La5	38	38	38							15	26	38	38	38	38	38	38	38	38	38	38	38	38	38
La6			5	15	26	38	38	38	38	44	44	38	38	38	38	38	38	38	38	38	38	38	38	38
La7	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44
La8	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38
Sat 1																					5	15	26	38
Sat 2																					5	15	26	38
	278	284	289	261	272	284	284	284	284	305	316	322	322	322	240	240	240	240	240	240	250	270	292	316

Based on 2 Halcyon at VCC and Elekta end of life

Av planned attendances per day based on 15 minute appointements

Linac	2023/24												2024/25											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
La1	44	44	44	44	44	44	44	44	44	44	44	44	44	44										
La2	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38
La3	38	38	38	38	38	38	38	38	38								38	38	38	38	38	38	38	38
La4	38	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44
La5	38	38	38							15	26	38	38	38	38	38	38	38	38	38	38	38	38	38
La6			5	15	26	38	38	38	38	44	44	38	38	38	38	38	38	38	38	38	38	38	38	38
La7	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44
La8	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38
Sat 1																					5	15	26	38
Sat 2																					5	15	26	38
	278	284	289	261	272	284	284	284	284	267	278	284	284	284	240	240	278	278	278	278	288	308	330	354

Based on 3 Halcyon VCC and Elekta end of life

Av planned attendances per day based on 15 minute appointements

Linac	2023/24												2024/25											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
La1	44	44	44	44	44	44	44	44	44	44	44	44	44	44										
La2	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38
La3	38	38	38	38	38	38	38	38	38	38	38	38	38	38										
La4	38	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44
La5	38	38	38							15	26	38	38	38	38	38	38	38	38	38	38	38	38	38
La6			5	15	26	38	38	38	38	44	44	38	38	38	38	38	38	38	38	38	38	38	38	38
La7	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44	44
La8	38	38	38	44	44	44	44	44	44	38	38	38	38	38	38	38	38	38	38	38	38	38	38	38
Sat 1																					5	15	26	38
Sat 2																					5	15	26	38
	278	284	289	267	278	290	290	290	290	305	316	322	322	322	240	240	240	240	240	240	250	270	292	316

Av maximum attendances per day based on 15 minute appointements

Number of Malignant Referrals and average wait days per site		2019/20														2022/23												
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Cancer: Brain/CNS	No.of Pts																								1			
Cancer: Breast	No.of Pts	109	99	90	111	82	108	107	102	95	98	86	83	1170		76	80	75	94	90	96	80	86	71	105	82	123	1058
Cancer: Colorectal	No.of Pts	17	25	26	20	13	25	19	14	21	13	18	27	238		21	19	31	23	14	25	22	16	19	10	19	20	239
Cancer: Gynaecological	No.of Pts	37	23	23	35	19	21	19	26	19	30	15	22	289		16	29	30	19	25	17	24	26	14	16	18	17	251.0
Cancer: Head & Neck	No.of Pts	24	20	33	24	26	23	21	21	24	27	26	22	291		21	24	22	22	24	18	32	10	24	36	31	22	286
Cancer: Leukaemia/Lymphoma	No.of Pts	10	7	13	19	12	13	14	14	16	11	12	15			8	7	9	13	11	13	11	12	13	12	10	8	
Cancer: Lung	No.of Pts	52	53	32	62	55	46	54	44	52	44	35	43	572		29	28	45	44	41	31	38	30	31	22	27	41	407
Cancer: Neurological	No.of Pts	6	8	3	8	6	8	6	12	6	15	4	6	88		9	6	7	4	4	6	7	3	8	4	11	11	80
Cancer: Other cancers	No.of Pts			1			1	1	1	4	1							1			1							
Cancer: Skin	No.of Pts	24	12	17	15	7	20	12	18	8	22	36	24			23	20	22	22	19	20	17	18	13	21	22	16	
Cancer: Soft Tissue Tumours	No.of Pts	5	5	4	5	1	3	6	1	4	5	3	4			1	3	3	6	1	5	5	2	1	4	5	5	
Cancer: Soft tissue/Bone	No.of Pts																											
Cancer: Unknown primary	No.of Pts	5	3	4	2	8	8	5	5	4	5	6	12			5	3	4		2	5	5	6	3	5	3	3	
Cancer: Unspecified site	No.of Pts	3	6	2	2	3	5	1	5	2	3	4	3			1	6	8	4	4	13	10	4		2			
Cancer: Upper Gastrointestinal	No.of Pts	11	16	19	22	19	13	23	11	19	14	17	12	196		12	17	20	9	19	19	14	18	16	16	8	15	183
Cancer: Urological	No.of Pts	104	80	88	88	79	84	93	90	76	112	87	76	1057		79	73	83	65	81	81	87	80	57	83	104	104	977
Malignancy of unknown primary (CUP/MUO) [Malignant	No.of Pts																							1				
Non Cancer	No.of Pts																									1		
Suspected Malignancy	No.of Pts	2	4	6	6	11	5	2	5	5	4	5	5			1	2	4	2	1	1	3	2	3	1	1	4	
Uncertain Neoplasm	No.of Pts				1			1	1		1		1			2	1				1	2		2			2	

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

SCHEME TITLE	Provision of Clean Room Design, Build & Validation Services
DIVISION / HOST ORGANISATION	NWSSP
DATE PREPARED	16 January 2024
PREPARED BY	Peter Stephenson, Head of Finance & Business Development
SCHEME SPONSOR	Neil Frow, Managing Director

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

As part of the Transforming Access to Medicines (TRAMS) Project South-East Wales Hub there is a requirement to engage a specialist clean room contractor for a Design, Build & Validation project. This is required to support preparative Radiopharmacy facilities in the South East Wales region. The case is prepared in the context of both:

- Urgent clinical need resulting from the closure of the legacy facility; and
- The Transforming Access to Medicines Programme, which has been taking a deliberate approach to replacing the facilities for this service.

The immediate commitment entailed in this contract is to carry out the outline design work for the whole TRAMs Hub and the detail design work for the Radiopharmacy. This work will proceed immediately upon ratification, during Q4 of the current year, over into Q1 of next. The contract also contains <u>options</u> for the build, but we are not committed at this stage to carry them out, pending the main investment decision on the project.

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

1.2 Period of contract including extension options:

Expected Start Date of Contract	01/02/2024

Expected End Date of Contract	30/06/2024
Contract Extension Options **(E.g. maximum term in months)**	The contract also contains options for the build, but we are not committed at this stage to carry them out, pending the main investment decision on the project. If the options are taken up the maximum duration could extend out to March 2029 (60 months)

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

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

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☐
If not, please explain the reason for this in the space provided.		
2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES		

This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.

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

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

Prevention	☐	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED
Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining

The following investment options were identified:

1. Re-investment of the unit in its current location, within the Nuclear Medicine department of UHW
2. Replacement Unit elsewhere on the UHW campus
3. Replacement Unit within the site footprint of St Mary's Pharmaceutical Unit (SMPU).
4. Replacement Unit within the footprint of Imperial Park building 5 (IP5), Newport
5. Replacement Unit as part of a deliberate investment in the TRAMS South East Wales Hub, at a site other than IP5. The other candidate site is in Coryton.
6. Augmentation of the existing SBUHB unit at Singleton to provide capacity to serve the whole of South Wales

The above options were fully evaluated on a number of criterion and Options 1, 2, 5 and 6 were excluded as viable standalone investment options by having been scored "0" on key success factors. Options 3 and 4 scored as viable, although some doubt remains about the practical viability of Option 3 for SMPU and the risk to the other services on the site of a major building project there. As the lower scoring of the compliant options, Option 3 was not taken forward in this case.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

The option to develop the facility at IP5 was the preferred option. This was based on a detailed evaluation covering economic, commercial, and financial factors. In particular:

- The site is available for immediate development and is strategically aligned with the TRAMS programme;
- It meets the capacity demand for service to patients;
- It meets all current and envisaged regulatory requirements;
- It provides a pleasant and functional work environment;
- It is accessible to all current and future staff; and
- It facilitates timely and reliable delivery to all major hospitals in the region.

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
With the legacy radiopharmacy unit having closed, there is a direct impact on patient wellbeing from life critical scans having to be delayed and rescheduled.	Service continuity measures have been put in place involving supply from outside the region, including by Swansea Bay University Health Board, Birmingham, and Bristol NHS Trusts. These arrangements are temporary in nature and are not currently meeting the whole clinical demand.

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

An Open Procedure Find a Tender process was undertaken detailing the overall requirement. Phased project to be delivered in 5 Phases:

1. Outline Design of the whole to RIBA Stage 2 including layouts, estimating and time, cost, and power requirements for each subsequent phase. Floor plans and exterior elevations will also be produced. Location of required drainage points in suite "R" will also be determined during this phase.
2. Detail Design of Suite "R" Radio pharmacy estimated size 374 square metres.
3. Build and Validation of Suite "R" Radio pharmacy.
4. Detail Design, Build, and Validation of Suite "A" Aseptic suite for SACT preparation estimated size 475 square metres.
5. Detail Design, Build, and Validation of Suite "B" Aseptic suite for CIVA preparation estimated size 483 square metres.

6.3 What is the approximate timeline for procurement?

The contract will be awarded as a whole with immediate notice to proceed with Stage 1, but with separate notice to proceed for each subsequent phase. The Contracting Authority does not undertake that the Phases 2 to 5 will be authorised by any specific time, or at all, and break clauses will be included between phases. Progress between phases will depend both on satisfactory completion of the prior stage, and on the availability of funding to the Contracting Authority.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Lena Boghossian – Head of National Sourcing
Signature:	
Date:	17.01.2024

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	Excluding VAT (£k) **£5,705**	Including VAT (£k) **£6,845**
The nature of spend	**Capital** ☒	**Revenue** ☐

How is the scheme to be funded? Please mark with a (x) as relevant.
 	
    Existing budgets   ☐
    Additional Welsh Government funding   ☒
    Other ☐		

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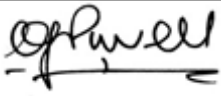
PROFILE OF EXPENDITURE

Phase	Content	Cost	VAT	Total	Status
1	Outline Design	£77,230	£15,446	£92,676	Committed
2	Radio Design	£95,995	£19,199	£115,194	Committed
3	Radio Build	£1,644,500	£328,900	£1,973,400	Option
4	SACT Build	£2,040,000	£408,000	£2,448,000	Option
5	CIVA Build	£1,847,000	£369,400	£2,216,400	Option
Total				**£6,845,670**	

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	It is proposed to manage the investment as a project within the TRAMs Programme.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Colin Powell
Signature:	
Service Area:	Pharmacy Technical Services
Date:	17/01/2024

10. APPROVALS RECEIVED

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

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

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	18 January 2024
HTW – Senior Management Team	

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

SCHEME TITLE	Provision of Medical Consumables Commercial Storage Facilities & Distribution Services
DIVISION / HOST ORGANISATION	NWSSP
DATE PREPARED	11 January 2024
PREPARED BY	Peter Stephenson, Head of Finance & Business Development
SCHEME SPONSOR	Jonathan Irvine, Director, Procurement Services

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The Covid-19 Pandemic saw the on-going distribution of consumable items to support the Health & Social Care environment, in volumes that have never previously been seen.

The existing three Warehouses in Bridgend, Denbigh & Newport operate on a 'Min/Max' stock level with regular inbound delivery of items to match common usage and all sites have limited additional capacity for storage of items. The Newport warehouse utilised all usable spare capacity to hold additional key items and the Pandemic store was at capacity through turnover of Pandemic consumables and as a result additional storage space at St Athan air base (2 x additional hangars) was secured, plus a reliance on local hauliers to receive and store stock on behalf of the NHS. At the time modelling on future orders to secure sufficient items to ensure adequate resilience showed that there would more than likely be a need to hold stock of approximately 15,000 (possibly more) pallets to be available at any one time.

To establish additional resilience and to enable the holding of the necessary goods, NWSSP SES and SC, L&T engaged with agents and transport providers to establish options around being able to hold up to 15,000 pallets as stock holding at any one time and consideration to expand further. For resilience the decision was made to mirror the stock split as per the existing warehousing, and place 40% in South-West Wales, 40% South-East Wales, and 20% in North Wales.

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There is a possibility that costs could be reduced if all of the items are stored in one location, but this would provide no resilience from fire, flood or adverse weather over the winter period, plus does not provide a geographical spread of stock. In addition, the three locations would ensure a further spread of stock within reasonable distance of or currently located NWSSP warehouses.

An open tender process was undertaken in 2021 based on the identified main requirements and the three geographical areas throughout Wales. Initially a 12-month contract was awarded until the end of November 2022. A 12-month contract extension was then utilised to continue the service provision until 30th November 2023.

Following further consideration, it has been decided that there is still an on-going requirement for the provision of these additional storage facilities and distribution services in order to continue to be able to meet the required capacity and demands of the NHS throughout Wales.

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

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/12/2023
Expected End Date of Contract	30/11/2024
Contract Extension Options **(E.g. maximum term in months)**	Contract can be extended by a further 12 months in two six-month blocks.

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

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐

Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☐
If not, please explain the reason for this in the space provided.		

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

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

3. OPTIONS CONSIDERED

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

3.1 Please state alternative options considered and reasons for declining
This is a renewal of an existing facility but one where the planned expenditure has been halved compared to the existing contract. This is due to maximising options within NWSSP accommodation for storage and reducing the overall amount of consumables that needs to be stored.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The benefits of these contracts will be: • The ability to store sufficient levels of consumables to meet current guidance in the event of a resurgence in COVID; and • A significant saving on current contract prices due to greater flexibility in storage options and an overall reduced level of stored items.

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

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The risk of not proceeding with the scheme is that NWSSP would be unable to store the quantities of medical consumables/PPE that is required by Welsh Government.	All available storage options within NWSSP have been explored and utilised where possible.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☒	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance
6.2 Please outline the procurement strategy
The contract renewals were the subject of a formal tender exercise.
6.3 What is the approximate timeline for procurement?
The contracts have already been procured with a contract renewal date of 1 December 2023 for a period of 12 months with the option to extend for a further two six-month periods.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Lena Boghossian – Head of National Sourcing
Signature:	
Date:	16.01.24

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £940	**Including VAT (£k)** £1128
The nature of spend	**Capital** ☐	**Revenue** ☒

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

Existing budgets	☒
Additional Welsh Government funding	☐
Other	☐

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

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Rental Costs	470	470	-	-	940	1128

Overall Total	470	470	-	-	940	1128

8. PROJECT MANAGEMENT (if applicable)

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

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Jonathan Irvine
Signature:	
Service Area:	Procurement Services
Date:	16.01.24

10. APPROVALS RECEIVED

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

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

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	18 January 2024

| HTW – Senior Management Team | |

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

SCHEME TITLE	RENEWAL OF MAMHILAD HOUSE LEASE
DIVISION / HOST ORGANISATION	NWSSP
DATE PREPARED	16 January 2024
PREPARED BY	Peter Stephenson, Head of Finance & Business Development
SCHEME SPONSOR	Andy Butler, Director of Finance & Corporate Services

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The Counter Fraud Service Wales Team occupy part of the 1st Floor in Block B South, Mamhilad House, on the Mamhilad Estate. The lease for this accommodation expired on the 7th October 2023, and we have negotiated with the landlord for renewal of a further 10-year lease with a break clause at the end of Year 5. The new lease will be £21,576 p.a. which is an increase on the current figure of £16,182. The new lease is based upon a charge of £12 per square foot which is in line with the rents being currently charged elsewhere on the estate. The nature of the work undertaken by the Counter Fraud team, and particularly the requirement to conduct formal interviews which may lead to criminal investigations, requires the team to be based in a self-contained space.

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	08/10/2023
Expected End Date of Contract	07/10/2033

Contract Extension Options (E.g. maximum term in months)	Lease has a five-year break clause.

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

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

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☐
If not, please explain the reason for this in the space provided.		

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

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

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

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

Click **here** for more information

Prevention	☐	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

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

3.1 Please state alternative options considered and reasons for declining
Other accommodation options have been considered but the nature of the work undertaken by the Counter Fraud Team requires a self-contained and separate location for which the current offices provide an appropriate solution.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The Counter Fraud Team is able to continue providing services to NHS Wales from a location that meets its needs.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
The Counter Fraud Wales Service would struggle to deliver its current service provision to NHS Wales, given the need for confidentiality.	Alternative accommodation would have to be secured but the nature of the work of the team makes sharing office space impossible.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.		
Competition	**Single source**	
3 Quotes ☐	Single Quotation Action	☐
Formal Tender Exercise ☐	Single Tender Action	☐
Mini competition ☐	Direct call off Framework	☐
Find a Tender ☐ (replaces OJEU Public Contract regulations 2015 still apply)	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

This is not a procurement contract but rather a renewal of a building lease.

6.3 What is the approximate timeline for procurement?

The existing lease expired on the 7th October 2023. The new lease is currently being negotiated but will be backdated to the 8th of October 2023.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Principal Property Surveyor Specialist Estate Services	Andrew Nash
Signature:	
Date:	17/01/2024

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£215**	**Including VAT (£k)** **£259**
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Lease	21.5	21.5	21.5	150.5	215	259

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	21.5	21.5	21.5	150.5	215	259
Overall Total						

8. PROJECT MANAGEMENT (if applicable)

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

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Andrew Butler
Signature:	
Service Area:	Director of Finance and Corporate Services
Date:	18/01/2024

10. APPROVALS RECEIVED

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

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

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	18 January 2024

HTW – Senior Management Team	

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	30 January 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

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

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	This report details Chair's Urgent Action taken between the **22/11/2023 – 23/01/2024**. There were five (5) urgent items of business for the Trust Board that were considered via Chairs Urgent Action during this period: 1. First Floor Ward Enhanced Ventilation Solution 2. NHS Wales Shared Services Partnership (NWSSP) Registration Authority Policy. 3. Extension to the PSC contract to deliver SST-Wide Operational Dashboards – 'Healthcare Analytics' 4. RD& I Commercial Delivery Support 5. Employee Assistance Programme (EAP)

	No objections to approval were received in respect of the items of business considered. A number of queries were raised and subsequently addressed; these are detailed in the report.

RECOMMENDATION / ACTIONS	To **CONSIDER** and **ENDORSE** the Chairs Urgent Action taken between the **22/11/2023 – 23/01/2024.**

GOVERNANCE ROUTE	
Trust Board Members – Via Email	**22/11/2023**: Extension to the PSC contract to deliver SST-Wide Operational Dashboards – 'Healthcare Analytics'.
Trust Board Members – Via Email	**22/11/2023**: RD& I Commercial Delivery Support
Trust Board Members – Via Email	**22/11/2023**: Employee Assistance Programme (EAP)
Trust Board Members – Via Email	**13/12/2023**: First Floor Ward Enhanced Ventilation Solution
Trust Board Members – Via Email	**18/01/2024:** NHS Wales Shared Services Partnership (NWSSP) Registration Authority Policy
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Trust Board **APPROVED** each item of business considered via Chairs Urgent Action.	

7 LEVELS OF ASSURANCE – N/A

APPENDICES – N/A

1.   **SITUATION**

This paper provides the Trust Board with an overview of key decisions and outcomes considered via Chairs Urgent Action between the **22/11/2023** – **23/01/2024**.

2.   **BACKGROUND**

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

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

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

3.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following is a summary of the key outcomes from the items of business considered by the Trust Board via Chairs Urgent Action since the last formal meeting of the Trust Board at the end of November 2023:

3.1 Extension to the PSC contract to deliver SST-Wide Operational Dashboards – 'Healthcare Analytics'.

The Trust Board were sent an email and Chair's Urgent Action Report on the **22 November 2023** in relation to the **Extension to the PSC contract to deliver SST-Wide Operational Dashboards – 'Healthcare Analytics'** that required urgent approval and asked to:

- **APPROVE** the request for an extension to the **PSC contract to deliver SST-Wide Operational Dashboards – 'Healthcare Analytics'** as a one off, non-recurrent sum of **£150,000 excluding VAT**.

The following approvals were received:

Recommendation approved by:
- Donna Mead, Chair
- Steve Ham, CEO
- Stephen Harries, Vice Chair
- Andrew Westwell, Independent Member
- Matthew Bunce, Executive Director of Finance

3.2 RD& I Commercial Delivery Support

The Trust Board were sent an email and Chair's Urgent Action Report on the **22 November 2023** in relation to the **Research, Development and Innovation Commercial Delivery Support** that required urgent approval and asked to:

- **APPROVE** the request for a four-month contract for **RD&I commercial delivery support** as a one off, non-recurrent sum of **£299,000 excluding VAT**.

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The following approvals were received:

Recommendation Approved by:
- Donna Mead, Chair
- Steve Ham, CEO
- Stephen Harries, Vice Chair
- Andrew Westwell, Independent Member
- Matthew Bunce, Executive Director of Finance

3.3 Employee Assistance Programme (EAP)

The Trust Board were sent an email and Chair's Urgent Action Report on the **22 November 2023** in relation to the **Employee Assistant Programme (EAP)** that required urgent approval and asked to:

- **APPROVE** the open tender contract renewal with a contract award date of 1st March 2024 in the sum of **£283,000 excluding VAT**.

The following approvals were received:

Recommendation Approved by:
- Donna Mead, Chair
- Steve Ham, CEO
- Stephen Harries, Vice Chair
- Andrew Westwell, Independent Member
- Matthew Bunce, Executive Director of Finance

3.4. First Floor Ward Enhanced Ventilation Solution

The Trust Board were sent an email and Chair's Urgent Action Report on the **13 December 2023** in relation to the **First Floor Ward Enhanced Ventilation Solution** that required urgent approval and asked to:

- **APPROVE** the replacement of the temporary First Floor Ward ventilation system with a permanent installation as a betterment until the service relocation to the New Hospital and the commitment to spend a total of **£653,000 (including VAT).**

On 16 December 2023 Professor Andrew Westwell asked the following:

"My only concern here is that the expenditure profile (p.6/7) seems to stretch over 3 years to end of construction phase, which would only allow patients and staff to experience the benefits of the ventilation system for a short time before the move to the new VCC. Could we have reassurance over timescales please?"

On 18 December 2023 Jason Hoskins, Assistant Director Estates, Environment & Capital Development responded stating:

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"In response to the question posed the £60K outlined as year one was approved and spent this year. It covers the design to go to tender which has been completed.

I included for transparency."

On 18 December 2023 Hilary Jones asked the following:

"Would it be possible to know how many contractors tendered for this work – and is it a fixed price contract – or could there be a requirement for further funding at some point in time?"

On 18 December 2023 Jason Hoskins, Assistant Director Estates, Environment & Capital Development responded stating:

"This was tendered via procurement to the open market. We received two returns."

Following the responses from Jason Hoskins, the following approvals were received:

Recommendation Approved by:
- Donna Mead, Chair
- Steve Ham, CEO
- Andrew Westwell, Independent Member
- Hilary Jones, Independent Member
- Gareth Jones, Independent Member

3.5 NHS Wales Shared Services Partnership (NWSSP) Registration Authority Policy

The Trust Board were sent an email and Chair's Urgent Action Report on the **18 January 2024** in relation to the **NHS Wales Shared Services Partnership (NWSSP) Registration Authority Policy** that required urgent approval and asked to:

- **APPROVE** the NHS Wales Shared Services Partnership (NWSSP) Registration Authority Policy

On 19 January 2024, Vicky Morris asked the following:

"Can I just clarify where and when this has been considered. I believe that this has been to QSP but it doesn't state this on the front sheet (copied Liane in for this purpose) and unclear where this policy has been between exec team review and now to allow it to go to Board?? The EQIA (which if I remember correctly) was a query and on the front sheet this is now clarified.

Great to have the clarity and for Liane to confirm its passage through QSP."

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On 20 January 2024, Liane Webber responded stating:

> *"This was one of the polices that was presented at September's QSP Committee but not approved due to issues around the EqIA, which was subsequently completed and sent out with the amended policy to obtain out of committee approval (along with the Sharps Policy, as per attached). Following confirmation of approval from Vicky, Stephen and Hilary we looked to obtain Out of Board approval but unfortunately didn't receive the appropriate number of responses. I believe the intention was to submit it to January Trust Board but understand from the discussions I've had with NWSSP that it is now particularly urgent.*

On 21 January 2024, Gareth Jones advised the following:

> *"By way of background, this originally included a requirement for an agreement between the Trust and NWSSP which clearly didn't make sense.*
>
> *That has now gone away and I am content to approve as requested."*

The following approvals were received:

Recommendation Approved by:
- Donna Mead, Chair
- Carl James, Acting CEO
- Stephen Harries, Vice Chair
- Vicky Morris, Independent Member
- Andrew Westwell, Independent Member
- Gareth Jones, Independent Member

3   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☒

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial impact was captured within the documentation considered by the Board.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal impact was captured within the documentation considered by the Board.

4   RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

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TRUST BOARD

Policy on the Use of Small Animals in Research

DATE OF MEETING	30 January 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	Sarah Townsend, Head of Research & Development Christopher Cotterill-Jones, Research Delivery Manager
PRESENTED BY	Dr Jacinta Abraham, Executive Medical Director and Board Lead for RD&I
APPROVED BY	Jacinta Abraham, Executive Medical Director

EXECUTIVE SUMMARY	The Trust's desire to accelerate and enhance its radiation research portfolio is in line with the Health and Care Research Wales's (HCRW) "Moving Forward: A Cancer Research Strategy for Wales" [CReSt, 2022] and is outlined in the Velindre University NHS Trust's (VUNHST) Radiation Research Strategy 2020-2025 and Overarching Cancer Research and Development Ambitions 2021-31 documents. To fulfil this aspiration, collaboration with Cardiff University (CU) research in this area is key.

	To ensure that the organisation is compliant with its regulatory and ethical requirements in this research area, the Trust recognises the need to implement a Policy on the Use of Small Animals in Research.
	The policy and the associated Integrated Impact Assessment have been submitted to the VUNHST Policy Process Manager and VUNHST ED&I Manager for approval.

RECOMMENDATION / ACTIONS	Trust Board is requested to review, discuss, and **APPROVE** the Policy on the Use of Small Animals in Research for implementation in the Trust.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Velindre Cancer Services SLT (the original SARRP business case)	07/09/2023
RD&I Sub-Committee (the original SARRP business case)	19/09/2023
Advancing Radiotherapy Fund (the original SARRP business case)	25/10/2023
Executive Management Board	02/01/2024
RD&I Sub-Committee Chair's Urgent Action	08/01/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

A original business case (BC) submitted to the Advancing Radiotherapy Fund (ARF) to support the employment, by Cardiff University (CU), of a research technician for three years to run the XStrahl Small Animal Radiation Research Platform (SARRP) has identified the need for the Trust to have a Policy on the Use of Small Animals in Research.

The points raised through each stage of the governance process were recorded and addressed prior to progressing to the next stage.

The Executive Management Board **ENDORSED FOR APPROVAL** the Policy on the Use of Small Animals in Research. This incorporates the EMB feedback and subsequent feedback from the Trust Chair, Prof Donna Mead, OBE, and Trust Chief Executive, Steve Ham.

The Trust RD&I Sub Committee endorsed the original BC for approval and supports the publication of the attached Policy that is based on the Cancer Research UK's (CRUK)

Policy on the of Use of Animals in Research. The policy was **ENDORSED FOR APPROVAL** through RD&I Sub-Committee Chair's Urgent Action.

The policy and the associated Integrated Impact Assessment have been submitted to the VUNHST Policy Process Manager and VUNHST ED&I Manager for approval.

7 LEVELS OF ASSURANCE	
NOT APPLICABLE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
1	Policy on the Use of Small Animals in Research
2	Document for Approval Checklist and Integrated Impact Assessment for the policy

1.   SITUATION

The Trust Board are requested to discuss and **APPROVE** the attached Policy at Appendix 1 on the Use of Small Animals in Research. This policy will ensure the Trust is compliant with its regulatory and ethical requirements associated with the research activity that will accelerate and enhance its radiation research portfolio to the benefit of its patient population.

2.   BACKGROUND

The Trust is committed to the advancement of radiation research within the Trust's research portfolio and this intention is clearly summarised in both the Trust Radiation Research Strategy 2020-2025 and the Overarching Cancer Research Ambitions 2021-2031 document. This is in line with HCRW strategies that have identified radiotherapy research as one of six priority areas of strength in Wales, requiring further development.

Despite this the capacity to grow preclinical and translational research is hampered by the lack of a SARRP facility to exploit biological understanding of the effects of radiotherapy and evaluate novel radiotherapy combination in vivo. Significant preparatory work has been undertaken by multidisciplinary professional individuals employed across VUNHST and CU to support the Cardiff University SARRP equipment

funding application. The BC submitted to ARF to fund a Cardiff University employed research technician for 3 years to run the SARRP supports the main funding application to Cardiff University to procure the SARRP platform.

The BC has been submitted and approved through the Trust governance framework subject to the Trust implementing a Policy on the Use of Small Animals in Research.

To develop this policy, the websites of two highly cancer research active NHS organisations (The Christie NHS Foundation Trust [https://www.christie.nhs.uk/] and The Royal Marsden NHS Foundation Trust [https://www.royalmarsden.nhs.uk/]) were reviewed to determine if an NHS organisation policy existed, and could be considered for adaptation by the Trust. Neither organisation had their own specific NHS policy on the use of animals in research.

However, both NHS organisations partner with academic institutions who do undertake animal research. The Christie NHS Foundation Trust partners with the Manchester Cancer Research Centre, which is part of The University of Manchester. The Royal Marsden NHS Foundation Trust partners with The Institute of Cancer Research, which is a college of the University of London. Both academic institutions are signatories of the "*Concordat of Openness on Animal Research in the UK"* and are committed to the principles of replacement, refinement, and reduction – the 3Rs, and conforming to the ARRIVE (Animal Research: Reporting of In Vivo Experiments) guidelines.

The Trust's relationship with Cardiff University is in line with that of The Christie NHS Foundation Trust's partnership with The University of Manchester, and The Royal Marsden NHS Foundation Trust's partnership with the University of London. The submitted BC supports the main funding application to Cardiff University to procure the SARRP platform, with animal research being conducted at Cardiff University. Cardiff University is a signatory of the "*Concordat of Openness on Animal Research in the UK"*. Cardiff University's Animal Research webpages [https://www.cardiff.ac.uk/research/our-research-environment/integrity-and-ethics/animal-research] confirm the organisation's commitment to the principles of the 3Rs and their support and endorsement of the ARRIVE guidelines.

Given there is no specific NHS policy on the use of animals in research, the Trust's "Policy on the Use of Small Animals in Research" has been developed based on the information published on Cardiff University's Animal Research webpages and in the Cancer Research UK's "Policy on use of animals in research".

This policy had been has progressed through the Trust's RD&I governance route, described above. The policy and the associated Integrated Impact Assessment have been submitted to the VUNHST Policy Process Manager and VUNHST ED&I Manager for approval.

3.   ASSESSMENT

To ensure the Trust is compliant with its regulatory and ethical responsibilities in relation to its involvement in the use of small animals in research an appropriate policy is required.

4.   SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board are requested to review, discuss, and **APPROVE** the Policy on the Use of Small Animals in Research for implementation in the Trust.

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*	09 - Future Direction of Travel

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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) Radiotherapy research is one of six priority areas of strength in Wales, identified for further development. The Trust Board's approval of a business case award to support staff costs for the SARRP platform was subject to implementation of a Trust Policy on the Use of Small Animals in Research. b) The implementation of a Policy on the Use of Small Animals in Research will ensure that the Trust only supports animal research being undertaken in line with the UK's legal and ethical provisions, plus any related standards, guidance, and codes of conduct.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	This relates to the Trust's implementation of a Policy on the Use of Small Animals in Research. There is no anticipated impact on the Trust's Socio-Economic Duty in implementing this policy.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies, please list below:
	Not applicable

	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*	Yes - please outline what, if any, actions were taken as a result
	The Equality Impact of implementing a Policy on the Use of Small Animals in Research has been considered and there are no matters of concern to raise.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	There are no specific legal implications for the Velindre University NHS Trust from implementing this Policy on the Use of Small Animals in Research.

	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

This section is not applicable.

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

APPENDIX 1.   **Policy on the Use of Small Animals in Research**

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eOfSmallAnimalsInR

APPENDIX 2.   **Document for Approval Checklist and Integrated Impact Assessment for the policy.**

20240116_Integrate
dImpactAssessmentI

Ref: (   )

POLICY ON THE USE OF SMALL ANIMALS IN RESEARCH

Executive Sponsor & Function	Executive Medical Director and Board Lead for Research, Development & Innovation
Document Author:	Head of Research & Development
Approved by:	Executive Management Board
Approval Date:	
Date of Equality Impact Assessment:	
Equality Impact Assessment Outcome:	
Review Date:	
Version:	0.1

CONTENTS

1 INTRODUCTION.

Velindre University NHS Trust (the Trust) is responsible for the provision of non-surgical tertiary oncology services to the population of South-East Wales. These services are delivered at a specialist treatment, teaching, research and development centre – Velindre Cancer Centre.

The Trust is committed to the delivery of a varied portfolio of research into new ways to prevent, diagnose and treat cancer, and to optimise the effectiveness of existing cancer treatment.

In the pursuit of developing new treatments, the Trust recognises that animal research remains part of understanding disease processes and ensuring medicines are safe for patients.

In the UK, the use of animals in experiments and testing is regulated under the Animals (Scientific Procedures) Act 1986 (ASPA), as amended[1]. The implementation of this Act regulated by the Home Office in England, Scotland, and Wales and by the Department for Health, Social Security and Public Safety in Northern Ireland.

Under the Animals (Scientific Procedures) Act 1986, as amended, the principles of the 3Rs (replacement, reduction, and refinement) provide a framework for conducting humane animal research and promote the use of alternative methods to reduce the number of animals used.

The Trust recognises the principles of replacement, reduction, and refinement of animals in research, and actively supports their implementation.

2 OBJECTIVES.

This policy covers:
- Trust statement of policy on the use of animals in medical research.
- Legal controls on animal use.
- How the Trust implements this policy and support the principles of the 3Rs.

The policy does not aim to be comprehensive. However, it sets out principles for good practice and refers to other publications that provide advice or instruction on specific aspects, including statutory requirements.

3 SCOPE.

This policy is intended to provide general guidance on the use of small animal research. However, for completeness references are made to specially protected species (SPS) including pigs.

It sets out the expectations of the Trust for animal research and is therefore useful for Trust researchers, staff, and Board and Committee members involved in reviewing proposals to the Trust that may support the conduct of animal research projects.

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[1] As amended by the following UK Statutory Instruments:
The Animals (Scientific Procedures) Act 1986 (Amendment) Regulations 1998. (SI1998/1974).
The Animals (Scientific Procedures) Act 1986 Amendment Regulations 2012. (SI2012/3039).
The Animals (Scientific Procedures) Act 1986 (EU Exit) Regulations 2019. (SI2019/72).

4   STATEMENT OF POLICY.

The Trust does not take the decision to provide its support to animal research lightly.

The Trust does not conduct animal research within its premises.

The Trust commits to provide its support only to the conduct of high-quality animal research by other organisations, which will ultimately be of benefit to the Trust's patient population.

The Trust is committed to the 3Rs of reduction, replacement, and refinement, as basic principles of humane animal research. Any animal research requesting Trust support must follow these principles to improve animal welfare.

The Trust will only provide its support to animal research where the Trust is satisfied that:

a. The animal research is sponsored by an organisation who is a signatory of the Concordat of Openness on Animal Research in the UK [https://concordatopenness.org.uk/].

b. The animal research study design is scientifically robust, and the animal model is appropriate and relevant to the research question being asked.

c. There are no feasible alternatives to using an animal model.

d. All reasonable efforts have been made to address the principles of the 3Rs.
   - **Replacement** – methods which avoid or replace the use of animals in research that has the potential to cause them harm.
   - **Refinement** – improvements to procedures and husbandry which minimise actual or potential pain, suffering, distress, or lasting harm and/or improve animal welfare in situations where the use of animals is unavoidable.
   - **Reduction** – methods which minimise animal use and enable researchers to obtain comparable levels of information from fewer animals or to obtain more information from the same number of animals, thereby reducing future use of animals.

e. All animal research will be done in strict compliance with:
   - Applicable law including, in the UK, the Animals (Scientific Procedures) Act 1986, as amended.
   - Ethics Committee requirements, in the UK, the Animal Welfare and Ethical Review Body.
   - All applicable standards, guidance and codes of conduct relevant to animal research listed on the Home Office [https://www.gov.uk/guidance/research-and-testing-using-animals] and Department for Environment, Food & Rural Affairs (Defra) [https://www.gov.uk/government/organisations/department-for-environment-food-rural-affairs] websites.

f. Welfare standards are consistent with the principles of UK legislation, and the relevant standards, guidance and codes of conduct laid down by the Home Office and Defra, above, are applied and maintained. This also applies to any animal research that is to be performed outside the UK.

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g. The animal research has been successfully independently peer reviewed by appropriate expert reviewers, and that the researchers have adequately responded to any concerns those expert reviewers have raised.

h. The animal research involving the use of SPS or pigs, includes an appropriate independent review by the National Centre for the Replacement, Refinement and Reduction in Research (NC3Rs) and that the researchers have adequately responded to any concerns those expert reviewers have raised.

The Trust recognises that horses, cats, dogs, and non-human primates (NHPs) are designated SPS under the Animal (Scientific Procedures) Act 1986, as amended, due to public concerns regarding their use in research and their additional welfare needs. The Trust will only support the use of these species in animal research in the limited circumstances for toxicology and safety pharmacology studies where required for safety or regulatory purposes. The Trust expects researchers to take every possible measure to avoid the use of SPS.

5 LEGAL CONTROLS ON ANIMAL USE.

The Trust will only support animal research on the basis that the researchers, those organisations sponsoring the research, and the bodies funding the research comply with the UK's legal provisions, plus any related standards, guidance, and codes of conduct issued by government departments and the specific conditions of licences.

UK legislation, standards, guidance and codes of conduct applicable to animal research are listed on the Home Office [https://www.gov.uk/guidance/research-and-testing-using-animals] and Department for Environment, Food & Rural Affairs (Defra) [https://www.gov.uk/government/organisations/department-for-environment-food-rural-affairs] websites.

Support for any animal research involving regulated procedures under the ASPA is on the absolute condition that no work can commence until the licence authorisations required under the Act have been granted and that it will be terminated if such authorisations are subsequently withdrawn.

6 POLICY IMPLEMENTATION AND SUPPORTING THE 3RS.

The Trust is committed to ensuring that the policy on animal research is implemented effectively, particularly with respect to the 3Rs.

This is important in reducing animal use in research, improving welfare standards and for ensuring appropriate animal models for scientific benefit are used, and that experiments are scientifically robust and reproducible.

The Trust supports the 3Rs through a variety of mechanisms:

a. **Research that supports the 3Rs** – the Trust's strategy focuses on donor and patient research. The Trust is committed to the endeavours of cancer-relevant initiatives and projects that replace or reduce the need for animals in cancer research in the future. This includes contributions to biobanks, organoid projects, mathematical and computer modelling, and the development of new *in vitro*

(non-animal technology) models. The Trust also promotes and encourages the archiving and sharing of resources as a means of reducing and refining animal use.

b. **Conditions of support** – it is a condition of Trust support that the conduct of animal research is strictly in accordance with the law and complies with standards, guidance, and codes of conduct issued by the Home Office and Defra.

   In addition, the animal research should comply with guidance documents published by National Centre for the Replacement, Refinement and Reduction of Animals in Research (NC3Rs), particularly the "Responsibility in the use of animals in bioscience research" [https://www.nc3rs.org.uk/3rs-resources/responsibility-use-animals-bioscience-research] and the Animal Research: Reporting of In Vivo Experiments (ARRIVE) guidelines [https://arriveguidelines.org].

   Where the animal research involves NHPs, the research must also comply with the NC3Rs Non-human primate accommodation, care and use guidelines [https://www.nc3rs.org.uk/3rs-resources/non-human-primate-accommodation-care-and-use-guidelines].

c. **External Grant / Business Case application requirements** – it is a condition of Trust support that external funding body applications made by the lead organisation sponsoring the research must provide detailed information about the animal research to the funding body.

   This must include clear justification in the application regarding the species, type, and number of animals to be used and the experimental design and statistical analysis.

   Researchers undertaking animal research are encouraged to use the NC3Rs experimental design resources, including the online Experimental Design Assistant [https://www.nc3rs.org.uk/our-portfolio/experimental-design-assistant-eda], and the ARRIVE guidelines, to improve the reproducibility and reporting of animal research.

7   OPENNESS IN ANIMAL RESEARCH

The Trust strives to be open and honest about how, why, and when it supports animal research, and will only support animal research projects in line with this policy.

8   REFERENCES

The following documents have been referenced in the development of this policy.

a. Animals (Scientific Procedures) Act 1986. Available at: https://www.legislation.gov.uk/ukpga/1986/14/contents [Accessed 05 Jan 2024].

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g. UK Government Home Office (2023). *Animal testing and research: guidance for the regulated community. [online].* https://www.gov.uk/guidance/research-and-testing-using-animals. [Accessed 19 Dec 2023].

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i. Percie du Sert N, Hurst V, Ahluwalia A, Alam S, Avey MT, Baker M, Browne WJ, Clark A, Cuthill IC, Dirnagl U, Emerson M, Garner P, Holgate ST, Howells DW, Karp NA, Lazic SE, Lidster K, MacCallum CJ, Macleod M, Pearl EJ, Petersen O, Rawle F, Peynolds P, Rooney K, Sena ES, Silberberg SD, Steckler T and Wurbel H (2020). *The ARRIVE guidelines 2.0: updated guidelines for reporting animal research.* **PLoS Biol.** doi: 10.1371/journal.pbio.3000410. [Accessed 19 December 2023].

j. National Centre for the Replacement, Refinement and Reduction of Animals in Research (2023). *ARRIVE guidelines. [online].* https://arriveguidelines.org/. [Accessed 20 December 2023].

k. National Centre for the Replacement, Refinement and Reduction of Animals in Research (2017). *Non-human primate accommodation, care and use,* 2nd edition. London: NC3Rs. *[online].* https://www.nc3rs.org.uk/3rs-resources/non-human-primate-accommodation-care-and-use-guidelines. [Accessed 19 December 2023].

l. Cardiff University. *Animal research. [online].* https://www.cardiff.ac.uk/research/our-research-environment/integrity-and-ethics/animal-research. [Accessed 18 December 2023].

APPENDIX 1

DOCUMENT FOR APPROVAL CHECKLIST

This form should be completed and approval to proceed obtained before you start producing your document. The Equality and Health Impact Assessment, known as the Integrated Impact Assessment, should also have been started and any Welsh Language requirements considered.

To be completed by document author.

1. **Proposed/existing title of document.**

Policy on the Use of Small Animals in Research

2. **'Owning group' – which advisory group, forum, sub-committee, or committee will own the document?**

Name of Group	RD&I Sub-Committee	**Chair of Group**	Prof Andrew Westwell	
Please indicate (further details may be requested if applicable)	**Internal Trust Group**		**Yes**	**No**
	Multi-Agency Group		**Yes**	**No**
	Regional Group		**Yes**	**No**

3. **What type of document are you proposing/adopting/reviewing? Please select**

Policy	X	**Strategy**		**Procedure**		**Guideline**	
Protocol		**Other**	Please describe				

New	X	**Existing**	

4. **Which category will it be/is it?**

Clinical		**Corporate**	X

If it is a corporate document will/does it impact on patient/donor care?

Yes		**No**	X

5. **What is the reason for developing/adopting/reviewing this document?**
Please tick the box that is most relevant. If there are no relevant boxes, please tick other and ensure that you specify the reason in the box

	Insert tick for most relevant
Improve/standardise clinical care/organisational procedures	x
In response to complaint, incident or claim	
In response to alerts, safety notifications, WHCs, etc.	
Re-organisation of service/department	
New/amended legislation	
All Wales documents / national guidance documents to be adopted for use	
Replacing/updating existing written control documents. If so, which ones (Please include policy reference and full name:	
Other (please specify):	

6. **What will be/is the aim of the document? What risks are being mitigated?**

This policy covers:
- Trust statement of policy on the use of animals in medical research.
- Legal controls on animal use.
- How the Trust implements this policy and support the principles of the 3Rs.

The policy does not aim to be comprehensive. However, it sets out principles for good practice and refers to other publications that provide advice or instruction on specific aspects, including statutory requirements.

A business case submitted to Advancing Radiotherapy Fund (ARF) to fund a Cardiff University employed research technician for 3 years to run the SARRP supports the main funding application to Cardiff University to procure the SARRP platform.

This was contingent to the Trust's implementation of a "Policy on the Use of Small Animals in Research".

7. **Which other written control documents will be/are relevant to the document?**

Document Number	Document Name List all document names and numbers that are relevant to this document
	Not applicable.

8. **What will be/is the scope of this document?**
What service area is covered by the document? Who does it affect? What patient groups? What professional groups or individuals does it affect? What competence is required by staff to use this procedure, e.g. completion of specific training, e-learning, formal qualification, competency framework, is required from users of the procedure?

The policy sets out the expectations of the Trust in respect of animal research and is therefore useful for Trust researchers, staff, and Board and Committee members in

reviewing proposals to the Trust that may support the conduct of animal research projects.

9. **Collaboration with Key stakeholders – What staff groups/professional groups/clinical specialities/services will be/are responsible for implementing/complying with this document?**
These key stakeholders' will need to be involved in the development/adoption/review of the document to eliminate any barriers to its implementation prior to approval (see policy for guidance).

The key stakeholders within the Trust are those researchers, staff, and Board and Committee members that would be involved in reviewing proposals to the Trust that may support the conduct of animal research projects.

These would include, but are not limited to:
- Trust Board
- Executive Management Board.
- Trust Research, Development, and Innovation Sub-Committee.
- Velindre Cancer Charity Funding Committee.
- Advancing Radiotherapy Funding Committee.

10. **Collaboration with others**
Involvement is an essential component of developing/adopting/reviewing the document.
Please indicate which of the following need to be considered when developing/reviewing this document.

Compliance with legislation / regulation / alert	Please tick √
Consent	
Deprivation of Liberty Safeguards (DOLS)	
Mental Capacity Act (MCA)	
Mental Health Act	
Safeguarding	
Data Protection/Records Management and Information Governance	
Welsh Language	
Counter Fraud	
Equality, Diversity, and Inclusion	
Socio Economic Duty	
National Safety Standards for Invasive Procedures (NatSSIPs)	
Alert/NCEPOD	
Interested Parties	
NICE Guidance	
Patient/Donor Information	
Training / Learning and Development	
Legal	
Financial	
Workforce	
Medicines Management	
Medical Devices	

Infection Prevention & Control	
Business Continuity / Emergency Planning / Major Incident	
Health and Social Care (Quality and Engagement) (Wales) Act 2020	

11. Who will be/is the sponsoring Executive/Director Lead and date they agreed to own this document?

Job Title	Executive Medical Director
Date	15 January 2024

12. Who will be/is the lead author/main contact for this document?
An individual's name and details will need to be provided as a contact for this document for any queries arise both during development and after approval.

Name	Sarah Townsend
Job Title	Head of Research & Development
Email Address	sarah.townsend@wales.nhs.uk

Date of Completion:	16 January 2024	Name of person completing this form	Sarah Townsend, Head of Research & Development
Chair of the Owning Group:	Prof Andrew Westwell	Signature of the Chair of the Owning Group:	

PLEASE SEND COMPLETED CHECKLIST FORM TO THE
POLICY PROCESS MANAGER VUNHST.PoliciesManagement@wales.nhs.uk

APPENDIX 2

TYPES OF WRITTEN CONTROL DOCUMENTS (DEFINITIONS)

Written Control Document – Is a supporting strategy, procedure, protocol, guideline or standard referred to collectively as other Written Control Documents within this Policy.

Strategy - A strategy is a broad statement of an approach designed to accomplish the desired objectives or goals and can be supported by other Written Control Documents. Strategies are always organisational wide and required to be approved by the Board via the Scheme of Delegation.

Policy – A written statement of intent, describing the broad approach or course of action that the Trust is taking with a particular issue. Policies are underpinned by evidenced based procedures and guidelines and are mandatory. Policy documents may be used to support the Trust during legal action.

The formulation of policies allows the Trust to produce formal agreements, which clearly defines the commitment of the organisation and the obligations of individual staff.

Procedure - A standardised method of performing clinical or non-clinical tasks by providing a series of actions to be conducted in an agreed and consistent way to achieve a safe, effective outcome. This will ensure all concerned undertake the task in an agreed and consistent way. These are often the documents detailing how a policy is to be achieved.

Procedures can be written as part of a policy document (in which case they are mandatory) or as 'stand-alone' documents (in which case they are discretionary).

Where procedures are formulated utilising evidence-based knowledge and best practice guidelines, they must include reference of any researched evidence used.

'Stand-alone' procedures give the user the means to carry out specific tasks. This may be within the overall control framework of the organisation or to regulate activities to achieve a quality outcome. 'Stand-alone' procedures do not have the same status in law as a policy; however, failure to follow a specific procedure may prejudice the successful defence of a claim against the organisation.

Protocol - A written code of practice, including recommendations, roles and standards to be followed, which can also include details of competencies and delegation of authority.

Protocols are different from policies as they lack the 'mandatory' element and by allowing for professional judgement, individual cases and competency to play a role they are flexible working documents.

Within a protocol it must be clear by whose authority is it being implemented, what the scope of the protocol is and what procedure is to be followed if practice is to be outside of the protocol.

In the case of clinical protocols, clinicians must be advised in every document that it is for their guidance only and the advice should not supersede their own clinical judgement.

Guidelines - Give general advice and recommendations for dealing with specific circumstances. They differ from procedures and protocols by giving options of how something might be carried out. They are used in conjunction with knowledge and expertise of the individual using them.

Guidelines are not prescriptive. However, whilst guidelines are not mandatory, it could prove difficult to defend a case where agreed guidelines had not been followed.

National Clinical Guidelines - The National Institute Health and Clinical Excellence (NICE) defines guidelines as:

> *"systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Research has shown that if properly developed, disseminated and implemented, guidelines can lead to improved patient care" (NICE 1999).*

Standards - The Royal College of Nursing definition is:
> *"to provide a record of service or representation of care which people are entitled to experience, either as a basic minimum or for use as a measure of excellence" (RCN 1997)*

> The Health and Care Standards define standards as:
> *"Standards are a means of describing the level of quality health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality" (Welsh Government 2015).*

Standard statements are accompanied by a description of the structure and process needed to attain specified observable outcomes.

Standards are not generally prescriptive; it could prove difficult to defend a case if a standard is not adhered to.

CLASSIFICATION OF DOCUMENTS

Clinical – Clinical Written Control Documents relate to the care and treatment of patients within the organisation and offer an evidence-based approach to making a series of clinical decisions for patients with a given condition.

Corporate – Corporate Written Control Documents relate to the management of the organisation and formulate the organisation's response to known situations and circumstances.

Employment – Employment Written Control Documents relate specifically to the management of employees (however defined) within the organisation and are a written source of guidance on how a wide range of issues should be handled within an employing organisation, incorporating a description of principles, rights and responsibilities for managers and employees.

APPENDIX 3

DOCUMENTS RESERVED FOR APPROVAL BY THE TRUST BOARD AND OR ONE OF ITS COMMITTEES, GROUPS OR FORUMS

AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Standing Orders	**Director of Corporate Governance and Chief of Staff**	**Executive Management Board**	**Audit Committee**	**Trust Board**
Risk Management Trust Assurance Framework	**Director of Corporate Governance and Chief of Staff**	**Executive Management Board**	**Audit Committee**	**Trust Board**
Citizen Engagement & Involvement Partner & Stakeholder Engagement Corporate Governance	**Director of Corporate Governance and Chief of Staff**	**Executive Management Board**	**Quality, Safety & Performance Committee**	**Trust Board**
Standing Financial Instructions Financial Management Financial Governance Commissioning Arrangements	**Executive Director of Finance**	**Executive Management Board**	**Audit Committee**	**Audit Committee**
Information Governance Health Records	**Executive Director of Finance**	**Executive Management Board**	**Quality, Safety & Performance Committee**	**Quality, Safety & Performance Committee**
All aspects of Workforce and Organisational Development including Wellbeing, Equality, Diversity & Human Rights (including all-Wales workforce policies on behalf of the Trust Board). Welsh Language	**Executive Director of Organisational Development and Workforce**	**Executive Management Board**	**Local Partnership Forum Quality, Safety & Performance Committee**	**Trust Board**

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AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Clinical Audit & Effectiveness Inquests Clinical Strategy	**Medical Director**	**Executive Management Board**		**Quality, Safety & Performance Committee**
Research & Development Innovation Intellectual Property Policy	**Medical Director**	**Executive Management Board**		**Research, Development & Innovation Sub Committee**
Medicines Management Civil Contingency/Emergency Planning Arrangements	**Chief Operating Officer**	**Executive Management Board**		**Executive Management Board**
Major Incident Plan/Business Continuity	**Chief Operating Officer**	**Executive Management Board**	**Strategic Development Committee**	**Trust Board**
Quality, Safety and Performance of patient and service user centred healthcare Patient Experience including Complaints, Incidents & Litigation Safeguarding Human Tissue Act	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**Executive Management Board**		**Quality, Safety & Performance Committee**
Infection Prevention & Control	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**	**Infection Prevention & Control Management Group**	**Executive Management Board**	**Quality, Safety & Performance Committee**
Nursing Services Nutrition Allied Health Professional Services Health Sciences	**Executive Director of Nursing, Allied Health Professionals & Health Sciences**			**Executive Management Board**

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AREAS COVERED	DOCUMENT SPONSOR	ENDORSING GROUP	ENDORSING BODY	APPROVING BODY
Integrated Medium Term Plan Performance Management Framework	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**	**Strategic Development Committee**	**Trust Board**
IM&T Arrangements and Digital Delivery Health & Safety Performance Arrangements Estate Plans	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**		**Quality, Safety & Performance Committee**
Strategy Planning Sustainability/Environment Management	**Director of Strategic Transformation, Planning & Digital**	**Executive Management Board**		**Strategic Development Committee**
Investments Fundraising Bequests Donations	**Executive Director of Finance**	**Executive Management Board**		**Charitable Funds Committee (in conjunction with Charitable Fund Trustees)**

POLICY OR WRITTEN CONTROL DOCUMENT TEMPLATE

Ref: (   )

(DOCUMENT TITLE)

Executive Sponsor & Function

Document Author:

Approved by:

Approval Date:

Date of Equality Impact Assessment:

Equality Impact Assessment Outcome:

Review Date:

Version:

TEMPLATES FOR DOCUMENTS

The template and control sheet should be used by anyone wishing to formulate any written control system. Documents should be formatted in line with Corporate Style as follows:

Electronic format	Microsoft Word - PDF Read only
Front cover	Corporate template
Audit trail	Use Policy process
Body text	Arial 12
Headings	Arial 12 (UPPER CASE)
Tables and charts	Arial (size as appropriate)
Use of bold	Headings only
Alignment	Justified
Line spacing	Body text single
Paragraph spacing	One line between paragraphs. Two lines between main sections.
Underlining	None
Contents page Contents page if >3 pages	As template Use judgement - help reader to find relevant information more easily.
Staff Names	Use titles rather than names.
Logo	Use Trust logo.
Headers and footers	Arial 9
Margins	Top and bottom of page 2.5cm, sides 2.5cm.
Document Title	To be included in the header on every page
Page numbering	To be included in the footer (e.g. page x of x)
Bullets	• Use standard bullets only, as they do not always format across different systems.
Abbreviations	State in full in first usage with abbreviation in brackets.
Printing	A4/double sided.
Referencing	All reference material should be listed in full at the end of every document in Harvard style.
Glossary of terms	As all policy documents are subject to the Freedom of Information Act, they need to be user friendly as they are documents that can be held up to public scrutiny. Therefore, all abbreviations, jargon and specific wording must be clearly explained to the reader.
Version Control	Reference Number provided by the Corporate Governance Manager. Documents to state 'Draft' whilst in development.

COMPONENTS OF A POLICY

All Policies must include the following headings as a minimum

Introduction/Aim	What is the purpose of the document? What is it about? Why is it needed? This should include where necessary reference to external regulations or other relevant guidance. This may require information relating to audit, risk management, quality and safety.
Objectives	What will the document achieve?
Scope/Area of Application	Exactly who the policy applies to and the consequences for non-compliance where appropriate: - All staff? - Directorate/Clinical Department/Corporate Department specific?
Roles and Responsibilities	- Who is responsible for implementation? - Which groups of staff are able to carry out the procedures required? - What action points does the document raise? - Who is responsible for ensuring action points are undertaken? - Who is accountable if the responsibilities are not followed?
Main Body	Show how the document aims and objectives will be achieved. Reference evidence appropriately.
Resources	Are there any resource issues in order for the document to be implemented? Financial/Time/Training – these must be identified as if there are no resources the document will not be achievable.
Training	- Are there any training issues and if so, who is responsible for the training programme? - Who will keep a record of those members of staff who have been trained? - Will there be update training? How often? If the document compliance is not carried out for any length of time at what stage will the person cease to be authorised to carry out that policy? Where appropriate, specify the grade and required education and training of staff implementing the document.

Implementation and Policy Compliance	How will the document be implemented? • Action Plan? • Timescales? • What level of training should they have? This will be the main part of the policy, generally divided into sections and describe in detail what has to be done in order to comply with the policy and achieve the policy objective. The document needs to set out how compliance with the policy is to be measured and reported.
References	Policies must be based on sound evidence and be appropriately referenced. Name any recognised relevant professional body, for example the source of your evidence base. Where appropriate, specify what is required to be documented in patients' notes. Clinical policies should also include a review of the evidence used and a reference list of that evidence.
Health and Care Standards	This section should outline how the policy or written control document contributes to compliance with the Health and Care Standards and should also indicate to which Standards this area of activity is linked.
Integrated Impact Assessment	Has an equality and health impact assessment been carried out? 　If 'no' the reason for this will be explained at the beginning of the document. 　If 'yes' the impact will be included in the document and appended. Explain how the document promotes equality of opportunity and/or good relations between different groups. For further information contact the Equality, Diversity and OD Manager
Environmental Impact	Does an Environmental Impact Assessment need to be carried out? For further information contact the Trust's Environmental Development Officer.
Audit	This is required to ensure that the document is appropriate and achievable and that there is compliance with the document by staff. An audit tool must therefore be built into the policy document.
Review	Generally, 3 years unless legislation requires differently – check with Corporate Governance Manager.
Getting Help	Details of the specific office or department to contact for interpretations, resolution of problems and other special situations.

A policy may also need to contain the following additional components	Related Policies and/or written control documents Where other policies are relevant these should be listed. Information, Instruction and Training This section is relevant where instruction, training and supervision is necessary for to meet the policy requirements. It should detail when, how often and by whom the action will be taken and any requirement for keeping training records should be indicated. Main Relevant Legislation A list of the relevant statutory provisions which influence the organisation's operation in relation to the policy.

CHARACTERISTICS OF POLICIES AND WRITTEN CONTROL DOCUMENTS

The overall goal is for the design to be simple, consistent and easy to use.

Writing Style:
- Factual - accuracy should be double checked
- Should not provide information that may be quickly outdated
- If an acronym is used, it should be in full initially
- Not excessively technical, must be simple enough to be understood by a new member of staff

Policies should:
- Be written in clear, concise and simple language wherever possible
- Identify the rule rather than how to implement the rule
- Be based on sound evidence and be appropriately referenced.
- Be readily available and their authority should be clear.
- Indicate designated "experts" who can interpret documents and resolve problems
- Represent a consistent, logical framework for action

Written Control Documents should:
- Be clear in terms of how the procedure helps the organisation achieve its aims and objectives.
- Be developed with the client/patient/relative/carer/objective in mind. Well-developed and thought-out procedures provide benefits to the procedure user.
- Involve users in their development where appropriate to engender a sense of ownership

Design and Layout of Policy and Written Control Documents
- Use Arial text
- Number paragraphs and pages
- Generous use of white space
- Structure the presentation so that the reader can quickly focus on the aspect of policy relevant to the decision in hand
- Headings need to be consistent, e.g. location on each page, type size, bold etc.
- Footer should contain: the page number

APPENDIX 5

Integrated Impact Assessment Process and Form

The Equality Act 2010 requires the undertaking of equality and health impact assessments and all Trust policies will require the completion of such before the policy is consulted upon. This is a process to find out whether a 'policy' will affect people differently on the basis of their 'protected characteristics': age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation and if it will affect their human rights. It also takes account of Welsh Language issues. It is designed to ensure that we are taking into consideration the needs of all individuals who work for us and/or access our services.

The Integrated Impact Assessment (IIA) is a process that considers how the health and well-being of a population may be affected by a proposed action, be it a policy, programme, plan, project or a change to the organisation or delivery of a particular public service. Some impacts of policies on health may be direct, obvious and/or intentional, whilst others may be indirect, difficult to identify and unintentional. The IIA is a systematic, objective, flexible and practical way of assessing both the potential positive and negative impacts of a proposal on health and well-being and suggests ways in which opportunities for health gain can be maximised and risks to health minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework. This will ensure that any negative or indirect discrimination which could be an outcome of the policy, etc. is identified and risk assessed, linking to the Trust Risk Management Policy and Strategy. All final policies must include reference to the Integrated Impact Assessment that has been undertaken.

Where a procedure or other written control document has been developed in support of a policy it may not be necessary to undertake a further Integrated Impact Assessment. If an IIA has not been completed the reason for this will be explained at the beginning of the document. Where an IIA has been completed, the impact will be included in the document.

IIAs will be published as part of the consultation process and they will be available on our internet and intranet sites alongside the relevant policy or written control document.

One of the key requirements is the need to involve stakeholders in the process, whether internal or external. This ensures that any potential areas for discrimination are identified and solutions are sought to prevent discrimination.

In addition, the Trust's IIA process also includes the Welsh language and carers as well as adopting a human rights-based approach, ensuring dignity and respect are also evaluated in the process.

Equality Impact Assessment (EQIA) Group

The Trust has established an Equality Impact Assessment Group, which has representation from each division and hosted organisations, as well as Sustainability, Quality and Risk, Governance, Workforce and Occupational Development, Finance, Welsh Language and Staff side representation. The group meets monthly to undertake assessments with the relevant policy leads etc. Once the IIAs are complete, the policy/ procedure/ guidance/ business plan/proposed service change can then go out to full

internal consultation, before being submitted to the relevant advisory group, forum, sub-committee or committee and, where required to the Trust Board for approval. This process ensures that the Trust does not approve documents or services changes which have not been appropriately impact assessed and enables the Trust to meet its statutory duties as part of the Equality Act 2010.

The group meets monthly to conduct assessments with the policy or service lead. It you are planning to write a policy, change a procedure and develop a service you need to ensure that it undergoes and assessment and that you attend one of the meetings.

An Integrated Impact Assessment form must be completed as part of the assessment process. Prior to attending the EQIA Group meeting the policy author/lead will be required to complete and forward the first page of the Integrated Impact Assessment form to the Equality, Diversity and OD Manager.

To arrange for your policy or written control document to be assessed at a future EQIA Group, or to attend one of the meetings, please contact the Trust's Equality, Diversity and OD Manager.

Integrated Impact Assessment		
Ref no:		
Name of the policy, service, scheme, or project: Policy on the Use of Small Animals in Research		
Service Area: Research, Development & Innovation		

Preparation	
The purpose and aims of the policy, procedure, strategy or decision required Please include: - the overall objective or purpose - the stated aims (including who the intended beneficiaries are) - a broad description of how this will be achieved - the measure of success will be - the time frame for achieving this - a brief description of how the purpose aims of the policy are relevant to equality and intended beneficiaries.	A recent business case submitted to the Advancing Radiotherapy Fund (ARF) to support employment, by Cardiff University, of a research technician for three years to run the XStrahl Small Animal Radiation Research Platform (SARRP) identified the need for the Trust to have a "Policy on the Use of Small Animals in Research". The prepared "Policy of the Use of Small Animals in Research" covers: - Trust statement of policy on the use of animals in medical research. - Legal controls on animal use. - How the Trust implements this policy and support the principles of the 3Rs. The policy does not aim to be comprehensive. However, it sets out principles for good practice and refers to other publications that provide advice or instruction on specific aspects, including statutory requirements. This policy is intended to provide general guidance on the use of small animal research. However, for completeness references are made to specially protected species (SPS) including pigs. It sets out the expectations of the Trust for animal research and is therefore useful for Trust researchers, staff, and Board and Committee

	members involved in reviewing proposals to the Trust that may support the conduct of animal research projects.
Who is the Executive Sponsor?	**Jacinta Abraham, Executive Medical Director**
We have a legal duty to engage with people with protected characteristics under the Equality Act 2010 identified as being relevant to the policy. • What steps will you take to engage and consult with stakeholders, (internally and externally)? • How will people with protected characteristics be involved in developing the policy, procedure, strategy and or decision from the start? • Outline how proposals have/will be communicated? • What are the arrangements for engagement as the policy/procedure/strategy or decision is being implemented?	The Trust **does not** conduct animal research within its premises. The policy sets out the Trust's expectation to provide its support only to the conduct of high-quality animal research by other organisations, which will ultimately be of benefit to the Trust's patient population. The protected characteristics that could be considered relevant to this policy are: • Race • Religion and Belief There may be certain individuals who do not wish to, or cannot be, involved in handling animal tissue due to being people with those protected characteristics described above. However, given that the Trust **does not** conduct animal research within its premises and will only provide its support to research conducted at high-quality ethical partner organisations who maintain research integrity through robust policies and procedures. It is expected that these partner organisations will have considered protected characteristics as part of their Equality / Impact assessment of their policies and procedures. The policy covers the requirements in relation to legislative / regulatory and animal welfare, that the Trust expects to be satisfied before providing its support to any research activity involving small animals.
Does the policy assist services or staff in meeting their most basic needs such as; • Improved Health • Fair recruitment etc.	This policy describes how the Trust commits their support to the conduct of high-quality animal research by partner organisations, that will ultimately be of benefit to the Trust's patient population. The Trust is committed to the advancement of both medicinal product and radiation research within the Trust's research portfolio. This intention is clearly summarised in both the Trust Radiation Research

	Strategy 2020-2025 and the Overarching Cancer Research Ambitions 2021-2031 document. This is in line with HCRW strategies that have identified radiotherapy research as one of six priority areas of strength in Wales, requiring further development. This policy would ultimately benefit patient oncology treatment options and in turn improve patient health.
Who and how many (if known) may be affected by the policy?	Given this policy is about the Trust's support of small animal research being conducted at partner organisations, the outcomes of which will ultimately benefit oncology patients, it is not possible to estimate the number of patients who will benefit from this policy. This policy addresses a need identified in how the Trust provides commitment to support research activities involving small animals being conducted at high-quality partner organisations who maintain research integrity through robust policies and procedures. It is expected that these partner organisations will have considered protected characteristics as part of their Equality / Impact assessment of their policies and procedures.
In review of the Well-being of Future Generations Act Which Well-being Goals does this contribute to and how? Please select from drop down box, if multiple, please list. If none, how will it be adapted to contribute to one?	**A Healthier Wales** The Trust providing its support to the conduct of high-quality animal research by partner organisations, will ultimately be of benefit to the Trust's patient population. In not supporting the conduct of high-quality animal research by partner organisations, patients could be denied the outcome of certain research where the inclusion of animal research was appropriate. This could affect a patient's treatment options and their prognosis. In particular progressing radiotherapy research to ensure infrastructure supports excellence and attracts large grants.

Evidenced used/considered Your decisions must be based on robust evidence. What evidence base have you used in support? Evidence includes views and issues raised during engagement; service user or citizen journeys, case studies, or experiences; and qualitative and experience-based research, not just quantitative data and statistics. Please list the source of this evidence; • Identify and include numbers of staff, broken down by protected characteristics and other relevant information • What research or other data is available locally or nationally that could inform the assessment of impact on different equality groups? Is there any information available (locally/nationally) about how similar policies/procedures/strategies or decisions have impacted on different equality groups (including any positive impact)? Do you consider the evidence to be strong, satisfactory or and are there any gaps in the evidence?	There is no specific NHS policy on the use of animals in research, the Trust's "Policy on the Use of Small Animals in Research" has been developed based on the information on Cardiff University's Animal Research webpages and in the Cancer Research UK's "Policy on use of animals in research". These can be accessed as follows: a. Cardiff University. *Animal research. [online].* https://www.cardiff.ac.uk/research/our-research-environment/integrity-and-ethics/animal-research. [Accessed 18 December 2023]. b. Cancer Research UK (2022). *Cancer Research UK: Policy on use of animals in research. [online].* https://www.cancerresearchuk.org/sites/default/files/cruk_animal_research_policy-version_2.pdf. [Accessed 18 Dec 2023]. To develop this policy, the websites of two highly cancer research active NHS organisations (The Christie NHS Foundation Trust [https://www.christie.nhs.uk/] and The Royal Marsden NHS Foundation Trust [https://www.royalmarsden.nhs.uk/]) were reviewed to determine if an NHS organisation policy existed, and could be considered for adaptation by the Trust. Neither organisation had their own specific NHS policy on the use of animals in research. However, both NHS organisations partner with academic institutions who do undertake animal research. The Christie NHS Foundation Trust partners with the Manchester Cancer Research Centre, which is part of The University of Manchester. The Royal Marsden NHS Foundation Trust partners with The Institute of Cancer Research, which is a college of the University of London. Both academic institutions are signatories of the "*Concordat of Openness on Animal Research in the UK"* and are committed to the principles of replacement, refinement, and reduction – the 3Rs, and conforming to the ARRIVE (Animal Research: Reporting of In Vivo Experiments) guidelines.

	The submitted business case to the ARF identified the need for the Trust to have a "Policy on the Use of Small Animals in Research" to provide its support to research being conducted at Cardiff University. Cardiff University is a signatory of the "*Concordat of Openness on Animal Research in the UK*". Cardiff University's Animal Research webpages [https://www.cardiff.ac.uk/research/our-research-environment/integrity-and-ethics/animal-research] confirm the organisation's commitment to the principles of the 3Rs and their support and endorsement of the ARRIVE guidelines.
Who is involved in undertaking the Integrated Impact Assessment?	Sarah Townsend, Head of Research & Development. Christopher Cotterill-Jones, Research Delivery Manager

Equality Duties, Sustainable Development Principles

Does the policy/procedure, strategy, e-learning, guidance etc., meet: • Public Sector & specific duties -Equality Act 2010 • Welsh Language Standards (2011) • Sustainable Development Principles?	Protected Characteristics									Additional		Ways of Working				
	Race	Sex/Gender	Disability	Sexual orientation	Religion and Belief	Age	Gender reassignment	Pregnancy and Maternity	Marriage/ civil Partnerships	Welsh Language	Carers	Long-Term	Collaboration	Involvement	Prevention	Integration
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 favourably?			-													

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 an 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

Reason for your decision (including evidence used). Include details of how it might impact on people from this group and how opportunities to advance equality and good relations have been maximised.	
Protected Characteristics & Other Areas	**Impact – operational & financial**

• **Race**
• **Sex**
• **Disability**
• **Sexual orientation**
• **Religion belief & non belief**
• **Age**
• **Gender Identity**
• **Pregnancy & maternity**
• **Marriage & civil partnership**
• **Carers**
	The protected characteristics that may be considered relevant to this policy are:
	  • Race
	  • Religion and Belief
	
	There may be certain individuals who do not wish to, or cannot be, involved in handling animal tissue due to being people with the protected characteristics described above.
	
	However, given that the Trust **does not** conduct animal research within its premises it is expected that consideration to these protected characteristics will have formed part of the Equality / Impact assessment of the policy of the organisation where the research is taking place.
	
	In this case the research will be conducted at Cardiff University premises under Cardiff University's policy on use of animals in research. Therefore, it is expected that Cardiff University has considered the people with protected characteristics as part of the Equality and Quality Impact Assessment for their policy.

Welsh Language Standards	**Impact – Operational & Financial**
Does the policy, service, or project have positive or negative effects on: a) Opportunities for persons to use the Welsh language? b) Does it treat the Welsh language less favourably than the English language?	This Trust "Policy on the Use of Small Animals in Research" has no direct impact on: a) Opportunities for persons to use the Welsh language. b) The treatment of the Welsh language less favourably than the English language.

| The Welsh language Standards are:
1. Operational Standards – how we operate.
2. Service Delivery – how we deliver our services.
3. Record Keeping – how we keep a record of our services e.g., language needs of patients or donors.
4. Policy making – how we develop our policies.
5. Supplementary Standards – how we report on our services | |

Wellbeing Goals

How does the policy/procedure, strategy, e-learning, guidance etc. embed, prioritise the Well-being Goals and Sustainability Development Principle of the Well-being of Future Generations (Wales) Act 2015?

Please describe and provide evidence below of how the 5 ways of working have been met, inclusive of the 7 well-being goals, to maximise the social, economic, environmental, and cultural wellbeing of people and communities in Wales.
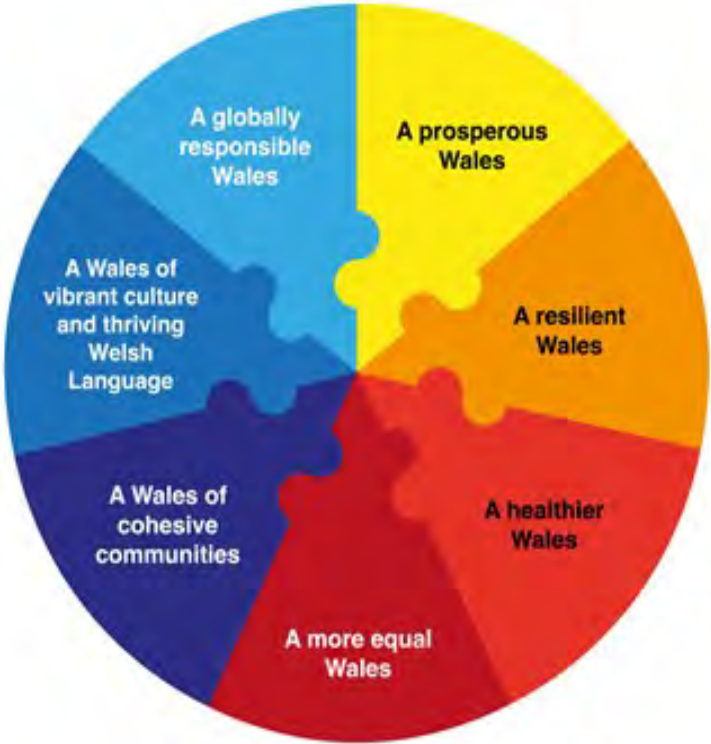
This policy does not directly impact on the Trust's delivery of the Well-being Goals.

This policy's longer-term impact would be in meeting the objectives of **A healthier Wales**.

The Trust providing its support to the conduct of high-quality animal research by partner organisations, will ultimately be of benefit to the Trust's patient population.

In not supporting the conduct of high-quality animal research by partner organisations, patients could be denied the outcome of certain research where the inclusion of animal research was appropriate. This could affect a patient's treatment options and their prognosis.

Sustainable Development Principles	
Hirdymor · Long Term Balancing short term with long term needs	The Trust commitment to advancing its radiation research portfolio is in line with Health and Care Research Wales (HCRW) strategies that have identified radiotherapy research as one of six priority areas of strength in Wales, requiring further development. This commitment and intention is clearly outlined in both the Trust Radiation Research Strategy 2020-2025 and the Overarching Cancer Research Ambitions 2021-2031 document.
Cydweithio · Collaboration Working together to deliver aims and objectives.	Despite the Trust's commitment to the advancement of radiation research, the capacity to grow preclinical and translational research is hampered by the lack of a Small Animal Radiation Research Platform (SARRP) facility to exploit biological understanding of the effects of radiotherapy and evaluate novel radiotherapy combination in vivo. Significant preparatory work has been undertaken by multidisciplinary professional individuals employed across VUNHST and Cardiff University to support the Cardiff University SARRP equipment funding application. The business case submitted to ARF to fund a Cardiff University employed research technician for 3 years to run the SARRP supports the main funding application to Cardiff University to procure the SARRP platform. This was contingent to the Trust's implementation of a "Policy on the Use of Small Animals in Research".
Cynnwys · Involvement Involving those with an interest and seeking their views	The development of this Trust "Policy on the Use of Small Animals in Research" is a requirement of the Trust's support of a business case to the ARF. The business case has been considered through the Trust's governance route as follows: • Velindre Cancer Services Senior Leadership Team (07 Sep 2023). • Research, Development & Innovation Sub-Committee (19 Sep 2023). • Advancing Radiotherapy Fund (25 Oct 2023). • Executive Management Board (02 Jan 2024).

	The views of the members of each group in the Trust's governance route were sought as part of the process and feedback has been incorporated at each stage.
Putting resources into preventing problems occurring or getting worse	The Trust commitment to advancing its radiation research portfolio is in line with Health and Care Research Wales (HCRW) strategies that have identified radiotherapy research as one of six priority areas of strength in Wales, requiring further development. The commitment and intention is clearly outlined in both the Trust Radiation Research Strategy 2020-2025 and the Overarching Cancer Research Ambitions 2021-2031 document. The Trust is supportive of the business case submitted to the ARF to fund a Cardiff University employed research technician as part of a main funding application to Cardiff University to procure the SARRP platform. This will provide capacity to grow preclinical and translational research in radiotherapy that is currently hampered by the lack of a SARRP facility.
Considering impact on all well-being goals together and on other bodies	The policy does not directly impact on the Trust's delivery of well-being goals. The policy's longer-term impact would be in meeting the objectives of "A Healthier Wales", part of which includes using technology to support high quality, sustainable services. The Trust's support in enabling the growth of preclinical and translational research in radiotherapy will ultimately provide better treatment options for oncology patients, as part of the Trust's patient population.

Social Economic Impact	Impact – Operational & Financial
How does the policy/procedure, strategy, e-learning, guidance etc. ensure transparent and effective measures to address the inequality of outcome that result from socio-economic disadvantage? Examples of inequality of outcome might include for example, education attainment, employment and earning potential, health and mental health access to services and goods, opportunity to participate in public life, housing.	Not required. This relates to the Trust's implementation of a Policy on the Use of Small Animals in Research. There is no anticipated impact on the Trust's Socio-Economic Duty in implementing this policy.

Positive Action	Impact – Operational & Financial
If the policy, procedure, strategy and or decision is intended to increase equality of opportunity through positive action, does it appear to be lawful? **Positive action** is defined as voluntary **actions** employers can take to address any imbalance of opportunity or disadvantage that an individual with a protected characteristic could face.	The implementation of this Trust policy is not likely to require actions to address any imbalance or opportunity or disadvantage that an individual with a protected characteristic. As described above, there may be certain individuals who do not wish to, or cannot be, involved in handling animal tissue due to being people with the protected characteristics described above. However, the Trust will not conduct the animal research at its premises. This policy is to allow the Trust to provide its support to such research at another organisation, therefore it is expected that consideration to these protected characteristics will have formed part of the Equality / Impact assessment of the policy of the other research organisation.

Outcome report

Equality Impact Assessment: Recommendations Please list below any recommendations for action that you plan to take as a result of this impact assessment.				GIG CYMRU NHS WALES	Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

	Action Required	Potential Outcomes	Timescale	Lead Officer	Resource Implications
1	No specific recommendations identified because of this impact assessment.				
2					
3					
4					
5					

Risk Assessment based on above recommendations – if policy is approved in original format refer to grading in Annex 1

Recommendation	Likelihood	Impact	Risk Grading

Reputation and compromise position	Monitoring Arrangements
The Trust recognises the importance of inclusivity and accessibility for patients and donors, their families, as well as staff. Therefore, it is a priority that they feel respected, valued, and keep their dignity. Potential discrimination can lead to negative attention as be costly in respect to reputational as well as in monetary terms. This policy may be considered relevant to the protected characteristics of "race" and "religion and belief". However, the Trust **will not** conduct the animal research at its premises. This policy is to allow the Trust to provide	Part of the Trust's cycle for review of policies or through the RD&I Sub-Committee's review of research related policies

its support to such research at another organisation, therefore it is expected that consideration to these protected characteristics will have formed part of the Equality / Impact assessment of the policy of the other research organisation.

Training and dissemination of policy

There are no specific training requirements identified for the implementation of this policy.

Those stakeholders within the Trust are those researchers, staff, and Board and Committee members that would be involved in reviewing proposals to the Trust that may support the conduct of animal research projects need to ensure they have read and follow the policy.

Is the policy etc. lawful?	Yes ☐		No ☐		Review date
Does the EQIA group support the policy be adopted	Yes ☐		No ☐		
Signed on behalf of Trust Equal Impact Assessment Group			Signed Lead Officer		
Date:			Date:		

Annex 1

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty	No or minimal impact or breach of guidance/statutory duty Potential for public concern Informal complaint Risk of claim remote	Breech of statutory legislation Formal complaint Local media coverage – short term reduction in public confidence Failure to meet internal standards Claims less than £10,000 Elements of public expectations not being met	Single breech in statutory duty Challenging external recommendations Local media interest Claims between £10,000 and £100,000 Formal complaint expected Impacts on small number of the population	Multiple breeches in statutory duty Legal action certain between £100,000 and £1million Multiple complaints expected National media interest	Multiple breeches in statutory duty Legal action certain amounting to over £1million National media interest Zero compliance with legislation Impacts on large percentage of the population Gross failure to meet national standards

LIKELIHOOD DESCRIPTION	
5 Almost Certain	Likely to occur, on many occasions
4 Likely	Will probably occur, but is not a persistent issue
3 Possible	May occur occasionally
2 Unlikely	Not expected it to happen, but may do
1 Rare	Can't believe that this will ever happen

TRUST BOARD

People Policies

DATE OF MEETING	30/1/2024

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?	**Choose an item**

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	This paper sets out the key updates and changes to a number of Workforce and OD polices within the Trust.

RECOMMENDATION / ACTIONS	Trust Board are asked to endorse the amended and new policies and processes for Board approval
GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board (Run)	30/10/2023

Local Partnership Forum	07/12/2023
Quality Safety and Performance Committee	16/1/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Local Partnership Forum, Executive Management Team and Quality Safety and Performance committee endorsed the Policies for Board approval.	

APPENDICES	
Ap. 1	All Wales NHS Dress Code
Ap. 2	Annual Leave Policy (Agenda for Change)
Ap. 3	Redundancy and Security of Employment Policy
Ap. 4	Recruitment and Selection Policy

1.   SITUATION

This paper provides an overview of updates made to Workforce and OD Policies, bringing them up to date with current employment legislation and best practice.

2.   SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The following are the changes or additions to current policies to bring them up to date with current legislation and best practice:

All Wales NHS Dress Policy
- Amendments to the principles set out in the Policy, specifically in relation expectations of all NHS Staff and those working in a clinical environment

Annual Leave Policy (Agenda for Change)
- Policy revised in partnership with TU colleagues and consulted with both divisions
- Policy sets out terms and conditions and expectation of staff who are employed under the agenda for change terms and conditions
- Aligned to updates in relevant polices, i.e. MAWW, Special Leave etc.

Redundancy and Security of Employment Policy
- Policy revised in partnership with TU colleagues and consulted with both divisions
- Legislative updates made

- Aligned to relevant polices, i.e. OCP and Redeployment Procedure

Recruitment and Selection Policy
- New Policy developed by the Attraction, Recruitment and Section Task and Finish Group

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 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 polices 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 polices 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 polices new and revised have undergone a detailed EQIA utilising the Trust's toolkit. In relation to the annual leave policy amendments have been made regarding part-time staff

	returning from maternity leave and the potential of discrimination. The policy has been amended following this review to state that staff should work in partnership with managers on returning form maternity leave to take their annual leave. All other policy or procedure no issues identified.
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.

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

www.cymru.gov.uk

All Wales NHS Dress Code
Free to Lead, Free to Care

GIG CYMRU NHS WALES

Her Iechyd Cymru | Health Challenge Wales

Introduction

The All Wales Dress Code was developed to encompass the principles of inspiring confidence, preventing infection and for the safety of the workforce.

The public expect all healthcare workers to project a professional image. Though not all staff may be required to wear a uniform, the requirement to present a smart, professional image applies to everyone.

Securing the confidence of the public is paramount in delivering exemplary health care services. Evidence has shown that the public is concerned about a number of issues relating to the wearing of NHS uniforms and the comportment of NHS staff.

The evidence base for the All Wales Dress Code was developed by the Department of Health in England. *"Uniforms and Workwear: an evidence- based document on the wearing and laundering of uniforms"* was originally published in 2007 and updated in 2010. It is available at **http://www.dh.gov.uk/publications**.

The wearing of an NHS uniform and/or workplace clothing must address key Health and Safety recommendations:

- Adhere to infection prevention and control protocols especially in relation to hand washing techniques
- the identification a corporate image for the individual
- provide a professional image to promote public confidence
- provide the wearer with mobility and comfort
- be resilient to withstand rigorous laundering
- take into account staff safety in relation to situations involving violence and aggression

The dress code specifies the principles that all NHS staff must adhere to and highlights specific expectations for all staff directly involved in the delivery of clinical services. The dress code applies equally across clinical and non-clinical staff working within NHS Wales.

Principles and expectations

PRINCIPLE 1

All staff will be expected to dress in smart (that is, neat and tidy) clean attire in their workplace.

Expectation:

All staff

- Staff must adhere to the NHS Wales Dress Code principles on the wearing and laundering of uniforms/work attire
- Staff must wear their uniforms/work clothes in a manner that will inspire public confidence
- The special needs of pregnant staff must be assessed and advice obtained from their occupational health departments
- The special needs of disabled staff must be assessed and advice obtained from their occupational health departments

Staff working in the clinical environment

- Clean uniform/work attire must be worn for each shift/work day
- Clinical staff must have access to a change of uniform should their uniform be contaminated during their shift/work day
- Where staff launder their own uniforms, written instructions must be adhered to which reflect current best practice guidelines (Appendix 2)
- Staff should use additional protective clothing when anticipating contact with blood and/or bodily fluids in line with their local infection prevention and control policies

PRINCIPLE 2

All staff will present a professional image in the workplace.

Expectation:

Staff working in the clinical environment

- Staff will wear their hair neatly; medium length/long hair must be tied up off the shoulder and secured
- Staff must not wear jewellery except for plain wedding ring/kara/ear studs
- No wrist watches are to be worn under any circumstances in the clinical environment
- Staff with pierced ears may wear one set of stud earrings only
- Staff with new piercings (where the piercing cannot be removed for a specific time period) must cover them with a 'Blue' plaster
- Staff with established body piercings, other than earrings, (one set of studs) should cover them when in the workplace
- Staff with beards must keep the beard neatly trimmed
- Staff must not wear false nails and/or nail varnish
- Staff must keep their finger nails clean and short
- Staff must wear footwear that complies with the relevant health and safety requirements, for example, soft soled for reduced noise, low heeled for manual handling and ease of movement, and closed toes for protection

PRINCIPLE 3

Staff should not socialise outside the workplace or undertake social activities while wearing an identifiable NHS uniform.

Expectation:

Staff working in the clinical environment

- Where changing facilities are available, staff must change out of their uniform at the end of a shift before leaving their place of work
- Where changing facilities are **NOT** available staff should ensure their uniform is covered up before leaving their place of work
- Staff must not wear their uniforms in public places, for example, shops (if staff need to enter public places in the course of their duties they must make every effort to cover their uniforms)
- Staff who are permitted to wear a uniform to and from work, or work in the community setting, must cover their uniform when travelling

PRINCIPLE 4

All clinical staff must wear short sleeves or elbow-length sleeves in the workplace to enable effective hand washing techniques.

Expectation:

Staff working in the clinical environment

- Staff will comply with the above in order to ensure that correct hand hygiene can be performed before contact with patients

PRINCIPLE 5

All staff must wear clear identification at all times.

Expectation:

All staff

- Staff must wear identification (for example, a security coded name badge) that includes their title, name and profession at all times , in line with their local policies, for example, a Lone Worker Policy
- Staff identification must be clearly visible

PRINCIPLE 6

Staff who wear their own clothing for work should not wear any clothing that is likely to cause a safety hazard.

Expectation:

All staff

- Staff should not wear any loose clothing that may compromise their health and safety in the work place
- Footwear should be comfortable and practical for the role undertaken

Implementation and monitoring

The All Wales NHS Dress Code will replace any local policy in order to ensure equity and parity across all healthcare organisations. Compliance will be monitored through local agreement at a local level.

In line with the Welsh Assembly Government Inclusive Policy Guidelines this document will be reviewed in December 2012.

References

Department of Health (2010) "Uniforms and Workwear: an evidence-based document on the wearing and laundering of uniforms"

Department of Health (2006) Safety First: a report for patients and healthcare managers DoH: London

Health and Safety Commission (2000) Securing Health Together HSE: London

HMSO (1974) Health and Safety at Work Act 1974 HMSO: London

HMSO (1992) Manual Handling Operations Regulations HMSO: London

HMSO (1999) Management of Health and Safety at Work Regulations
HMSO: London

HMSO (2002) Control of Substances Hazardous to Health Regulations
HMSO: London

HMSO (2002) Personal Protective Equipment Regulations
HMSO: London

HMSO (2006) Health Act 2006 Code of Practice HMSO: London

Jacob, G (2007) Uniforms and Workwear. An evidence base for developing local policy
Department of Health, London

NHS Borders (2004) Dress Code/Uniforms Policy

Royal College of Nursing (2009) Guidance on uniforms and work wear

Royal College of Nursing (2005) Wipe It Out. RCN Campaign on MRSA. Guidance on uniforms and clothing worn in the delivery of patient care Royal College of Nursing: London

Appendix 1

Supporting information

Good Practice	Rationale	Supporting Information and /or additional comments
Wear short sleeves or roll the sleeves to elbow length before carrying out clinical procedures	Cuffs become heavily contaminated and are more likely to come into contact with patients They may act as a vehicle for transmitting infection Long sleeves or cuffs prevent effective hand washing and compromise patient safety	Some staff working in an outdoor environment, for example, ambulance personnel, paramedics and others delivering emergency care, may be exempt from this requirement
Dress in a manner which is likely to inspire public confidence	People may use general appearance as a proxy measure of competence and professional practice	
Clinical staff who do not wear a uniform should not wear any loose clothing such as unsecured ties, draped scarves, headdress or similar items	This type of clothing may make contact with the patient and their environment during clinical procedures and may be a vehicle for transmitting infection	This type of clothing could have staff safety implications. A risk assessment should be carried out.
Where changing facilities **are provided** clinical staff who wear a uniform must change out of their uniform before leaving the workplace Staff who are permitted to wear a clinical uniform to and from work should have it covered up when travelling	There is no current evidence of an infection risk caused by travelling in uniform, but patient confidence in the health and social care staff may be undermined Staff may be vunerable to attack if seen off site in uniform	This does not apply to staff who are permitted to travel during the course of their duties, for example, community staff

Good Practice	Rationale	Supporting Information and /or additional comments
Staff should not go shopping, socialising or undertake similar activities in public when in uniform	There is no current evidence of an infection risk from travelling or shopping in uniform, but patient confidence in health and social care staff may be undermined	There is a public perception (as evidenced by the media) that associates staff wearing uniforms with the spread of infection
Wear clear identifiers; uniform and/or, name or identity badge	Patients wish to know who is caring for them. Name badges and uniforms help them to do this	Identification is important to promote patient and client safety
Staff must change as soon as is practical if uniform or clothes become visibly soiled or contaminated with blood or body fluids	Visible soiling or contamination might be an infection risk, and is also likely to affect patient confidence	Organisations must ensure that there is a local arrangement for this
All staff should secure long hair	Patients generally prefer to be treated by staff with tidy hair and a neat appearance. Long or unsecured hair may make contact with the patient and their environment during clinical procedures and may be a vehicle for transmitting infection	Long hair should be tied back and off the collar
Staff must be issued with a sufficient number of uniforms to allow them to wear a clean uniform each shift Written instructions must be provided to staff who launder their own uniforms; the guidance must reflect current best practice guidelines	A clean uniform should be worn for each shift A sufficient supply of uniforms for the recommended laundry practice should be provided	Providing staff with clear instructions on the cleaning of uniforms means that uniforms will be processed in line with the current recommendations (Appendix 2) Staff who have too few uniforms may be tempted to reduce the frequency of laundering

Good Practice	Rationale	Supporting Information and /or additional comments
Wrist or hand jewellery must not be worn in the clinical environment	Wrist watches must be removed before performing any clinical procedure and to promote good hand hygiene Hand/wrist jewellery can harbour microorganisms and can reduce compliance with hand hygiene	Centres for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the ICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No. RR-16)
Clinical staff should keep finger nails short and clean Clinical staff must not wear false nails or nail varnish	Long and/or dirty nails can present a poor appearance and long nails are harder to keep clean. Long and/or dirty nails may be a vehicle for transmitting infection	Centres for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the ICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No. RR-16)
Footwear worn in the clinical areas should be suitable for purpose and comply with the relevant health and safety requirements	Closed toe shoes offer protection against spills. Soft soles reduce noise, low heeled to comply with manual handling policies	

October 2010

Appendix 2

Guidance for healthcare staff laundering uniforms/workwear in the home

For staff working in some clinical environments a laundry service is provided by the employing organisation. With the introduction of a national NHS uniform and the instigation of on-site changing facilities for all healthcare staff, the next logical progression will be the reintroduction of laundry services to negate the need for staff to leave the premises with used or contaminated clothing.

Until such services have been reinstated and where currently the employer does not provide such a service it is sensible to issue staff with guidance on how best to launder their uniforms at home.

Such guidance should include:

- Where on-site changing facilities already exist and once they have been made available, staff should remove their uniform on site.

- For transportation, uniforms should be placed in a clear plastic bag or a water soluble bag suitable for use in domestic washing machines*.

- Uniforms should be washed at the hottest temperature suitable for the fabric. A wash for 10 minutes at 60°C should remove most micro-organisms**.

- Ensure that the machine is not overloaded to allow for optimum wash efficiency and dilution factor.

- Staff should wash their hands after loading the machine.

- Use of a biological washing agent is preferable.

- Tumble dry on the hottest temperature as recommended by the manufacturer or air dry thoroughly before ironing on the hottest setting as advised by the manufacturer.

* *Plastic bags with a water soluble tie and seam, suitable for use in domestic washing machines, clearly labelled for staff use with instructions printed on them, are now available through a Welsh Health Supplies contract. Ideally these should be available for the transportation of all uniforms but as a minimum should be considered for use where uniforms are visibly soiled or during an outbreak of disease. The use of such a bag would negate the need for staff to handle the uniform in the home. The whole bag can be placed safely into the machine. On no account should the soluble bags used by hospital laundries be issued to staff even during an outbreak. They are not suitable for use within a domestic machine where the dilution and temperatures reached are not of the magnitude that can be achieved in a commercial setting.*

**Employing organisations should take into account the manufacturer's washing instructions during the procurement process for uniforms purchased outside of the national contract.*

Ref: WF35

Annual Leave and Bank Holiday Policy and Procedure (Agenda for Change Terms and Conditions)

Executive Sponsor & Function:	**Director of Organisation Development and Workforce**
Document Author:	Senior People & OD Business Partner
Approved by:	Trust Board
Approval Date:	
Date of Equality Impact Assessment:	September 2023
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Table of Contents

1. Policy Statement

Annual leave is an important wellbeing entitlement, which is encouraged to be taken by all employees to assist them to achieve a healthy balance between their work and home life. The Trust recognises that the effective management of annual leave by individual employees and line managers is essential to the health, safety and well-being of our employees and the ability of the Trust to continue to deliver high quality services which meet the requirement of its service users.

There is a requirement to provide a statutory minimum amount of annual leave each year. However, NHS employers want to reward and retain high quality, hardworking staff and therefore offer an enhanced annual leave entitlement. Whilst it is important to book annual leave at regular intervals for adequate rest breaks, it is also recognised that annual leave requests may be declined due to operational requirements and in exceptional situations, an employee may be asked not to take previously agreed annual leave or previously agreed annual leave may need to be cancelled, if not doing so would cause a detriment to the operation of the service. In these cases, managers will be mindful of providing as much notice as possible and will seek to be as flexible as possible with the employee.

2. Scope

This document provides a consistent, fair and equitable approach to the management of annual leave and bank holiday entitlements for agenda for change staff groups employed within Velindre NHS Trust.

It does not vary any contractual terms which apply but provides clarity and consistency in the way these are applied within Velindre University NHS Trust.

3. Aims and Objectives

The aim of this document is to provide guidance on how to manage annual leave and bank holiday entitlements, including when transferring or leaving the organisation, and the provisions relating to the carrying over of annual leave due to absence from work.

4. Responsibilities

4.1.   Individual Employee Responsibilities

Employees are responsible for:

- Ensuring that their annual leave is planned and taken, where possible, at regular intervals throughout the leave year, subject to approval and the needs of the service.

- Ensuring that where staff work shifts, weekends and bank holidays, they request their annual leave (which includes their bank holiday entitlement) generally proportionate to these working arrangements e.g. there is not a disproportionate taking of annual leave on particular shifts. If this occurs

managers will speak to staff to discuss reasons and agree an outcome that takes account of business and personal needs.

- Requesting leave via ESR providing a minimum of 72 hours' notice, prior to taking such approved leave. In exceptional circumstances shorter notice periods may be approved by departmental managers. Ensuring that, in exceptional circumstances, where the provision of notice has not been possible, ESR should be completed (and authorised by management) within 72 hours of the employee's return to work.

- Ensuring that the Bank Holiday process below is followed.

   Bank Holidays **are included** in all employee's annual leave entitlement balances. Therefore, any bank holidays not worked (that fall on an employee's normal working day) needs to be booked off as leave on ESR in the same way as annual leave.

   If an employee is not scheduled to work on any of the bank holidays, the relevant number of days (up to the maximum for that year* days (pro-rata part time staff) needs to be booked at the start of the annual leave year. Staff should book these days on ESR at the commencement of the new annual leave year (or when they commence in post), but in any event no later than the actual bank holiday date(s).

   If an employee is scheduled to work, or as part of their shift pattern may be required to work on a bank holiday, they are not required to this day / these days off on ESR at the start of the annual leave year. Where an employee is required to work or be on-call on a bank holiday they are entitled to take the equivalent of their bank holiday day off, at another time. By not booking their Bank Holiday entitlement off on ESR in advance this ensures that the corresponding number of hours are still available within the employee's annual leave allowance to be taken at another time.

   Employees should note that the Trust regularly undertakes audits to ensure ESR is up to date and to provide assurance that leave is being accurately recorded. Should an employee not book their bank holiday leave and this results in them overtaking their annual leave entitlement, the monetary value of these days will be claimed back as an overpayment of salary, via payroll, in accordance with the Trust's Recovery of Overpayments Policy. It is an employee's responsibility to maintain accurate records and their manager is accountable for ensuring this compliance. If an audit shows that records are repeatedly not up to date, both the employee and their line manager may be asked to explain the reason. If this is identified as a conduct concern the matter may need to be dealt with under the Trust's Disciplinary Policy.

   N.B   *The Bank Holiday entitlement may vary each year depending on when they fall and therefore will be calculated accordingly.* * Noting that where the annual leave year runs from 1st April to 31st March, the Easter bank holiday dates may fall in the same annual leave year, resulting in one year having more bank holidays than the annual statutory days and the next one having fewer.

4.2. Managers Responsibilities

Managers are responsible for:

- Working with their employees to ensure that they appropriately manage their annual leave throughout the leave year and ensuring that they apportion their leave so they can have regular rest breaks across the year.

- Calculating the annual leave entitlement for those staff employed on part-time contracts, who have not completed a full 'ESR' month who are, reaching 5 or 10 years' service during the annual leave year; who have requested to change their contracted hours during the annual leave year. In these circumstances the manager is responsible for checking the accuracy of the leave calculation on ESR and recalculating where necessary. (ESR will calculate annual leave entitlement automatically for staff where applicable and managers can use the annual leave calculators on the intranet for this purpose).

- Checking that where a bank holiday(s) fall on an employee's normal working day and they are not required to work it, that the leave has been requested and approved. Should an employee not book a bank holiday(s), the manager will bring this matter to their attention immediately and request that they submit retrospective and if appropriate prospective bank holiday leave requests. Where this becomes a regular pattern and a cause for concern, the manager should seek advice from the People and OD Department.

- Approving annual leave requests in a timely manner when an employee submits it through ESR. Until leave is approved on ESR it will not be deducted from the employee's annual and bank holiday leave total, resulting in an inaccurate entitlement.

- Ensuring that employees take the minimum statutory leave per year, in accordance with the Working Time Regulations (advice on this can be sought from People and OD).

- Encouraging staff to use their full contractual entitlement to support and promote their health and wellbeing.

- Ensuring service delivery is maintained by arranging appropriate cover for staff on annual leave. This may mean that managers have to decline annual leave requests where it would have an extreme negative impact on the service, or not agreeing to colleagues in the same team, taking their leave at the same time.

- Ensuring that where staff work shifts, weekends and bank holidays, they take their annual leave (which includes their bank holiday entitlement) generally proportionate to these working arrangements e.g. there is not a disproportionate taking of annual leave on weekend shifts and discussing the reasons with staff where there are any business concerns or wellbeing concerns around how leave is being taken.

5. Booking Leave and Compliance

5.1 Annual Leave Year

Agenda for Change Staff

The annual leave year will run from 1st April to 31st March for all staff groups covered by Agenda for Change NHS Terms and Conditions of Service.

5.2 Annual Leave Entitlements

Part-time employees will be entitled to a pro-rata share of the whole-time equivalent annual leave and bank holiday entitlement (as defined in *Appendix 1 and 2)*
All employees are required to book and take their annual leave in hours. Their leave application will be based on the actual hours due to be worked on the day in line with normal working patterns.

Please Note: The calculation of annual leave entitlements in hours contained in Appendix 1 have been rounded up or down to the nearest 0.5 decimal point (i.e. the nearest ½ hour). Velindre NHS Trust may use of their discretion to round to the nearest ¼ hour.

5.3 Bank Holiday

The NHS terms and conditions of service allows for 8 bank holiday days per year*:
Good Friday, Easter Monday, May Day, Spring Bank Holiday, August Bank Holiday, Christmas Day, Boxing Day and New Year's Day.

To ensure consistency and equal allocation of bank holidays for all employees the Trust also converts this element of leave into hours **which are** then added to an employee's overall annual leave entitlement. *This will result in a deduction of hours, equivalent to those that would have been worked, from the employee's aggregated entitlement on each bank holiday that falls on a scheduled working day, on which they are not required to work.*

Staff who are not rostered to work on a bank holiday but agree to do so on a voluntary basis, will be entitled to paid overtime. They are __not__ however, entitled to an additional day off in lieu, as this day is already added into their annual leave / bank holiday entitlement and can therefore be taken off on an alternative date.

N.B **The Bank Holiday entitlement may vary each year depending on when they fall and therefore will be calculated accordingly*

5.4 Calculation of Annual Leave

- Annual Leave entitlements are set out in Appendix 1
  An annual Leave calculator is available on the People and OD pages of the Trust intranet, under the policies and procedures section". Search for the

Annual Leave and Bank Holiday Policy and Procedure. The annual leave calculator is an accompanying document.

5.5 Entitlement on Joining the Trust

Annual leave and bank holiday entitlement in the first year will be pro-rata, based on the number of complete days worked after the date of joining and before the end of the annual leave year (rounded up or down to the nearest *½ hour).*

For Example:
Mr. Jones joins the Trust on 12th September and works 32 hours per week.

Annual Leave

(Full annual entitlement ÷ days per year) x No of calendar days remaining in the leave year
 (173hrs ÷ 365 days) x 201 days = 95.25 hours (*Rounded to **95 hours**).*

Bank Holidays

(Pro rata bank holiday entitlement in hours ÷ 8) x No of bank holidays remaining in the leave year in days.

(51 ÷ 8) x 3 = 19.12 (Rounded to **19 hours** bank holiday leave).

Total entitlement for that year: = 95 +19 = 114 hours.

*In some annual leave years, there may be 9 bank holidays, if Easter is early and falls in March. In this situation the formula should be (51÷ 9) x 4 = 22.66 (Rounded to **23 hours** bank holiday leave).*

5.6 Booking Annual Leave and Bank Holiday Leave

Staff should book annual leave or bank holiday leave, according to the number of hours they would have been due to work during the shift or working day on which they wish to take leave.

For example:

Part-time employee works 22 hours;
Monday and Tuesday's – 7.5 hour days;
Wednesday and Thursday's 3.5 hour days.

For recording purposes for a day's leave on ESR, the employee would book either 7.5 or 3.5 hours depending on the working day the annual leave falls.

5.7 Entitlement on Termination from the Trust

Employees who leave the Trust will be entitled to the pro-rata of their annual leave and bank holiday entitlement for each completed day worked in the current leave year (round up to the nearest *½ hour*).

For Example
Mr. Jones works 22.5 hours per week and leaves the Trust on 27th July. .
Annual Leave
(Yearly entitlement ÷ days per year) x No of days worked up until & including termination date (121.5 hrs ÷ 365 days) x 118 days = 39.27 hrs (*Rounded to* **39.5 hours** *annual leave*).

Bank Holidays
(Pro rata bank holiday entitlement ÷ number of bank holidays in the year) x No of days worked in the leave year.

(4 ÷ 8) x 36 = **18 hours** bank holiday leave).

Total entitlement for the year: = 39.5 + 18 = 57.5 hours.

Please note - *Managers need to remember to deduct any annual leave and bank holidays already taken to calculate if there is any outstanding leave accrual due to be paid upon leaving.*

5.8 Transferring to another post within the same Trust (Velindre)

Both positive and negative annual leave balances will be carried with the individual when they transfer to another post within the Trust.

5.9 Outstanding Leave on Termination from the Trust

The manager will work with the employee to ensure that all outstanding annual leave is taken before their termination date, where possible.

Where service provisions, long term sickness or maternity/adoption leave prevent the employee taking their leave, the Trust will make a payment to the employee for outstanding leave due. Advice from the People and OD Department needs to be sought in all cases of this nature.

5.10 Carry Over of Annual Leave

5.10.1 Normal circumstances

Employees are responsible for managing their annual leave throughout the leave year, ensuring that they take regular annual leave for rest breaks across the whole year.

NHS Terms and Conditions of Service Annex 0, confirms existing arrangements (Section 1) which state that where employees are prevented from taking their

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full allowance, they shall be allowed to carry forward annual leave into the next holiday year.

Subject to the exigencies of the service up to a maximum of 5 days can be carried forward on application and approval by the line manager to be taken in the following leave year. Any one-off exceptions to this, will be agreed by the Executive Management Team and communicated as appropriate.

5.10.2. Long Term Sickness Absence

Where staff return from long term sickness absence, they should be expected to take any outstanding leave within the current leave year. This should be managed carefully, taking account of the needs of the service and the practicalities of the employee being able to use up all of their entitlement in that leave year.

Employees on long term sick leave will be given the opportunity to take annual leave during their sick leave period. Please refer to Trust Managing Attendance at Work Policy.

Where the employee has not taken their annual leave entitlement during the period of sickness absence, and the sickness absence spans two or more leave years, they will accrue annual leave for the period of their sick leave and can be asked to take all of their accrued, but untaken annual leave, by the end of the leave year in which they return.

The leave entitlement for the previous year/years will be the *statutory* element of their leave not their full contractual annual leave and bank holidays.

Where an employee returns to work in a new leave year, after a period of long term sickness absence, they are entitled to carry over the statutory element of their leave, in line with (Working Time Regulations. - refer to the Trust Managing Attendance at Work Policy, Section 8.4). Managers need to remember to deduct any annual leave and/or bank holidays that they took before or during their period of sickness absence.

Any annual leave accrued, at the time of the return to work, may also be taken to extend an agreed phased return to work i.e. in exceptional circumstances whereby a phased return to work is extended beyond the maximum 4 weeks period (in line with the Trust Managing Attendance at Work Policy).

5.11 Sickness Occurring during Annual Leave

When an employee falls sick during annual leave they will be required to report that episode of sickness in line with normal notification procedures and produce a fit note covering the period from the first day of sickness (in line with Section 7 of the Trust Managing Attendance at Work Policy).

In order to allow annual leave to be reinstated a medical fit note needs to be received within 3 working days of the beginning of the illness (unless abroad). In such cases

the employee will be deemed to have been on sickness absence rather than annual leave from the date of the certificate.

Only in exceptional cases will a foreign medical certificate of more than one month be accepted for payment purposes. A United Kingdom fit note should be obtained on return to the country.

5.12 Maternity/ Adoption and Parental Leave

5.12.1. Annual Leave

Annual leave will continue to accrue during all forms of paid and unpaid parental leave, as set out in the NHS Terms and Conditions of Service. Managers are encouraged to discuss with employees prior to their leave and reach agreement where possible when they will take said leave. Employees are encouraged to take any outstanding annual leave due to them before the commencement of Occupational Maternity Leave / adoption or parental leave, or towards the end of the leave period, if the leave period falls within the current annual leave year and there is sufficient time to take this leave. It should be noted that the provisions relating to the carry forward of annual leave will apply equally to staff on all forms of parental leave.

Employees returning to work on reduced hours need are encouraged to take any accrued annual leave either prior to the commencement of all forms of parental leave or prior to their return.

Employees not intending to return to work following all forms of parental leave should take any outstanding annual leave prior to commencement of that leave. The date of termination of service will then be calculated as the last working day plus any outstanding annual leave days, plus the full parental leave period.

As statutory paternity leave is shorter in length, the above provisions do not apply, apart from leave continuing to accrue during periods of paternity leave.

5.12.2. Accrual of Bank Holidays

In accordance with the Maternity and Parental Leave Regulations 2008, employees are entitled to accrue bank holidays (pro rata) that fall during their parental leave. Please refer to the Maternity, Adoption, Paternity and Parental Leave Policy for further information.

5.13 Annual Leave Entitlement on Changing Contracted Hours

Where employees change their contracted hours / sessions, this will result in a re-calculation of their annual leave entitlement based on completed days on the new and the old contracted hours /sessions to give the full year entitlement. Depending on the change, the annual leave entitlement may go up or go down. *For staff on ESR the system will calculate this automatically, managers should however check the accuracy of this calculation (please refer to section 4.2).*

If a reduction in contracted hours /sessions results in leave being overtaken, upon agreement with the individual, this will either be deducted from the following years annual leave entitlement, or a financial deduction made from their salary.

5.14 Annual Leave Entitlement for Term-time Working

An employee who wishes to work term time will have their annual leave and bank holiday entitlement annualised, and the entitlement *included* in their salary payments, over the period of the year.

Please liaise with the Trust's Payroll Department, should you wish to see your calculations.

5.15 Annual Leave Entitlement for Annualised Hours Working

The calculation of annual leave for employees who work annualised hours is as follows:

Total hours worked in the year = 850.
Annual weekly average = 850 ÷ 52.143 = 16½ hours (to the nearest ½ hour).

Refer to **Appendix 1** for appropriate entitlements.

e.g. 89 hours annual leave, 26½ hours bank holiday leave.

Total entitlement = **115½ hours.**

** Employees may opt to reduce their annualised hours by deducting their annual leave entitlement. Any subsequent time off with then be unpaid and agreed by the manager.

5.16 Annual Leave accrual for regular overtime

The Trust's position on this is to pay as overtime rather than given as annual leave.

6. Bank Holidays Falling on Saturday or Sunday

When any of the Christmas /New Year bank holidays falls on a Saturday or Sunday arrangements will be made to ensure that the right of staff to receive three public holidays are preserved. The Trust will communicate this, as relevant, on the years that it applies.

7. Sickness Occurring during a Bank Holiday

Employees **will not** be entitled to an additional day if they fall sick or are already away from work sick on a bank holiday. Please refer to the Managing Attendance at Work Policy for further information Statutory Entitlements during long term sickness absence.

8. Annual Leave When Under Suspension

Please refer to the Trust's Disciplinary Policy and Procedure Section 10.7.

9. Purchase of Annual Leave

The Trust operates an Annual Leave Purchase Scheme, which provides staff with the opportunity to apply to purchase additional annual leave, with the associated cost being deducted from their salary on a monthly basis, if approved. The purchase of additional annual leave is subject to certain conditions and is at the line manager's discretion.   Please refer to the Trust's Purchase of Annual Leave Scheme Procedure.

10. Equality Impact Assessment Statement

The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees, reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment (EQIA) and received feedback on this document and the way it operates. The EQIA has been undertaken to identify and address any possible or actual negative impact that this document may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership) race, disability, sexual orientation, Welsh language, religion or belief, gender, transgender, age or other protected characteristics.

The assessment found that there was no impact to the equality groups mentioned and this policy will have a positive impact on all of the 'protected characteristic' groups. 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.

11. Getting Help

Further information and support is available from your divisional People and OD Department.

NWSSP staff should refer any queries to nwssp.hrcontactpoint@wales.nhs.uk.

12. Related Policies

Recovery of Overpayments Policy;
Purchase of Annual Leave Scheme;
Managing Attendance at Work Policy;
Maternity, Adoption, Paternity and Parental Leave Policy;
NHS Terms and Conditions Handbook;
Special Leave Policy

Appendix 1 – Annual Leave Entitlement – Agenda For Change (A4C) Staff

In accordance with Section 12 of the NHS Terms and Conditions of Service annual leave entitlement, all previous NHS service, whether continuous or not, will be aggregated. The Trust will verify as much previous NHS service as possible e.g. contacting the previous employer using an Inter Authority Transfer (IAT).

In circumstances where it is not possible for the Trust to confirm all of the employees previous NHS service (i.e. previous NHS employer no longer exists) the employee will be required to provide evidence to confirm these periods of employment e.g. contract of employment, offer letter, payslips etc.

Employees are entitled to receive extra annual leave at defined intervals, as shown in the table below.

Annual Leave entitlement increased by 1 day per annum following Pay Circular AFC, M&D & ESP (W) 01/2021 issued in December 2021

Table 1:- ANNUAL LEAVE ENTITLEMENT (COMPLETE YEAR) FOR A4C STAFF EXCLUSIVE OF BANK HOLIDAYS

Formula: Weekly contracted hours ÷ 5 x No. of annual leave days' entitlement based on 28 days, 30 and 34 days

WEEKLY BASIC CONTRACTED HOURS	ON APPOINTMENT	AFTER 5 YEARS' SERVICE	AFTER 10 YEARS SERVICE
	28 DAYS	30 DAYS	34 DAYS
HOURS EQUIVALENT:			
37.5	210	225	255
37.0	207.25	222	251.75
36.5	204.5	219	248.25
36.0	201.75	216	245
35.5	199	213	241.5
35.0	196	210	238
34.5	193.25	207	234.75
34.0	190.5	204	231.25
33.5	187.75	201	228
33.0	185	198	224.5
32.5	182	195	221
32.0	179.25	192	217.75
31.5	176.5	189	214.25
31.0	173.75	186	211
30.5	171	183	207.5
30.0	168	180	204
29.5	165.25	177	200.75
29.0	162.5	174	197.25
28.5	159.75	171	194
28.0	157	168	190.5
27.5	154	165	187
27.0	151.25	162	183.75

26.5	148.5	159	180.25
26.0	145.75	156	177
25.5	143	153	173.5
25.0	140	150	170
24.5	137.25	147	166.75
24.0	134.5	144	163.25
23.5	131.75	141	160
23.0	129	138	156.5
22.5	126	135	153
22.0	123.25	132	149.75
21.5	120.5	129	146.25
21.0	117.75	126	143
20.5	115	123	139.5
20.0	112	120	136
19.5	109.25	117	132.75
19.0	106.5	114	129.25
18.5	103.75	111	126
18.0	101	108	122.5
17.5	98	105	119
17.0	95.25	102	115.75
16.5	92.5	99	112.25
16.0	89.75	96	109
15.5	87	93	105.5
15.0	84	90	102
14.5	81.25	87	98.75
14.0	78.5	84	95.25
13.5	75.75	81	92
13.0	73	78	88.5
12.5	70	75	85
12.0	67.25	72	81.75
11.5	64.5	69	78.25
11.0	61.75	66	75
10.5	59	63	71.5
10.0	56	60	68
9.5	53.25	57	64.75
9.0	50.5	54	61.25
8.5	47.75	51	58
8.0	45	48	54.5
7.5	42	45	51
7.0	39.25	42	47.75
6.5	33.75	39	44.25
6.0	33.75	36	41
5.5	31	33	37.5
5.0	28	30	34
4.5	25.25	27	30.75
4.0	22.5	24	27.25
3.5	19.75	21	24
3.0	17	18	20.5
2.5	14	15	17

2.0	11.25	12	13.75
1.5	8.5	9	10.75
1.0	5.75	6	7
0.5	3	3	3.5

Appendix 2 – Calculation of Bank Holiday Entitlement

CALCULATION OF BANK HOLIDAY ENTITLEMENT (COMPLETED YEAR)
Formula: Weekly Contracted Hours ÷ 5 x No. of Bank Holiday Days Entitlement

WEEKLY BASIC CONTRACTED HOURS	HOURLY ENTITLEMENT FOR FULL LEAVE YEAR	WEEKLY BASIC CONTRACTED HOURS	HOURLY ENTITLEMENT FOR FULL LEAVE YEAR
	(8 BANK HOLIDAYS)		(8 BANK HOLIDAYS)
37.5	60.0	20.0	32.0
37.0	59.0	19.5	31.0
36.5	58.5	19.0	30.5
36.0	57.5	18.5	29.5
35.5	57.0	18.0	29.0
35.0	56.0	17.5	28.0
34.5	55.0	17.0	27.0
34.0	54.5	16.5	26.5
33.5	53.5	16.0	25.5
33.0	53.0	15.5	25.0
32.5	52.0	15.0	24.0
32.0	51.0	14.5	23.0
31.5	50.5	14.0	22.5
31.0	49.5	13.5	21.5
30.5	49.0	13.0	21.0
30.0	48.0	12.5	20.0
29.5	47.0	12.0	19.0
29.0	46.5	11.5	18.5
28.5	45.5	11.0	17.5
28.0	45.0	10.5	17.0
27.5	44.0	10.0	16.0
27.0	43.0	9.5	15.0
26.5	42.5	9.0	14.5
26.0	41.5	8.5	13.5
25.5	41.0	8.0	13.0
25.0	40.0	7.5	12.0
24.5	39.0	7.0	11.0
24.0	38.5	6.5	10.5
23.5	37.5	6.0	9.5
23.0	37.0	5.5	9.0
22.5	36.0	5.0	8.0
22.0	35.0	4.5	7.0
21.5	34.5	4.0	6.5
21.0	33.5	3.5	5.5
20.5	33.0	3.0	5.0
		2.5	4.0
		2.0	3.0
		1.5	2.5
		1.0	1.5
		0.5	1.0

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Redundancy and Security of Employment Policy

Executive Sponsor & Function:	**Director of Organisation Development and Workforce**
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1 Policy Statement

Velindre University NHS Trust will take all reasonable steps to provide a stable work environment and to prevent all avoidable compulsory redundancies. It is the aim of this policy to ensure that the Trust retains the valuable knowledge, skills and experience of its workforce, by utilising a number of strategies, to assist employees at risk of redundancy to find suitable alternative employment.

At times of organisational change, it is particularly important to ensure that the Trust supports, guides, trains and develops its workforce, to minimise the risk of redundancy.

The policy should be read in conjunction with the relevant NHS Wales Organisational Change Policy (OCP). This policy will be applied to all proposed redundancy situations.

2 Scope of Policy

This policy will apply to all employees of Velindre University NHS Trust who are employed on a substantive or a fixed term contract (which is being terminated by reason of redundancy) where, at the proposed date of dismissal, they have accrued two years continuous service with the Trust / hosted organisation or another NHS employer.

3 Policy Principles

Subject to the procedures and processes outlined in this policy, when a potential redundancy situation arises the Trust will:

a) use early retirement and / or the Trust's Voluntary Early Release Scheme (VERS) where circumstances and / or resources allow.

b) after consultation identify, where possible, suitable alternative employment in the Trust for employees who have been identified as being at risk of redundancy.

c) liaise with local NHS employers, to establish whether they can assist with offering suitable alternative employment to those employees identified at risk of redundancy via the OCP or another process.

d) support employees who wish to retrain and are qualified to undergo training for posts in other disciplines / areas, where this option is reasonable and affordable.

e) take all steps to ensure that it can demonstrate that it has acted reasonably and fairly in respect of the reason for dismissal and the dismissal process.

4 Policy Legislation

For the purposes of this policy, the term "at risk" will apply to any employee or staff group who as a result of any of the reasons detailed below, face the possibility of being made redundant.

The Employment Rights Act 1996, Section 139(1) states that redundancy arises when an employee is dismissed in the following circumstances:

(i) Where the employer has ceased, or intends to cease, to carry on the business for the purposes of which the employee was employed, or has ceased, or intends to cease to carry on that business in the place where the employee was so employed; or

(ii) The fact that the requirements of that business for employees to carry out work of a particular kind or for employees to carry out work of a particular kind in the place where they were so employed, have ceased or diminished or are expected to cease or diminish.

The Trust will comply with the legislative requirements relating to individual and collective redundancy consultations. In particular, where the Trust is proposing to dismiss 20 or more employees, over a period of 90 days or less, it will consult with the appropriate trade union representatives. The Trust will also consult with each employee "at risk" of redundancy, on an individual basis.

All employees will have the right to representation by a trade union representative or accompanied by a Velindre University NHS Trust workplace colleague, at a redundancy consultation meeting.

5 Policy Operation

The policy shall operate in the following cases: -

1. Where the Trust Board has agreed, following discussions with the appropriate Divisional Director or hosted organisation director, that a department / ward, in their division / hosted organisation shall close (either temporarily or permanently), whether or not the services are to be transferred or are expected to do so.

2. Where it has been identified that a post or posts which is required to enable the Trust / hosted organisation to carry out work of a particular kind has ceased or diminished (or is expected to cease or diminish), including where this is necessitated by cost reduction.

3. Where it has been identified that a post or posts which is required to enable the Trust / hosted organisation to carry out work of a particular kind in the place where the posts are based has ceased or diminished (or is expected to cease or diminish), including where this is necessitated by cost reduction.

It should be noted that the above list is not exhaustive and could cover a range of service and organisational change situations.

6 The Policy Aims and Objectives

The main aim of the policy is to provide clear advice, support and guidance to managers and affected employees regarding their role(s) and responsibilities, in respect of a redundancy process. Both the manager and the affected employees, in consultation with the relevant trade

union representatives, will seek to explore all reasonable and practical measures, which could avoid the need for a compulsory redundancy situation.

The Trust will aim to prevent or reduce the need for compulsory redundancies, where appropriate, by taking advantage of other potential alternatives. Depending on the circumstances, these may include: -

(i) consider the withdrawal or elimination of overtime where management considers this to be practicable and it will not negatively impact on service delivery.

(i) Place restrictions on the filling of any Trust vacancies, which may provide "suitable alternative employment" for those employees identified as being 'at risk' of redundancy.

(ii) consider the use of short-term temporary staff in any period of organisational change, where it is necessary to appoint into vacant posts, to maintain service requirements, until the programme of change has been completed.

(iii) maintain a Trust Redeployment Register which will contain details of all employees at risk of redundancy. All vacant posts will be made available to suitable employees on the Trust Redeployment Register, in the first instance. Suitability will be assessed with reference to the information contained in the employee's CV and Collection of Information Document (*the Collection of Information Document is available from the People Team/Intranet*).

(iv) implement the NHS Wales OCP Appendix 5 Redeployment Policy. This policy will only apply where an OCP process results in a redundancy situation.

(v) implement the Velindre University NHS Trust Redeployment Procedure). This procedure will apply to any redeployment situations which fall outside the remit of an OCP process.

(vi) consider re-training of employees where this option is reasonable and affordable.

(vii) ensure that wherever possible or affordable, the reductions in employee numbers are achieved through a process of natural wastage, voluntary early release or by means of voluntary early retirement. It should be noted there is a lead time of approximately five months between the granting of early retirement and the payment of pension benefits.

(viii) consider proposals from employees who are prepared to reduce their hours voluntarily or request a flexible working arrangement etc.

(ix) liaise with local NHS organisations to identify potential suitable advertised posts. It should be noted that NHS organisations only have a responsibility to co-operate in respect of those staff seeking redeployment as the result of an OCP process.

(x) redeployment of the employee to a vacant post at a lower salary band / grade (this will not be more than one band lower than the employee's substantive band / grade). This option will only be considered by the Trust where an employee has been identified as being at risk of redundancy due to an OCP process. Protection

of earnings in such circumstances will be in accordance with Section 10 of the NHS Wales OCP. The employee will have a responsibility to actively seeking and applying for further suitable alternative posts, commensurate with the level of their pay protected band/ grade, as and when they arise within the Trust and local NHS organisations.

7   Roles and Responsibilities

7.1   Line Managers

Line managers have a duty to familiarise themselves with the policy and associated processes and to treat all employees fairly and equitably. Managers are responsible for identifying situations where redundancy may be a potential outcome of the process and to consider and lead on a fair redundancy process.

The line manager will be required to make the People Department aware of the details of any employee who has been identified as being potentially at risk of redundancy, to ensure that they and the affected employee receive timely and appropriate advice and support, throughout the process.

The following checklist should be used by the manager to confirm the support facilities which may be available and offered to affected employees during this process:

- Access to career advice.

- Access to advice on CV writing, statements of suitability, application forms, preparing for an interview and interview skills etc.

- Assistance to prepare CVs and submit personal details to be included on the Trust's Redeployment Register

- Assistance with access to job websites such as NHS Jobs, the Job Centre, recruitment agencies etc.

- Provided with information on how to access reasonable and affordable retraining opportunities, further education establishments etc.

- Access to suitable Trust and hosted organisation employees to act as mentors, provide advice and guidance as appropriate to the employee's needs.

- Signposting to independent financial and pension advice in the event of redundancy or early retirement situation; or

- Access to the Employee Assistance Programme, Occupational Health Services etc.

The above list is not exhaustive, it is intended to be general guidance on areas of possible advice and support.

7.2 Employees

Where it has been confirmed that an employee is at risk of redundancy, they will be designated by the Trust as a redeployment candidate.

Redeployment candidates may also request that their details be notified to other NHS Wales organisations for consideration of vacancies. It should be noted that these organisations have no obligation to co-operate with the redeployment process, unless the redeployment is related to an OCP case (covered under the separate OCP policy).

Where an employee is interested in a post advertised in another NHS organisation, the People Redeployment Case Manager will ensure that their details (as contained in the Information Collection Form) are forwarded to the Workforce Department of the NHS organisation, for consideration during the shortlisting process.

It will be the responsibility of the employee identified as at risk of redundancy to:

- maintain regular contact with their Redeployment Case Manager, including notifying them of any extended periods of absence, such as sick leave, annual leave, maternity leave etc., to ensure that information about appropriate vacancies is made available to them during the redeployment period.

- complete and sign the Information Collection Form (Appendix 1 of the Redeployment Procedure), within 7 days of receipt, providing all relevant information / documentation in relation to contact details, employment record, qualifications, experience and role / job preferences.

- complete and sign the Redeployment Scheme Employee Agreement Form (Appendix 2), within 7 days of receipt, to comply with the terms of the redeployment scheme and work proactively with the Trust to secure alternative employment, within the prescribed notice period timescales.

- access and review NHS jobs and other relevant internet job search sites, recruitment media etc. on a daily basis, to assist in the identification of potentially suitable internal and external NHS / public sector vacancies.

- consider and pursue all reasonable suitable alternative employment opportunities within the Trust / NHS Wales etc. as appropriate.

- comply with the relevant process for applying for / considering vacant posts for which they are potentially suitable (with reference to their knowledge, skills, qualifications and experience).

- bring to the attention of their Redeployment Case Manager any vacancies which they are interested in, and their Redeployment Case Manager may not be sighted on, to enable such opportunities to be explored via this process, if appropriate.

- contact the Redeployment Case Manager, should they require any additional information regarding vacant posts, to assist them to make an informed decision regarding the suitability of the vacancy.

- complete the relevant process for applying for / considering all identified suitable alternative posts and attend all associated arranged meetings, assessments, interviews etc.

- approach their manager to request reasonable time off work to attend meetings etc. in relation to their redeployment.

- co-operate fully when considering and being considered for suitable alternative posts. Whilst reasonable attempts will be made to accommodate employee's preferences, they should not unreasonably refuse to accept an offer of suitable alternative employment. Should an employee unreasonably refuse a post that has been assessed by the Trust as being one which could provide suitable alternative employment, the matter will be investigated. Should this process determine that the employee has unreasonably refused to participate in the relevant process / accept an offer of suitable alternative employment, it may result in the employee losing their entitlement to a contractual redundancy payment, upon termination of their employment.

- meet with a People and Relationship Manager should their Redeployment Case Manager believe that they have unreasonably refused an offer of suitable alternative employment.

All redeployment candidates will be entitled to be accompanied by a trade union representative or a work colleague, if they so wish during any redeployment related meetings. The employee's trade union representative or workplace colleague will not be permitted to attend any suitability assessment meetings / discussions or interviews.

7.3   People and Relationship Advisor / Manager

The Trust will nominate a People and Relationship Advisor/ Manager, to support employees at risk of redundancy. The People and Relationship Advisor/ Manager will act as the "Redeployment Case Manager" for all such redundancy cases.

It will be the role of the nominated Redeployment Case Manager to:

- work proactively with employees at risk of redundancy, to assist them to secure where possible, suitable alternative employment.

- ensure the identified employee's information is recorded on the Trust's Redeployment Register, to facilitate the appropriate management of their case.

- ensure the details / information contained within the Trust's Redeployment Register are maintained and kept up to date.

- review all vacancies that are submitted via the Trust's / hosted organisation's Scrutiny Process, to establish whether any of these posts could offer potential suitable alternative employment opportunity, to any employees on the Trust's Redeployment Register.

- as necessary, assist staff at risk of redundancy to access NHS jobs and any other

online recruitment sites, recruitment media etc. and to download / access vacancy information, if applicable.

- ensure that all appropriate, suitable vacancies and the associated recruitment documentation is made available to employees at risk of redundancy.

- discuss appropriate vacancies with employees on the redeployment register to assist them to assess and make an informed decision regarding their suitability of vacant posts, with particular reference to the person specification, job description and any other available vacancy related information.

- ensure that employees designated at risk of redundancy who meet the essential person specification criteria for the post are offered the opportunity to discuss the job with the appointing manager. This process will assist the manager to assess the employee's potential suitability for the post.

- liaise with the relevant People Manager, should a manager fail to agree to make an offer when an employee clearly meets the essential person specification criteria for the post. The People and Relationship Manager will ensure the matter is investigated and resolved appropriately and in a timely manner.

- liaise with the relevant People Manager, to determine the legal and contractual consequences, should an employee on the redeployment register decline to apply for a potential suitable alternative employment post, which has been brought to their attention or accept the offer of such a post.

- ensure employees designated as being at risk of redundancy have access to Employee Assistance Programme (EAP) support services, careers advice services etc., communicating the availability of such services as appropriate; and

- manage the workforce transactional processes associated with the redeployment or redundancy of an employee e.g. preparing reports for the Remuneration Committee etc.

7.4 Trade Union / Professional Organisation Representative

At the request of the employee identified as at risk of redundancy the trades union / professional organisation representative is responsible for:

- Supporting the employee and attending meetings with them in relation to their redundancy / redeployment. This **will not** include attendance at any formal meetings with a manager to discuss the suitability of a specific post or recruitment interviews.

- Working with the People Department to address any concerns the employee may have regarding the Trust's adherence to the provisions of this policy and associated terms and conditions of employment. Seeking to resolve any issues of concern, informally where possible.

8 Consultation and Selection for Redundancy Procedures

8.1 Ad Hoc / Individual Redundancy Consultation (<u>Non OCP Related</u>) (Less than 20 Employees)

In the event of the manager having to make an employee with two or more years continuous NHS service redundant, not as a result of an OCP process e.g., at the end of a fixed term contract, they are required to follow the three-step dismissal procedure, as set out below.

8.1.1 Three Step Dismissal Procedure

1. Provide the employee with a **written invitation to attend a dismissal meeting,** to set out the arrangements and reason for ending the contract of employment.

2. **Meet with the employee** to confirm the reason for the dismissal and to provide them with contractual notice.

   If the employee has 2 or more year's continuous NHS service, they may be entitled to a contractual redundancy payment. In these circumstances the employee must be advised of the redeployment process and the need to create a formal record using a 'Collection of Information Document" (*available from the People Team/Intranet*) to record their relevant personal details, circumstances, preferences, knowledge, skills, qualifications and experience. This information will be utilised to populate the employee's Trust Redeployment Record and assist with the search for suitable alternative employment to try to avoid a redundancy situation.

   Following the meeting we will provide the employee with **written confirmation** of the consultation meeting discussions. This letter must outline the reason for their dismissal and confirm the notice period and contract end date. If the employee is entitled to a contractual redundancy payment, this information along with the redeployment process information must also be outlined in the letter.

3. Provide the employee with a **right to appeal**. This must be clearly set out in the written confirmation of the consultation meeting discussions letter.

Where a fixed term post becomes redundant and the employee has less than 2 years continuous NHS Service, while they will not be entitled to a redundancy payment, the manager will still be required to follow the three-step procedure.

Approval must be obtained from the Trust Remuneration Committee for all redundancy payments and therefore, a paper with full details of the situation and costs should be submitted in advance. The paper should be written by the Manager, with input from the People and OD Team. A template can be obtained from the People and OD Team.

8.2 Ad Hoc / Individual Redundancy Consultation (<u>OCP Related</u>) (Less than 20 Employees)

In the event of the manager having to make an employee redundant as a result of an OCP process, they are required to adhere to the Organisational Change Policy requirements relating to at risk employees, set out below, prior to and in addition to the *three-step dismissal procedure* (*See 8.1.1 above*).

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1. Identify the employee(s) who are at risk of redundancy. The timing of this decision should be discussed and agreed with the local trade union representative(s).
2. Issue the employee with an OCP 'at risk' of redundancy letter.
3. If suitable alternative employment cannot be secured within the new structure the manager must instigate the *three-step dismissal procedure.*

The Trust will work in effective partnership with trade union representatives on all potential OCP redundancy situations to effectively manage and where possible minimise, the potential workforce implications.

8.3 Collective Redundancy Consultation (20 or More Employees)

Where it is anticipated that a significant number of compulsory redundancies may be required as a result of organisational change etc., the relevant Divisional / hosted organisation's Director will inform the Executive Management Board (EMB). There is no requirement to notify the Executive Management Board of ad hoc redundancies which arise outside of an OCP process. Such ad hoc cases will however (as noted above) be notified to the Trust's Remuneration Committee, by the People and OD Department.

In respect of potential collective redundancies (20 or more employees) which arise because of an OCP or any other process, the Trust will follow and adhere to the consultation principles outline in Section 5 and Appendix 2 of the OCP.

In respect of collective redundancies, the consultation should begin in good time and must, in any, event adhere to the following requirements:

20 – 99 employees are to be made redundant over a 90-day period; consultation must begin at least 30 days before the first dismissal takes effect.

100 plus employees are to be made redundant over a 90-day period; consultation must begin at least 45 days before the first dismissal takes effect.

NHS Wales and the Trades Unions recognise that should the Trust propose the need to dismiss 20 or more employees as redundant (within the meaning of the definition within the Trade Union and Labour Relations (Consolidation) Act 1992 (TULRCA)) at one establishment within 90 days or less, then the statutory consultation framework under Section188 TULRCA will be engaged.

During any collective redundancy consultation process the Trust will inform the relevant trade union representatives of the reason for the proposed redundancies and the number of employees affected. During the consultation process the following areas will be covered:

(i)   A commitment to keep local trade union representatives informed as fully as possible about workforce requirements and the proposed redundancy situation.

(ii) Information on alternative proposals which may be considered to avoid or reduce the number of redundancies.

(iii) Possible steps to take in order to mitigate or reduce the consequences of the redundancies.

(v)   Disclosure of information relating to:

    (a)   the reason for the proposal(s).
    (b)   the number and description of the employees affected by the proposals.
    (c)   the proposed redundancy selection criteria and seek to agree this in partnership.
    (d)   the dismissal process and the period over which the dismissals will take effect.
    (e)   the method of calculating (contractual or statutory) the amount of redundancy payment to made to the affected employees.
    (f)   arrangements for time off for employees to seek alternative employment opportunities or retraining opportunities; and
    (g)   arrangements for the additional assistance which will be provided to staff as outlined in Section 7.

The information set out in *point (v)* above will be provided in writing to each trade union representative during the meeting or as soon as practicable after the meeting.

Should the collective consultation process confirm that 20 or more employees will be made redundant, the next stage of the consultation process will commence. The manager, along with a People and Relationship Advisor / manager, will arrange one to one meetings with the affected employees and outline the selection for redundancy process.

During this meeting the manager and the People and Relationship Advisor / manager will provide appropriate support and advice to the affected employee. They will also create a formal record to record their relevant personal details, circumstances, preferences, knowledge, skills, qualifications and experience on an 'Collection of Information Document" (*available from the People Team/Intranet*). This information will be utilised to populate the employee's Trust Redeployment Record and assist with the search for suitable alternative employment.

Following this meeting, or where it is proposed that less than 20 employees will need to be made redundant, the process will revert back to the three-step dismissal procedure (See Section 8.2 above).

9   Suitable Alternative Employment

All eligible employees will be supported where possible to secure a suitable alternative employment post, with similar pay and conditions of service to avoid a redundancy situation. An offer of suitable alternative employment may be made without the employee participating in an interview / selection process, if the job is deemed to be same or very similar to the employee's existing job.

If there is only one suitable 'at risk' employee identified for a redeployment post, the Trust may offer it to that employee without any formal suitability assessment process.

An employee who is offered a new job to avoid compulsory redundancy will be provided with a copy of the job description and person specification, detailing the post and the requirements to perform effectively in the role. Where any of the terms and conditions attached to the post

differ from the employee's current post, these will be set out separately, in writing as will any protection arrangements which may apply.

There will be no limit on the number of posts which the Trust or the employee may identify as offering potential "suitable alternative employment". The limiting factor will be the number of vacant and fully funded posts available during the redeployment period.

The refusal to accept or apply for suitable alternative employment posts will affect an employee's eligibility to receive a contractual redundancy payment, as set out in Section 16.17 of the NHS Terms and Conditions of Service Handbook.

Any employee who unreasonably refuses an offer of suitable alternative employment will lose their entitlement to a contractual redundancy payment. In relation to redeployment into a suitable alternative employment post, the following criteria will be considered, as will the reasonableness of the employee's refusal of the post, if applicable:

- (i)   Nature of the job, including job content (including similarity to existing role)
- (ii)   Status of the role
- (iii)   Salary
- (iv)   Hours of Work
- (v)   Workplace (Base, including potential travel distance / time / modes of transport etc.)
- (vi)   Work environment
- (vii) Job / career prospects
- (ii)   Qualifications, knowledge and skills required for the role
- (iii)   Personal and/or domestic circumstances. In relation to personal circumstances employees will be expected to show some flexibility by adapting their domestic arrangements where possible*

*Account must be taken of the requirement to make reasonable adjustments for staff covered by the Equality Act 2010.

Any offer of employment, which is considered to be suitable by the Trust must be made in writing, providing sufficient details of the post and allowing reasonable time for the employee to consider it, prior to expiry of the notice period. The offered post should be available no later than four weeks, from the date the existing contract is due to end by reason of redundancy. The offer should, where appropriate, indicate any terms and conditions which differ between the existing and the new job. Where this procedure is followed and the employee fails to respond to any such offer, the employee shall be deemed to have refused the offer of suitable alternative employment.

The acceptance of a post which is considered suitable, may be subject to a four-week trial period. Trial period arrangements, including the mechanisms for assessment and review are set out in section 8 of the Velindre University NHS Trust Redeployment Procedure and Section 6.6 of the NHS Wales OCP Redeployment Policy.

In exceptional circumstances, the trial period can be extended for a maximum of 4 weeks by mutual agreement. This should be on the basis that further assessment of progress needs to take place, based on the assessment process, established, and agreed prior to the commencement of the trial period.

If the Trust and the employee agrees that an offered post does not provide suitable alternative employment, on or before the completion of a four-week trial period, a contractual redundancy payment may be payable, if suitable employment cannot be found before the end of the notice period.

If it is established by the Trust that an employee has unreasonably terminated their employment on or before the completion of an agreed trial period, they will not be entitled to a contractual redundancy payment.

10 Selection for Redundancy

The Trust will make appropriate arrangements to ensure that all employees affected by change and at risk of redundancy, including those on any form of authorised absence, which may include maternity leave, parental leave, carers leave, term-time working, long term sick leave or secondment, are considered at each stage of the process and are not disadvantaged in any way.

The organisational change process will, were applicable, identify the relevant group of employees from which redundancies may be necessary. This is known as the potential 'pool for selection'. The timing of when employees will be declared at risk of redundancy will be agreed in partnership with the trade unions, during any period of organisational change.

The pool for selection process will not apply to one off redundancy situations e.g. an employee's fixed term contract expires without renewal or a single employee (in a single, unique post) is determined to be at risk of redundancy as the result of an OCP process.

A redundancy selection process will comply with the following broad OCP principles:

- All employees affected by the proposed changes will be treated on the basis of equality.
- All employees at risk of redundancy will be supported, where possible, to secure a post with similar pay and conditions of service (suitable alternative employment).
- All employees will be treated fairly and with dignity and respect: Principles of equality will apply, and the processes will be transparent.
- Where there are fewer posts than employees, the selection for redundancy decisions will be based on the outcome of the prior consideration or restricted competition selection process. This process will fully consider the merits and the suitability of each of the eligible employee, identified as being at risk, based on a selection process which will thoroughly assess their knowledge, skills, experience etc.,
- The minimum required for a prior consideration or restricted competition selection process will be a formal selection interview.

10.1 The Selection Criteria

The Trust must use an objective redundancy selection criteria and process which is non-discriminatory and is applied in a fair and consistent manner to all affected employees, when there are more employees than posts. The following selection criteria will be applied in a redundancy situation (involving more than one employee) in accordance with the NHS Wales Organisational Change, Appointment and Selection Process.

(i) The qualifications which are essential for the post.
(ii) The knowledge and skills which are essential for the post.
(iii) Experience which is relevant to the post and the needs of the business.
(iv) Suitability for trial period / re-training to meet the criteria; and
(v) The need for reasonable adjustments to be made to the post in accordance with the Equality Act (2010).

Every employee involved in the process will be entitled to receive feedback on their performance during the selection process, from a nominated member of the interview selection panel.

11 Notification of Redundancy

Once employees selected for redundancy have been identified, they will be invited to discuss the matter at a formal meeting. During this meeting, they will be served in accordance with their contractual notice period. Following this meeting they will receive writing confirmation of their redundancy dismissal and right of appeal. In the absence of any agreement with the Trust, the employee will be obliged to serve their notice period. This process will be managed in accordance with the three-step dismissal procedure (noted in section 8.1.1).

All employees who are served with redundancy notice will be given reasonable time off work with pay to seek alternative employment. Employees will normally be allowed to leave before the expiry of the period of notice, if they have been offered other employment to begin prior to their termination date. In such cases it is important that the manager and the employee discusses this with the People Department, to ensure that the appropriate paperwork is completed in advance.

12 Notice Periods

Contractual notice should be served on any employee selected for redundancy unless their statutory notice period is greater.

In exceptional circumstances the Trust may, with the agreement of local Trade Union representatives offer an extended notice period, to maximise the possibility of redeployment opportunities arising.

Subject to mutual agreement an employee may leave before the expiry of notice and not lose their entitlement to their redundancy payment if the employee, obtains suitable employment outside the Trust / and wishes to take up the post before the end of the notice period. In such cases the new termination date will become the revised date of redundancy for the purpose of calculating the redundancy pay and;

In the event that an employee' engages in conduct resulting in a fair reason for dismissal during the notice period, they will lose their entitlement to a redundancy payment.

In respect of the notice, the Trust reserves the right to make a payment in lieu of notice and a contractual redundancy payment in full and final settlement (subject to statutory regulation in force from time to time) of the redundancy dismissal case.

13 Redundancy Pay

Contractual redundancy pay will be payable to employees dismissed by reason of redundancy who, at the date of termination of their contract, have at least 104 weeks of continuous full time or part time service with the Trust or another NHS employer. For the definition of continuous service, reckonable service, a month's pay and calculation of a redundancy payment please refer to section 16 of the NHS Terms and Conditions of Service Handbook.

There are also arrangements for early retirement on grounds of redundancy and in the interest of the service. Details of these arrangements can be found under Section 16.12 of the NHS Terms and Conditions of Service Handbook. To be eligible for this element of the scheme employees must have at least two years of continuous full-time or part-time service and two years qualifying membership of the NHS Pension Scheme.

14 Appeal Procedure

Employees have the right of appeal against a redundancy dismissal decision. Appeals should be made in writing to the Executive Director of OD and Workforce within 14 calendar days of receipt of written notification of the dismissal decision.

The appeal hearing should take place within 28 calendar days of the notification of the appeal being received. In some circumstances, it may be necessary to extend this deadline, but every effort will be made to hear the appeal promptly.

The dismissal appeal hearing will be undertaken in accordance with the provisions set out in the Dismissal Appeal Hearing Procedure (*Appendix 1*).

15 Equality Statement

The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

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 groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that there was no impact to the equality groups mentioned and this policy will have a positive impact on all of the 'protected characteristic' groups 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.

In the application of this policy all employees will be treated with dignity and respect, taking into account equality legislation.

The Trust is required to monitor the implications of this policy and to ensure that it assesses the impact of any proposed redundancies across the 'protected characteristics' and in respect of individual's human rights.

16 Getting Help

Employees at risk of redundancy have access to various support options. These can be accessed via the People and OD Department:

    (i)   assistance in accessing vacancies as appropriate.
    (ii)   support to prepare a CV, write an application form, update their interview skills etc.
    (i)   assistance in accessing vacancies as appropriate.
    (ii)   use of Trust facilities and assistance in applying for suitable alternative posts.
    (iii)   reasonable paid time off to attend interviews.
    (iv)   Access to training / re-training opportunities where these are reasonable and affordable.
    (v)   Signposting to financial and pension advice.
    (vi)   Access to Employee Assistance Programme, Occupational Health advice and support etc.

17 Related Policies and procedures

- All Wales Organisational Change Policy
- All Wales Organisational Change Redeployment Policy – Appendix 5
- Redeployment Procedure
- Retirement Policy
- All Wales Disciplinary Policy
- All Wales Respect and Resolution Policy

VELINDRE UNIVERSITY NHS TRUST

DISMISSAL APPEAL PROCESS

1. The individual to whom an appeal is made, must be specified within the letter informing the employee of the manager's decision to dismiss the contract i.e., Executive Director of OD and Workforce.

2. An employee who wishes to appeal against a dismissal must lodge their appeal within 14 calendar days of receiving written notification of original dismissal decision.

3. The employee's written request to lodge an appeal must clearly set out the reason for and the grounds on which the appeal is based.

4. An "appeals officer" will be appointed by the Executive Director of OD and Workforce. In dismissal appeal cases the appeals officer will be a senior manager nominated by the Executive Director of OD & Workforce, in line with the Trust's scheme of delegated authority.

5. The appeals officer nominated to hear an appeal must not have been involved in the process at any earlier point.

6. The appeal will be heard within 28 calendar days of the notification of the appeal being received. In some circumstances, it may be necessary to extend this deadline, but every effort will be made to hear the appeal promptly.

7. At least 14 calendar days before the appeal hearing the employee should submit, to the nominated appeals officer, any additional information / documentary evidence in support of their appeal.

8. The "manager" who made the original dismissal decision is required to provide a written Statement of Case, justifying the action taken at the dismissal meeting. This documentation must be exchanged with the employee and the appeals officer at least 10 days before the appeal hearing date. The Statement of Case may contain supporting documents and relevant policies etc.

9. The manager may be accompanied by a People and Relationship Advisor/People colleague, who supported the dismissal meeting process.

10. Another member of the People Team will be in attendance throughout the appeal hearing, to provide professional advice and to support the appeals officer and the employee. It is their role to ensure that all aspects of the appeal are fully explored. The appeals officer must ensure that they have access to appropriate professional, specialist, or technical advice, where necessary.

11. The purpose of the appeal hearing is to establish if the decision made by the manager was reasonable and fair in the circumstances.

12. The appeal hearing must restrict itself to looking at the grounds of appeal made by the employee and ensuring that these grounds are adequately examined, to reach a proper judgement on whether the appeal should be upheld or not. In most circumstances, the appeal hearing will not be a re-examination of all the evidence.

13. The appeal hearing will consider specifically whether the action decided upon by the manager was fair and reasonable at the time that the action was taken. The appeal hearing may also consider whether the procedure was applied correctly, when deciding on the action taken to dismiss.

14. The appeal will take account of any substantial new information cited in the grounds for appeal or presented during the appeal hearing process.

15. The decision(s) reached by the appeals officer is considered final. No further appeal mechanism will operate within Velindre University NHS Trust.

Conduct/Order of the Appeal Hearing

1. The Appeal Officer will act as chair of the appeal hearing and will introduce those present.

2. The manager (who made the dismissal decision or the previous course of action), the People and Relationship Advisor (who supported the dismissal meeting), the employee and his/her representative will remain present throughout the proceedings until the appeals officer adjourns, to deliberate in private.

3. The employee and his/her representative shall confirm the reason for and the grounds of their appeal and provide information supporting their case.

4. The appeals officer and their People support will have the opportunity to ask questions of the employee.

5. The manager and the People and Relationship Advisor will have the opportunity to ask questions of the employee.

6. The manager will present the justification for the decision that they took to dismiss the employee.

7. The employee or their representative will have the opportunity to ask questions of the manager and the People and Relationship Advisor.

8. The appeals officer and their People support will have the opportunity to ask questions of the manager.

9. The employee or their representative will have the opportunity to sum up their case. New information must not be introduced at this stage.

10. The manager will have the opportunity to sum up. New information must not be introduced at this stage.

11. The appeals officer may, at their discretion, adjourn the appeal hearing in order that further information may be sought and reviewed.

12. The appeals officer shall deliberate in private with their People support (to provide professional advice and support) only, recalling both parties to clarify points of uncertainty on evidence already given. If a recall is necessary, all parties shall return to the hearing.

13. When a decision is reached by the appeals officer, they should inform the employee and manager (who made the decision on the previous course of action) of the outcome immediately or within 7 calendar days. In either case, the decision will be notified in full, to all parties in writing, within 7 calendar days of the appeal hearing date.

14. The decision of the appeals officer is final and there is no further internal right of appeal.

Ref: TBC NEW POLICY

RECRUITMENT AND SELECTION POLICY AGENDA FOR CHANGE

Executive Sponsor & Function:	**Director of Organisation Development and Workforce**
Document Author:	Head of Workforce
Approved by:	Trust Board
Approval Date:	
Date of Equality Impact Assessment:	December 2023
Equality Impact Assessment Outcome:	No identified impact
Review Date:	Three years from date of approval
Version:	

1. Policy Statement

To ensure the Velindre University NHS Trust (the Trust) delivers its strategic aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure that the recruitment and selection of our people is conducted in a systematic, comprehensive and fair manner, promoting equality of opportunity at all time, eliminating discrimination and promoting good relations between all.

The Trust recognises our employees are fundamental to the success of the organisation and we are committed to attracting, appointing and retaining qualified, motivated people with the right skills and experience to ensure the delivery of a quality service for patient and donors.

In order to achieve this we will:

- Provide a well-defined Policy and supporting Procedures for managers to work within and ensure they are clear about the principles underlying the recruitment and selection processes
- Promote the values of the Trust and ensure that this is reflected in the selection of candidates
- Work at all times within current employment legislation and best practice guidelines to ensure a fair and equitable recruitment process
- Provide a workforce planning structure to ensure recruiting managers are fully considering the needs of the service before advertising
- Ensure that every post has a written job description and person specification that has been appropriately evaluated in line with Agenda for Change Handbook
- Employ staff on permanent contracts of employment as the norm, with fixed term contracts only used where necessary and appropriate. *NB: Any employee engaged on a fixed term contract will be entitled to terms and conditions of employment that are no less favorable on a pro-rata basis than the terms and conditions of a comparable permanent employee, unless there is an objective reason for offering different terms.*

2. Introduction and Aim

This policy aims to provide the framework for managers to recruit talented and motivated staff to deliver for our patients and donors within a positive legal and regulatory framework.

By following this Policy, appointing managers can be assured that they are operating within the confines of current employment legislation, and they are able to avoid discrimination and recruit safely without putting the Trust, our staff or patients and donors at risk.

3. Objectives

The objectives of this policy are to:

- Ensure that appointing managers and applicants are clear about their role and the role of other stakeholders in the recruitment and selection process
- Ensure that appointing managers and applicants are clear about the principles underlying the recruitment and selection processes
- Support managers in appointing the best candidate for each position
- Ensure that all necessary steps are taken before a new member of staff starts with the Trust
- Promote the Trust's vision and values ensuring that these are embedded into the recruitment and selection process and wider organisational culture

4. Scope

This procedure applies to all managers and staff who are involved in the recruitment and selection of staff employed under Agenda for Change Terms and Conditions and any other employees except for those appointed onto Medical and Dental Terms and Conditions.

For information on the appointment of employees under the Medical and Dental Terms and Conditions of Service please contact the People and OD team.

5. Responsibilities

Applicants are responsible for:

- Submitting an accurate, honest and complete application
- Rising requests for reasonable adjustment during the assessment process
- Notifying the appointing manager if they are unable to attend an assessment
- Providing the appropriate documentation to enable pre-employment checks to be undertaken

Mangers must:

- Effectively workforce plan their services ensuring vacancies are designed to meet the Trust's goals and objectives
- Detail the skills and requirements for the role in line with the Job Evaluation Procedure and DBS Procedure.
- Ensure that they follow this Policy and adhere to the recruitment and selection principles set out in the relevant documents
- Act in a way that ensures the Trust's recruitment, selection and appointment of staff is undertaken in a fair, anti-discriminatory and safe manner, and that the Trust's vision and values are considered as an integral part of the recruitment process
- Understand their role as recruiting manager and the role played by People and OD and Employment Services Team (NWSSP) and ensure that those elements of the process that they are responsible for are completed thoroughly and in a timely way
- Seek advice from the Workforce and OD function before making an offer of employment if they are unsure about the appointment or starting salary

The People and OD team is required to:

- Ensure individuals involved in the recruitment process are appropriately trained to undertake their roles
- Provide advice on legislation and the principles that govern the recruitment and selection process
- Provide advice on starting salaries and authorise any applications under the Incremental Credit Procedure.
- Ensure that managers have adequate information, guidance and support to fulfil their role in the recruitment and selection of staff
- Offer support and guidance to managers to help them meet the Disability Confident requirements
- Maintain close links with NWSSP to ensure compliance, quality and efficiency in all aspects of the recruitment and selection process

NHS Wales Shared Services Partnership provides recruitment services for all non-medical and dental appointments in NHS Wales. The Employment Services team is responsible for advertising and on-boarding into vacant posts in a professional, timely manner and ensuring that all the required pre-employment checks take place.

6. Values Based Recruitment

Values Based Recruitment is an approach to help attract and select employees whose personal values and behaviours align with those of the Trust. It is about enhancing existing processes to ensure that we recruit the right workforce not only with the right skills and in the right numbers, but with the right values to support effective team working and excellent patient and donor care.

Values Based Recruitment can be delivered in a number of ways, for example through pre-screening assessments, values based interviewing techniques or assessment centre approaches. It can sit within a competency based interview through asking questions that address matters such as ethical questions, interpersonal relationships or decision making.

6. The Recruitment and Selection Process

6.1 Before deciding to advertise a post, managers should be certain that a real vacancy exists and be clear about the requirements of the job.   Like for like replacements should not be taken for granted. Consideration should be given to whether or not there is scope for modernisation before replacing posts – when determining this managers may want to undertake a workforce planning exercise with support from the People and OD team. If there is a fundamental change to the post or this is a new post, the vacancy will need Scrutiny approval.

6.2 Each job should have a written job description and person specification that has been evaluated in line with the Agenda for Change Job Evaluation Procedure. These should be reviewed every time a vacancy occurs to ensure that they remain relevant and flexible, including making reasonable adjustments should people with disabilities apply. Changes to the job description or personal specification will need to be

reviewed by the People and OD team to ensure there is no impact to the pay band of the post.

6.3 Managers need to consider the role requirements to undergo criminal records checks through the Disclosure and Barring Service (DBS CHECK) to ensure the safety or our patients and donors. The requirement and level of checks needs to be clearly articulated on the Job Description. The DBS Procedure provides detailed information on assessing the role requirements for a DBS check.

6.3 When the appointing manager is satisfied that the vacancy details and job description are correct they should submit this for approval via Trac to the Head of Service, Finance Business Partner and People and OD team. NWSSP will then publish the vacancy to advert.

6.4 On occasion where a vacancy is a short-term secondment (no longer than 12 months) or a Temporary Movement to a higher band in line with Agenda for Change terms and conditions managers may be able to advertise through and expression of interest. All expressions of interest must be approved Scrutiny.

6.5 Applicants must provide detailed information regarding their full employment history to date in all cases.

6.6 All applicants will be shortlisted for interview on the basis of the information they provide on their application form. It is the responsibility of the appointing manager to oversee the shortlisting process to ensure that all decisions are based on the criteria set out in the person specification and that the decisions are valid, justifiable and fair. It is best practice for more than one person to shortlist candidates. Candidates who do not meet all of the essential criteria should not be shortlisted. In order to ensure a fair and transparent process, reasons for the selection or rejection of all candidates must be recorded on Trac.

6.7 The Trust is committed to improving the diversity of our people and to being a fully inclusive employer. Research has shown that diverse teams make better decisions and are more productive. This means we actively look to recruit from underrepresented groups, provide a fully inclusive and accessible recruitment process, offer an interview to disabled people who meet the minimum criteria for the job, and are flexible when assessing people's skills so applicants have the best opportunity to demonstrate that they can do the job. We also proactively offer and make reasonable adjustments as required.

6.8 All applicants must have a formal interview before an appointment can be made. This is essential as it provides an opportunity to discuss the candidate's application and employment history fully, and explore any areas of doubt or concern prior to an appointment being made. It is the responsibility of the appointing manager to oversee the interview process to ensure that all decisions are based on the criteria set out in the person specification and that the decisions are valid, justifiable and fair. It is expected that more than one person will interview candidates, and where possible, best practice would be for of an interview panel representing various gender and ethnicities undertake the interview process.

Discriminatory questions must be avoided (see Managers Guide to Conducting an Interview). To avoid discrimination during an interview, managers should bear in mind the following guidelines:

- Candidates should not be asked about their marital status, family commitments and/or domestic arrangements, nor should they be asked about any actual or potential pregnancy/maternity leave
- Ensure that questions focus on the applicant's ability to perform the role, not on potential difficulties he or she might have on account of an actual or potential disability
- Frame questions in a positive way so as to avoid the risk of the applicant believing you are looking for or anticipating problems
- Remember that there is no duty on applicants to voluntarily disclose a disability to a prospective employer and that it is unlawful to ask about an applicant's health (including any disability) before offering him or her a job.
- Don't place too much importance on length of experience as this will place younger applicants at a disadvantage. Instead, concentrate on the interviewee's type and breadth of experience, and their skills, competencies and talents.

6.9 Pre-employment checks seek to verify that an individual meets the preconditions of the role they are applying for. All offers of employment are therefore conditional and subject to the following pre-employment checks (as applicable to the post):

- Right to work checks (It is a criminal offence to appoint a candidate without the appropriate right to work in the UK)
- Identity checks
- Professional registration and/or qualification checks
- Employment history and references checks
- Work health assessments
- Discourse and Barring Checks

These checks are carried out by NWSSP Recruitment Services on behalf of the Trust more information can be found on the Trust's Attraction, Recruitment and Retention intranet page.

7. Recruitment and the Welsh Language

The Trust is committed to providing quality care for patients and donors through the medium of Welsh and Welsh language skills must be actively considered as part of the workforce planning and role design process.

Welsh language skills are needed to ensure patients and donors have access to services in their preferred language. Welsh language provision has been identified as a clinical need as well as a communication need as it enables a deeper understanding of patient outcomes and donor care.

To support these outcomes recruitment mangers are required to complete the following process:

- Complete the Welsh Language Assessment providing evidence of the language skills required for the specific post
- Ensure that the post has Welsh language support from the wider team should Welsh language skills not be needed for the specific role
- State the level of Welsh language skills required clearly
- State whether the post is Welsh language 'Desirable' or 'Essential'
- Ensure the Job description and advert are translated by sending it to Velindretranslations@wales.nhs.uk
- Send the completed language assessment form to the Trust Welsh language Manager

8. Making a Salary Offer

Velindre NHS Trust fully supports the principle of fair pay and want our people to be paid fairly and consistently for the work undertaken. The Agenda for Change NHS Terms and Conditions of Service Handbook (The Handbook), Section 12.2 gives the Trust discretion to take into account any period or periods of employment outside of the NHS judged to be relevant to NHS employment.

The appointing manager should not make a salary offer above the minimum of the pay band however managers can make an applicant aware of Incremental Credit Procedure and application process where reckonable service or equivalent relevant experience may apply.

9. Induction

It is vital for line managers to prepare for how a person is welcomed into their role and the Trust. Failure to do this can create a poor impression and undo much of the work which attracted the candidate to the job. As soon as the successful applicant accepts the job offer, managers should start to organise a carefully planned programme to settle them into the role, team and organisation, so they become effective as soon as possible, and want to stay.

In addition, the People and OD team delivers provides a Corporate Induction which is suitable for all new staff and which must be completed within eight weeks of starting employment. Line Managers must ensure that new starters are given time to undertake this programme.

10. Right to Recruitment Information

A candidate, both successful and unsuccessful, is entitled to make a request for their recruitment information, including shortlisting and interview criteria and scores or observations made on the candidate. It is therefore important that the process is accurately documented and the information is retained by the recruiting manager in the most secure and safe manner. The information should be destroyed after six months, unless there is a legal obligation on the Trust to retain this for longer (i.e. the recruitment process is subject to an employment tribunal claim against the organisation).

11. Audit and Monitoring

The Workforce and OD Department will monitor the application of this policy and documentation will be audited on a regular basis. All confidential records will be stored in line with the General Data Protection Regulations.

Anonymised data may be analysed to identify trends in recruitment relating to protected characteristics under the Equalities Act 2010 or other Trust initiatives. These findings may be used to inform future plans and activities for the Trust.

12. Review

The Workforce and OD Department will review the operation of the policy as necessary and at least every 3 years.

TRUST BOARD

RENEWAL OF NWSSP MAMHILAD LEASE

DATE OF MEETING	30 January 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	**Choose an item**

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

PREPARED BY	PETER STEPHENSON, HEAD OF FINANCE & BUSINESS DEVELOPMENT, NWSSP
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The 10-year lease of the offices used by the NHS Counter Fraud Wales Service expired on the 7th October 2023, and needs to be renewed. .

RECOMMENDATION / ACTIONS	The Trust Board is asked to approve the renewal of the lease for the Counter Fraud Wales Service offices covering part of the 1st Floor, Block B South, Mamhilad House.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Shared Services Partnership Committee	18/01/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The renewal of the lease was approved by the Partnership Committee.	

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

APPENDICES	

1.   SITUATION

This paper is prepared to seek the approval of the Trust Board for the signing and sealing of a (renewal) lease in relation to the offices used by the NHS Counter Fraud Wales Service comprising Part 1st Floor, Block B South, Mamhilad House.
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2.   BACKGROUND

The Counter Fraud Service Wales Team occupy part of the 1st Floor in Block B South, Mamhilad House, on the Mamhilad Estate. The lease for this accommodation expired on the 7th October 2023, and we have negotiated with the landlord for renewal of a further 10-year lease with a break clause at the end of Year 5. The new lease will be £21,576 p.a. which is an increase on the current figure of £16,182. The new lease is based upon a charge of £12 per square foot which is in line with the rents being currently charged elsewhere on the estate. The

nature of the work undertaken by the Counter Fraud team, and particularly the requirement to conduct formal interviews which may lead to criminal investigations, requires the team to be based in a self-contained space.

The lease renewal has been re-negotiated and the new lease is to be executed, by NWSSP's hosted Statutory Body - Velindre University NHS Trust. It requires two authorised signatories, which in this case is the Chair and Chief Executive of Velindre University NHS Trust who are to formally sign the contract and affix with a common seal.

3. ASSESSMENT

The lease will need to be signed by the Trust as the legal entity. In accordance with the Standing Orders, this must first be considered and approved by the Trust Board.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Approval is needed for the Trust to formally sign the lease on behalf of NWSSP.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: N/a Choose an item		
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe		☐ ☐ ☐ ☐ ☐
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	Choose an item N/a	

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	N/a
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	This paper has been produced for the sole purpose of gaining approval from the Trust in accordance with Standing Orders.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below:
	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: This arrangement relates to the receipt of income rather than the commitment of expenditure.

Page 4 of 6

	Type of Funding: **Revenue**
	Scale of Change Please detail the value of revenue and/or capital impact: The cost of the lease is consistent with that we already pay.
	Type of Change Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Choose an item
	N/a for reasons given above.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Choose an item
	Click or tap here to enter text
	The signing of the lease has legal implications for the landlord and tenant. However, Legal and Risk Services have helped to draw up the lease document which is a renewal of an existing lease.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*N/a*
WHAT IS THE CURRENT RISK SCORE	N/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*N/a*

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

TRUST BOARD

TRUST WIDE POLICIES UPDATE

DATE OF MEETING	30 January 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 **December 2023 to January 2024.**

RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the policies that have been approved during the period **December 2023** to **January 2024**.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	03/01/2023 30/10/2023 04/12/2023
Local Partnership Forum	07/12/2023
Quality, Safety and Performance Committee	16/01/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board **ENDORSED** the following policies for submission to the Quality, Safety and Performance Committee:
- WF04 Recruitment and Selection Policy (Agenda for Change)
- WF42 All Wales Dress Code
- WF35 Annual Leave and Bank Holiday Policy and Procedure (Agenda for Change Terms and Conditions)
- WF53 Redundancy and Security of Employment Policy
- QS15 Management of Violence & Aggression Policy
- QS26 Safe Use of Display Screen Equipment (DSE) Policy
- QS14 Safer Manual Handling Policy
- QS33 Control of Substances Hazardous to Health (COSHH) Policy
- QS09 Policy for Management of Latex and Latex Allergy

The Local Partnership Forum **ENDORSED** the following policy for submission to the Quality, Safety and Performance Committee:
- WF04 Recruitment and Selection Policy (Agenda for Change)
- WF42 All Wales Dress Code
- WF35 Annual Leave and Bank Holiday Policy and Procedure (Agenda for Change Terms and Conditions)
- WF53 Redundancy and Security of Employment Policy

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

APPENDICES	
Appendix 1	QS15 Management of Violence & Aggression Policy
Appendix 2	QS26 Safe Use of Display Screen Equipment (DSE) Policy

Appendix 3	QS14 Safer Manual Handling Policy
Appendix 4	QS33 Control of Substances Hazardous to Health (COSHH) Policy
Appendix 5	QS09 Policy for Management of Latex and Latex Allergy

1.   SITUATION/BACKGROUND

1.1   In accordance with the "Policy and Procedure for the Management of Trust wide Policies and other Written Control Documents", the Trust Board will receive all approved policy documents for information under the Consent Agenda.

1.2   The purpose of this report is for the Trust Board to note the policies that have been through the Trust governance process and approved during the period **December 2023 to January 2024.**

2.   ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1   Since the last Trust Board, the Quality, Safety and Performance Committee **APPROVED** the policies below, which have been uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
QS15 Management of Violence & Aggression Policy	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	16/01/2024	**1**
QS26 Safe Use of Display Screen Equipment (DSE) Policy	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	16/01/2024	**2**
QS14 Safer Manual Handling Policy	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	16/01/2024	**3**
QS33 Control of Substances Hazardous to Health (COSHH) Policy	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	16/01/2024	**4**

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
QS09 Policy for Management of Latex and Latex Allergy	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	16/01/2024	**5**

2.2 The Quality, Safety and Performance Committee also **ENDORSED** the following policies for **APPROVAL** at the January Trust Board, which are included separately under agenda item **6.1.3.2** for this meeting:

Policy Title	Policy Lead / Function	Endorsing Body
WF04 Recruitment and Selection Policy (Agenda for Change)	Executive Director of Organisational Development and Workforce	Quality, Safety and Performance Committee
WF42 All Wales Dress Code	Executive Director of Organisational Development and Workforce	Quality, Safety and Performance Committee
WF35 Annual Leave and Bank Holiday Policy and Procedure (Agenda for Change Terms and Conditions)	Executive Director of Organisational Development and Workforce	Quality, Safety and Performance Committee
WF53 Redundancy and Security of Employment Policy	Executive Director of Organisational Development and Workforce	Quality, Safety and Performance Committee

2.3 The Research, Development and Innovation Sub-Committee, via a Committee Chair's Urgent Action, also **ENDORSED** the following policy for **APPROVAL** at the January Trust Board, which is included separately under agenda item **6.1.3.1** for this meeting:

Policy Title	Policy Lead / Function	Endorsing Body
Policy on the Use of Small Animals in Research	Executive Medical Director	Research, Development and Innovation Sub-Committee

3.   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ⊠ • An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ☐ areas of priority • An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. • A sustainable organisation that plays its part in creating a better ☐ future for people across the globe	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ⊠ Timely ⊠ Effective ⊠ Equitable ⊠ Efficient ⊠ Patient Centred ⊠
	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Yes
	Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	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
All risks must be evidenced and consistent with those recorded in Datix	

Ref: QS15

MANAGEMENT OF VIOLENCE AND AGGRESSION POLICY

Executive Sponsor & Function:	Executive Director of Strategic Transformation, Planning and Digital
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety & Performance Committee
Approval Date:	16th January 2024
Date of Equality Impact Assessment:	November 2023
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. A positive impact has been identified.
Review Date:	16th January 2027
Version:	8.0

Item no	Contents	Page

1. Policy Statement

Velindre University NHS Trust recognises its duty to provide a safe and secure environment of service users, staff and visitors. Violent or abusive behaviour will not be tolerated, and appropriate action will be taken to protect staff, service users and visitors.

The Trust, whilst managing the risks from Violence and Aggression will work in partnership with the Welsh Government and will utilise guidance within the All Wales Violence and Aggression Training Passport and Information Scheme (V&A training scheme) to ensure adequate and effective training is provided to staff. The Trust is also supportive of the Obligatory Response to Violence published by the Welsh Government and the Crown Prosecution Service and supported by the All Wales Anti Violence Collaborative

Velindre University NHS Trust takes a zero-tolerance approach to violent or aggressive behaviour, aiming to minimise the incidents of violence and aggression faced by staff and tackle these effectively where they do occur by utilising criminal, civil and internal managerial actions.

2. Scope of Policy

This policy applies to all staff employed by or contracted to the Trust, including those within Hosted Organisations.

3. Aims and Objectives

The aim of the policy is to raise awareness that violence and aggression against NHS staff is unacceptable and will not be tolerated. It seeks to reduce and prevent incidents of violence and aggression towards NHS employees by supporting staff to identify and deal with unacceptable behaviour.

The objectives of the policy are to: -

- Provide appropriate staff training as identified by risk assessment and training needs analysis in line with the V&A training scheme.
- Reduce the effects of violent incidents and the risk of intimidation by provision of managerial support and aftercare at the earliest opportunity.
- Reduce the severity of injuries from violent incidents, by building staff confidence in de-escalation skills and breakaway techniques gained at training.
- Identify staff/groups via risk assessment, who may be considered as higher risk and ensure adequate controls to minimise the risks arising from violent incidents.
- Establish sanction procedures for those who demonstrate violent behaviour towards staff and outline the circumstances where sanctions will be applied.

4. Responsibilities

4.1 The Chief Executive

The Chief Executive has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

- an Executive Director to be appointed as a lead for health and safety

- the Trust Board and Executive Management Board to be informed as required on violence and aggression issues that affect employees and/or the public
- the Trust's Management of Violence and Aggression Policy to be implemented
- supporting the training and development of staff
- ensuring that there are sufficient resources for the implementation of this policy
- authorising the exclusion of service users or their relatives/carers or visitors, who represent an unacceptable risk of violence and aggression to staff and or other service users

4.2. Director of **Strategic Transformation, Planning and Digital**

The Director of Strategic Transformation, Planning and Digital has delegated responsibility at Trust Board level for managing health and safety and is responsible for ensuring that:

- the Trust's Management of Violence and Aggression Policy is reviewed as and when appropriate
- regular updates on violence and aggression issues are reported to the Executive Management Board
- activities are planned, measured, reviewed and audited so that legal requirements are satisfied and health and safety risks arising from potential violence and aggression are minimised
- information regarding the management of violence and aggression is effectively communicated throughout the Trust
- The approach to the management of violence and aggression is both systematic and appropriate

4.3. Executive Director of Organisational Development and Workforce

The Director of Organisational Development and Workforce is responsible for ensuring that: -

- there is an effective mandatory and induction training programme that includes the management of violence and aggression, which is appropriately monitored and recorded.
- reports on work related illness or work-related ill health are submitted to the Health Safety & Fire Trust Board Meeting. This should include information on work related stress and mental health wellbeing that may arise from an act of violence or aggression.
- arrangements are in place for health surveillance, support and counselling for employees.

4.4 Divisional Directors / Directors of Hosted Organisations

Directors have overall responsibility for making sure that arrangements are in place for:

- establishing a local health & safety group which comprises representatives from all relevant departments and staff representatives, within their service area, where issues or concerns regarding the management of violence or aggression can be discussed.
- liaising with the Trust Capital Planning and Estates Department

- ensuring that local procedures for the management of violence and aggression are developed and implemented in line with the overarching trust policy.
- preparing and implementing the organisational structure and allocating responsibility for the management of violence and aggression within the service area and that the identified personnel (e.g. Senior Manager) are aware of their responsibility.
- ensuring that risk assessments for the management of violence and aggression have been implemented for all relevant activities within the service area.
- ensuring that employees have access to a level of training appropriate to their role.
- ensuring that they are familiar with and ensure that all employees under their control are aware of any emergency plans for the management of violence and aggression.
- ensuring that effective local arrangements are in place are proportionate to the risk within their service.

4.5. Assistant Director of Estates, Environment & Capital Development

The Assistant Director of Estates, Environment & Capital Development will make arrangements to

- ensure that competent risk management and health and safety advice is available to all divisions and hosted organisations of the Trust and to support the appointed local lead managers in developing and maintaining their safety management systems and training in the management of violence and aggression. Competent advice may be sourced both internally and externally, dependant on the nature of the topic.
- provide support to the Executive Director with delegated responsibility for risk and health and safety management across the Trust, divisional directors, operational managers and health and safety leads in the implementation of policy,
- ensure that statistical information is available on health and safety performance throughout the Trust and interpret such information in order to evolve action plans to improve or maintain standards.
- investigate incidents and report to senior managers on findings and where necessary provide recommendations

4.6 Departmental Managers

Department managers have overall responsibility for making sure that arrangements are in place within their department to:

- identify any potential concerns arising from the management of violence and aggression on a day to day basis.
- ensure that a risk assessment is carried out, in line with current legislation and trust policy. The assessment should include sufficient information about the risks that are faced and the preventive / control measures that are required. The risk assessment should be regularly reviewed.
- identify any specific training that may be required by departmental staff via the PADR process and advise the Education and Development Team to ensure that this is reflected within the job profile on the ESR system.
- identify any health surveillance or support that may be required by staff following an incident and liaise with local Workforce personnel to ensure that an appropriate level of occupational health support is readily accessible to staff
- have access to specialist advice by liaising with the local Health & Safety lead, specialist advisor or the Trust Capital Planning and Estates Department

- ensure that individuals are aware of their responsibilities for the management of violence and aggression and have access to current information and risk assessments.
- develop and implement a local departmental procedure or safe system of work for the management of violence and aggression
- consult and involve staff and safety representatives with local management arrangements
- report **all** violent and aggression incidents.

Following a violent or aggressive incident the manger will:

- ensure that V&A incidents are reported in the incident reporting system Datix
- discuss the incident with the staff member
- where appropriate investigate the incident
- ensure the controls are adequate to manage the risk
- provide a supporting role to encourage staff well being
- ☐ refer staff to occupational health where required
- advise on workplace options and counselling available
- seek advice or guidance where necessary
- identify and escalate any identified risks, in accordance with the Trust risk assessment policy
- ensure that any outcome e.g. a change in process, further training required or a sanction against the perpetrator, will formally be fed back to the staff member concerned.

Services are strongly encouraged to ensure that their correspondence and information leaflets incorporate a statement to advise service users and their relatives of the appropriate standard of behaviour expected on Trust premises and towards Trust staff, noting that there will be consequences for non-compliance. Suggested wording for this statement is:

Velindre University NHS Trust aims to provide safe, high quality services to all service users. The Trust has a zero-tolerance approach towards violence and aggression against our staff and on our premises and may utilise CCTV and/or audio recording devices whenever personal safety is threatened. Evidence obtained will be used to secure sanctions against perpetrators."

4.7 Employees

All employees are expected to:

- act in a responsible manner and treat others with dignity and respect whilst performing their duties
- comply with policies and procedures developed to protect and control violence and aggression
- report all violent or aggression incidents (verbal or physical) including any form of intimidation or harassment regardless of an injury
- discuss any health and safety concerns with their manager
- cooperate with their manager in relation to health and safety and risk assessment
- undertake the relevant level of Violence & Aggression training and maintain their competence
- consider the offer of support and advice or counselling when given.

4.8 Occupational Health Departments

The Trust has service levels agreements in place for the provision of Occupational Health which is covered by local procedures. Please seek advice from your Organisational Development and Workforce department, who will be able to direct you to the appropriate service provider. Where health issues have been identified, a self-referral is available to the Employee Assistance Programme. The manager is also able to refer staff involved in an incident of violence and aggression to Occupational Health, however, this referral is not covered by the service level agreement and will incur an additional fee.

The role of the Occupational Health Department in the management of violence and aggression is to:

- provide expert advice on physical and psychological trauma
- undertake appropriate health evaluation
- provide a confidential counselling service that may be required following an incident of violence and aggression. (please note that a charge will be made for this service)

5. Definitions

The Health and Safety Executive define work related violence as:-

"Any incident where staff are abused, threatened or assaulted in circumstances relating to their work, involving explicit or implicit challenge to their safety, well-being or health. This can incorporate some behaviour identified in harassment and bullying, for example verbal violence".

6. Implementation/Policy Compliance

6.1 Incident Reporting

All violence and aggression incidents, including physical, verbal, harassment and abuse, must be reported through the Trust and Divisional Incident Reporting Procedures. Violent incidents where required should be appropriately investigated to identify the cause even where no injury occurs. Managers are responsible for ensuring any investigation outcome or further action required is added to the Datix incident system and any feedback to staff is formally noted on this record.

All Managers are required to assess whether staff involved in a violence and aggression incident require help and/or support, this could include:

- arranging cover for the staff member to seek medical advice
- providing assistance and support and appropriate debriefing
- where necessary staff should to be allowed to go home to recover
- arranging follow up support, occupational health or further training
- offering staff confidential advice from the employee assistance program (EAP).

It is recognised that staff have the choice as to whether debriefing or counselling is desired, it is not a mandatory requirement.

6.2   Risk Assessment

Managers are responsible for ensuring that risk assessments are completed for the staff within their control, including staff who are classed as public facing, lone workers and care or home visitors and also to ensure the risk assessment should identify the controls in place and any further actions required.

Individual risk assessments may be required for a small number of staff, (see appendix 3 All Wales V&A Training and Information Scheme Risk Assessment Form*).* It is not necessary to provide individual assessments for every staff member unless they have been identified as higher risk e.g. lone worker (including out of hours working and isolated working).

Consideration should be given to situations that may be identified both from local and national perspectives. These include service users and visitors who maybe under the influence of alcohol and/or drugs, confused, elderly, or suffering brain cancer/disease, suffering from a paranoid illness where their perception of reality is distorted and or unable to communicate or service users with a history of violent behaviour who are more likely to become violent again. However, it is essential to emphasise that reoccurrence of violence is not definite and may be preventable.

There are also some specific staff situations where the risk would appear to be higher, these include: Individuals or small numbers of staff alone on night duty, porters/security staff who assist others during violent incidents, dealing with relatives and carers who may be anxious or angry, areas with cash or drugs which could be deliberately broken into and or home visits

6.3   Lone worker assessment / domiciliary / home visits

The risk assessment needs to consider options to eliminate or control a hazard in order to decrease the degree of risk to as low as reasonably practicable.   The assessment should consider the suitability of the member of staff to undertake Lone Worker duties – expert advice is available from Occupational Health.

Written procedures are also required to ensure that support systems are in place for lone working including home visits, out of hours working and working in isolated areas. For further guidance on lone working please refer to the Lone Working Policy.

6.4   Personal Communication Devices

Due to the low severity of violence and aggression incidents, the Trust does not automatically provide staff with personal communication devices. If a need for staff to use such a device is identified via a risk assessment, local arrangements should be put in place to provide and monitor the use of such devices.

Personal communication devices could include telephones, mobile phones, radios, automatic warning devices and emergency alarms. It should be noted that personal communication devices alone will not prevent incidents from occurring. However, if used correctly and in conjunction with robust procedures, they will improve the protection of lone workers.

6.5   Sanctions available to the Trust

Managers may have an informal meeting with the perpetrator (service user) where a one-off incident occurs and discuss requirements for an improvement in behaviour. However, if no improvement is noted a formal meeting may be held.

A warning letter may be issued to a perpetrator whose behaviour is violent or aggressive towards staff, where the unacceptable behaviour has been established and meets the advice given within the V&A Training Scheme. (See appendix 1 & 2 for example of the Patient Undertaking letters).

The removal of treatment/service is a significant action and must be approved by the Chief Executive prior to initiation.   It will also ensure that those Trust services that may be affected are informed. This action will be undertaken within both the legal and control of data constraints.

Divisional procedures are in place for the removal of services for those service users who repeatedly refuse to co-operate with the required behaviour and/or present a serious threat. These procedures shall ensure that the service users and their GP are informed of the reason for and duration of such action.

Divisional sanctions may be developed, to ensure a consistent and common approach these will be discussed at Health Safety & Fire Trust Meeting.

Information sharing protocols with the Police, GP's and Ambulance services have been established to ensure that communications and risks related to the violent service users are appropriately handled.

Patients without capacity

Where patients do not have capacity to understand the ramifications of their behaviour, punitive actions are inappropriate, and the emphasis must be placed upon risk control measures to ensure that care can be provided in as safe a manner as is reasonably practicable.
Patient Undertakings, exclusion and legal action are usually inappropriate in these cases, although prosecution to determine a finding of fact rather than to achieve a criminal sanction may be a consideration.

Patients with fluctuating capacity

Where patients have fluctuating mental capacity, their capacity at the time of the incident should inform the action taken. Where the patient does not have capacity at the time of the violent or aggressive incident, opportunities should be taken to discuss the behaviour in as part of the therapeutic engagement process at the point that the individual has capacity.

Implementing Remedies/Sanctions Against Visitors and Relatives

The majority of incidents involving visitors take the form of verbal abuse and/or threatening behaviour. Verbal abuse is a form of violence. All incidents must be reported to the line manager and an online incident report form must be completed. Harassment is a criminal offence and violent incidents should be reported to the police.

If a situation escalates and involves a vulnerable adult (patient or relative) then a vulnerable adult referral form should be completed.

The exclusion of a visitor does not prevent them from attending the Trust for their own treatment. Staff may wish to seek advice and support from the Health & Safety team when considering applying remedies and/or sanctions. Example of a visitor undertaking letter is listed in the appendices.

6.6 Security Guards

Security guards employed by the Trust should be trained to the appropriate level as indicated in the V&A training scheme. The degree of involvement expected from security guards in a V&A incident should be clearly identified within localised procedures / emergency plans and their job descriptions.

6.7 Case Manager

The Trust considers it is not appropriate at this time to employ a full time Case Manager, due to relatively size of the organisation. However, the Trusts Health and Safety Manager will act as the Case Manager. If an incident occurs that is of the severity that would require advice and support from a Case Manager, staff and/or Service leads should contact the Divisional Health and Safety Advisors in the first instance.

6.8 Contacting the Police

The Trust supports prosecution action against individuals acting in a violent or aggressive manner towards staff. However, the trust itself cannot initiate a prosecution, this needs to be done by the victim or a witness to the incident. If the victim wishes police action to be taken, they, or local management on their behalf, should contact the police using either the 999 number in an emergency, or 101 where nonemergency crime or antisocial behaviour has been committed. Management/supervisory authorisation is absolutely not required before calling the police.

Staff should err on the side of caution and "if in doubt, call the police"

7. Equality Impact Assessment Statement

This policy has been screened for relevance to equality. A positive impact on the safety and wellbeing of staff has been identified.

8. References

The Health and Safety Executive Guidance on Violence in Health and Social Care

All Wales NHS Violence and Aggression Training Passport and Information Scheme

Obligatory Responses to Violence in Healthcare.

9.   Getting Help

Advisors for certain aspects of Health, Safety and Risk Management have been incorporated within the Trust structure, to provide specialist advice as outlined below:-

Assistant Director of Estates, Environment and Capital Development	Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ
Health and Safety	**Trust Health & Safety Manager** Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ Tel: WHTN 01875 6522
	VCC Health & Safety Advisor Velindre Cancer Centre Velindre Road Whitchurch Cardiff CF14 2TL Tel: 02920615888
	WBS Health & Safety Advisor Welsh Blood Service Ely Valley Road Talbot Green Pontyclun CF72 9WB Tel: 1797 2356
Occupational Health	Cardiff and the Vale University LHB Heath Park Cardiff CF14 4XW E-mail: occupational.health@wales.nhs.uk Telephone; 02920743264

Occupational Health provision has been established via formal service level agreements with the above-named local health board. Staff working outside the Geographical region of South East Wales are provided with Occupational Health services via local arrangements with their Occupational Health provider. Where practical, the occupational health provision should cover pre-employment checks, formal health surveillance, health assessments in connection with fitness to work, identification of occupational hazards and risks, along with support and advice for staff.

Employee Assistance Programme (EAP)

The Trust's EAP provider is Workplace Options, who provide the Employee Assistance Program which has a wide range of health and wellbeing services including counselling available to staff. Information on services available:

- Free of charge
- Available 24 hours a day, every day of the year
- Confidential
- Independent from your employer
- Immediate access to impartial specialists
- Support on an unlimited number of issues
- Saves time and legwork
- Helps you plan ahead with practical matters
- Supports you during more difficult times

10. Related Policies

This policy should be read in conjunction with, or reference made to, the following trust documents: -

Health, Safety and Welfare Policy	QS18
Lone working policy	QS30
Incident Reporting and Investigation Policy	QS 01
Security Policy	PP 02
Risk Management Process	GC 04b

11. Information, Instruction and Training

The V&A Training Scheme was developed in conjunction with Welsh Assembly Government and many other interested parties.
Its aims are to:

- achieve consistency in violence and aggression risk assessment
- provide training methods that are standardised across Wales
- reduce training resources and duplication, where staff moved from one Trust to another.

Welsh Assembly Government mandated all NHS staff are required to undertake Module A. Staff requiring Module B and C training will be identified by the risk assessment and the training needs analysis.

Violence and aggression training will be available at a divisional level and attendance information will be held within the Electronic Staff Record (ESR) system. Training compliance is monitored on a quarterly basis at the Health Safety & Fire Trust Board Meeting.

Module A: Induction and Awareness (Induction or via E Learning)
Provides all staff with general awareness and highlights appropriate local policy and procedures in place. Also gives a clear definition of violence and aggression and raises the importance of managing and reporting violence and aggression incidents in the workplace.

Module B: Theory of Personal Safety and De-escalation
Provides selected front-line staff identified via risk assessment /training needs analysis with a greater awareness of V&A issues and outlines the theory of personal safety and

de-escalation. Emphasis is placed upon the importance of de-escalation and the steps which can be taken to prevent incidents of violence and aggression occurring. This module is intended to develop the skills to recognise and de-escalate potential violent incidents and will include issues associated with customer care and diversity.

Module C: Breakaway and Escape Techniques
Provides selected front-line staff identified via risk assessment /training needs analysis with practical skills to enable them to break away from a situation of violence and aggression. Emphasis will be placed upon the importance of communication skills and management of personal safety throughout all breakaway techniques.

Exemptions:
New staff to Velindre University NHS Trust will be required to attend the correct level of training as identified via Divisional risk assessment. Exemptions from training will only be accepted where the staff member provides the training department will evidence from their previous employer of training attended. Any refresher training will coincide with the original training date proven.

12. Main Relevant Legislation

The Health and Safety at Work etc. Act 1974
The Management of Health and Safety at Work Regulations 1999
Assaults on Emergency Workers (Offences) Act 2018

Appendix 1:   **Velindre University NHS Trust**
Responsibilities and Rights – A Patient Undertaking

Patients Name:…………………………………………………………………………….	
NHS number:…………………………	GP/Consultant:…………………………………
Your Rights	**Your Responsibility**
Velindre University NHS Trust and its employees owe to me, as a patient, a duty of care and aim to provide services to meet my needs for healthcare and treatment at all times. Velindre University NHS Trust and its employees aim to provide health services that are sympathetic and responsive to my individual needs within the resources, which the Trust has available. Velindre University NHS Trust and its employees want to deliver appropriate and effective health care and treatment to me. Velindre University NHS Trust expects all its employees to treat me with courtesy and respect. Velindre University NHS Trust will only restrict or withdraw my rights to care in exceptional circumstances when I have failed to comply with any of my responsibilities in a manner which is deemed unacceptable.	I will not behave in a way, which can be considered to be violent or abusive. Violence includes any incident where any member of staff are abused, threatened or assaulted in circumstances related to their work. An act of violence may involve an explicit challenge to the safety, wellbeing or health of any member of staff or other patients. Violent behaviour may include verbal abuse, racial or sexual harassment, threat of injury, abuse of alcohol or drugs, destruction of Trust property as well as physical acts of violence. I will treat NHS staff, fellow patients' carers and visitors politely with respect at all times. I will not consume alcohol or take any form of non-prescribed medication or drugs whilst on any premises of the Trust. I accept and understand that Velindre University NHS Trust is obliged to provide a safe and secure environment for all its staff and to care for their health and safety. I accept and understand that no member of staff has to jeopardise their safety in providing me with care.

I confirm that I understand that if my behaviour has been unacceptable and if I do not comply with my responsibilities as a patient, then this can result in the withdrawal of my rights as a patient and I can lose my right to receive care from Velindre University NHS Trust except for treatment in an emergency.

Signature of Patient:	Signature of Named Nurse/Core worker:
…………………………………………….	………………………………………………….
Print Name:………………………………….	Print Name:………………………………………
Date:	Date
Witnessed by:…………………………………….and Date……………………………………………	

Patient letter 1 (Stage 2)

Insert patient name and address
Dear (insert patient name)
Re: Access to Velindre NHS Trust (insert name of service) Services

I write with reference to the alleged incident of violence and aggression on (insert date) at (insert site and location).
It is alleged that you (insert details of incident). An investigation has been undertaken as the Trust takes this issue very seriously and has a commitment and duty of care to ensure a safe and secure working environment for all members of staff.

I am taking this opportunity to express my concern at your behaviour towards staff involved; it is considered unacceptable and will not be tolerated by the Trust. As a result of the incident, I am writing you this letter. A meeting took place between (insert job titles of managers) on (insert date). We considered all of the evidence, which had been gathered from our investigation, including statements from staff and yourself. We also consulted relevant Trust policies and national guidance. After considering all of the above, we have come to the decision that although the Trust will continue to provide you with (insert service) Services at (insert site), your treatment will be subject to adherence to a Patient Undertaking agreement. A draft copy of the agreement is enclosed for your information.

A meeting has been arranged between yourself and (insert managers job title) on (insert date) at (insert location) in order to agree and sign the Patient Undertaking agreement. Failure to comply with conditions of the agreement, even if you refuse to sign it, is likely to lead to the Trust modifying services to you. Any future verbal or physical intimidation of staff is likely to lead to the Police being called and the Trust pursuing relevant legal sanctions.

In the meantime, to reduce the risk to our staff, I have put in place control measures (list control measures such as no home visits, visiting in pairs, no attendance at a base unless prior appointment arranged).

These control measures will be reviewed in (insert number) months' time. A copy of this letter will be kept on your patient record. Please note that if we consider you to be a risk to other healthcare professionals (such as your GP), we will inform them of the incident and the action we have taken.

Should you have any queries as to the contents of this letter, or arrangements for the meeting please do not hesitate to contact me.

Yours sincerely (Insert job title of Manager)

cc Insert details of patient/clients GP cc Prevention of Violence & Aggression Lead

Appendix 3 All Wales NHS Violence and Aggression - Risk Assessment Form

These risk assessments should be conducted in consultation with employees and reviewed at least annually or after a serious incident has occurred.   If a major change is required as part of a review a new form must be completed.

Section A: Administration Details

Division ……………………………………….

Primary Location (e.g. VCC, WBS, etc.…………………………………

Exact Location, (e.g. Interview Room, Reception)……………………………………….

Name of Assessor:……………….………………..	Date of Review: …………………………………………………
Designation:………………………………..	Name/Designation of Assessor: ………………………………………………… ………………………………………………… …………………………………………………
Date of Initial Assessment……………………	Date of Review …………………………………………………
	Name/Designation of Assessor ………………………………………………… …………………………………………………

Section B: Task or Activity

Description of task or activity which could lead to a risk of violence and aggression.

Personnel involved (e.g. carer, nurse, security staff, contractor, off site worker, etc.

	Section C: Assessment of Risk		
	h of the sections, tick the appropr		
1.a	**Is there any historical evidence of verbal or physical abuse to staff?**	Yes	No
	Verbal Abuse (with intent/directed at staff)		
	Verbal Abuse (abusive remarks not directed at staff)		
	Punch/strike/slap		
	Wounding		
	Kicking		
	Biting		
	Scratching		
	Grabbing by service user		
	Pushing or shoving		
	Hair Pulling		
	Stalking		
	Victimisation		
	Intimidation		
	Threat with / use of weapon (e.g. knives, needles, walking sticks etc.)		
	Harassment (racial, sexual, bullying)		
	Offensive Messages		
	Telephone abuse		
	Robbery		
	Other (Please specify)		
b	**Is it perceived that there could be a risk of any of the above** Please specify: If there is **no** perceived or known risk of verbal or physical aggression there is no need to continue with this assessment.		
2	**How often do violent incidents occur?**		
	Never		
	Every few months		
	Once a month		
	Several times a month		
	Once a week		
	Several times a week		
	Once a day		
	Several times a day		

3a	If hurt or wounded as a result of an attack, has it led to:	Yes	No
	Bruising/swelling		
	Dislocation		
	Fracture		
	Cuts		
	Multiple injuries		
	Sprains		
	Stress		
	Other		
b	**Is it perceived that an incident could lead to any of the above**		
	Please Specify		
4	**Following attacks or incidents of abuse, has this led to time off work?**	Yes	No
	A few hours		
	Days		
	Weeks		
	Months		

5	**When are violent incidents more likely to occur (Please Tick)** 8am to 5pm 5pm to 12 midnight 12 midnight to 8am at any time	**6.** **On what day of the week** **Mark days when incidents** **Are more likely to occur, if known** **7 = most likely, 1 = least likely** Monday to Friday Saturday and or Sunday Any Day		
7	**Is the workplace overcrowded?** All the time			
	Never			
	During specific times Please specify			

8	Are the following adequate	Yes	No	N/A	Are the following readily available for service users?	Yes	No	N/A
	Lighting				Public telephones			
	Temperature				Toilet			
	Ventilation				Light refreshments			
	Décor /Colour schemes				Information service			
	Housekeeping				Up to date magazines			
	Seating for patients/visitors				Children's play area			
	Other Please Specify				Music			
					Tv/Videos			

9	**Internal environmental issues**	Yes	No	N/A
	Are there excessive noises which could cause distraction?			
	Are there isolated areas such as treatment rooms, offices, etc.?			
	Are the rooms laid out in such a way as to allow staff to exit in an emergency?			
	Could the aggressor be situated between the employee and the door?			
	Are there designated waiting areas?			
	Are these adequately supervised?			
	Are there corridors/areas where aggressors could hide/congregate?			
	Is there adequate signage displaying the Trust Zero tolerance stance?			
	Are staff protected by additional security measures where required e.g. screens, security locks, intercoms, Internal CCTV, panic alarms?			
	Is money/valuables kept in the work area?			

10	**Are there potentially dangerous fixtures and fittings, e.g.**	Yes	No	N/A	11	**Is there room a room available to speak privately with:**	Yes	No	N/A
	Ash Trays					Service users			
	Tables					Visitors			
	Waste bins					Other staff			
	Seats								
	Sharp corners								
	Surgical/medical equipment								
	Office equipment								
	Other Please specify								

12	**External environmental issues**	Yes	No	N/A
	Are there adequate parking spaces within suitable distance from work area?			
	Is there adequate lighting?			
	Is it distant from the work area?			
	Have routes to parking areas/external walkways been surveyed for safety?			
	Is there CCTV coverage of routes?			
	Are these cameras monitored?			
	Is there a security escort service to parking areas when walking on external routes?			

13	**Are there any times when tasks are undertaken alone?**	**Yes**	**No**
	If yes please specify		
	Are there any procedures in place to help ensure safety?		
	If yes please specify		

14	**Are there alarm systems in place by which you can summon help?**	**Yes**	**No**	**N/A**
	If yes please state type of system			
	Are alarms fitted in rooms used for interviewing potentially aggressive/violent individuals?			
	Are these alarms accessible to staff?			
	Are the alarms easy to activate			
	Are staff trained in its use?			
	Do others know how to respond if the alarm is raised?			
	Are there documented procedures in place for ensuring this?			
	Can the alarm be heard in all areas of the ward/department?			

15	**Have staff attended appropriate training in accordance with the All Wales Violence and Aggression Training Scheme and Trust Policy**	**Yes**	**No**
	Level of training required, and number of staff identified in Training Needs Analysis as requiring each level of training:-		
	Module A - Induction and Awareness Raising		
	Module B – Theory of Personal Safety and De-escalation		
	Module C – Breakaway Techniques		
	Number of staff who have attended training:-	Numbers	
	Module A – Induction and Awareness Raising		
	Module B – Theory of Personal Safety and De-escalation		
	Module C – Breakaway Techniques		
	What procedures are in place to ensure that all staff (including medical staff) have information and access to violence and aggression training?		

16	**Is there a contingency plan if violence is threatened or breaks out toward:**	**Yes**	**No**
	Service users		
	Visitors		
	Staff		
	Please specify arrangements:		
	Are staffing levels adequate to ensure that contingency plans can be followed?		

17	**Home / Community Visits**	Yes	No	N/A
	Are home / community visits essential?			
	Is any information sought highlighting previous / known risks associated with the patient and / premises / or locality?			
	Where joint agency working takes place are there protocols for sharing information regarding known risks of violence and aggression?			
	Is joint agency visiting considered where appropriate?			
	Are individual risk assessments undertaken?			
	Is there a tracking system to ensure safety prior to, during and at the end of a visit (e.g. buddy systems, lone working procedures)?			
	Are mobile phones provided together with training in their use?			
	Are personal safety alarms provided and information given in their use?			

18	**Policy / Procedure**	Yes	No
	Is the Trust policy easily accessible to all staff?		
	Is there a Trust Information Leaflet available to all staff?		
	Do you have departmental policies / procedures?		

Section D: Current Risk Control Measures (see Section C)

Control Measures Currently in Use:

Initial Risk Rating Figure	**Section E: Initial Risk Rating Figure**
	(to calculate see Risk Matrix):

Probable Likelihood Rating [   ]   x Potential Severity Rating [   ] =

ik Rating Score [   ]

Section F: Additional Risk Control Measures Required

prioritised risk ol measures to be recorded within this box.   The request for these
register. a risk priority along with other risks within the location and will fo

No.	Risk Reduction Measures / Further Action

If the above control measures are implemented, calculate the **New** Risk Rating Figure:

Probable Likelihood Rating [ ]   x Potential Severity Rating [ ] = **Risk Rating Score** [ ]

| Section G: Action Plan Agreed with Manager |

....   ……………………………
Managers Signature

No	Action Plan	Responsible Person	Projected Completion Date	Date Completed / Signature

Once the above action plan has been implemented, calculate the **Final / Residual** Risk Rating Figure:

Probable Likelihood Rating [ ]   X Potential Severity Rating [ ] = **Risk Rating Score** [ ]

| Additional Comments |

Appendix 4 – Unacceptable Standards of Behaviour

The following are examples of behaviours that are not acceptable on NHS premises, or locations where patients receive treatment:

- Excessive noise e.g. loud or intrusive conversation, shouting or uncontrollable misbehaviour

- Threatening or abusive language involving excessive swearing or offensive remarks

- Derogatory racial or sexual remarks

- Wilful damage to Trust property

- Malicious allegations relating to members of staff, other patients or visitors (N.B. any allegations made by children against staff must be reported to a Named Professional for investigation)

- Offensive and derogatory comments relating to members of staff, other patients or visitors

- Language that belittles a person's abilities

- Inappropriate behaviour as a result of alcohol or misuse of drugs

- Threats or threatening behaviour

- Violence, perceived acts of violence or threats of violence

- Unreasonable behaviour and non-cooperation such as repeated disregard for hospital visiting rules

- Bullying, victimisation or intimidation

- Stalking

- Spitting

- Any explicit or implicit challenge to the safety, wellbeing or health of any member of staff or patient

- Theft

- Drug dealing

- Persistent smoking in inappropriate areas within the Trust (n.b., all Trust premises and property are smoke free.

It is important to remember that such behaviour can either be in person, by telephone, letter or email or any other form of communication such as graffiti on NHS property for example.

VISITOR UNDERTAKING (Stage 1)

<div style="border:1px solid black; padding:10px;">

Your Responsibilities

I will not behave in any way which can be considered to be violent or abusive.

Violence includes any incident where any members of staff are abused, threatened or assaulted in circumstances related to their work. An act of violence may involve an explicit challenge to the safety, well-being or health of any member of staff or other patients. Violent behaviour may include verbal abuse, racial or sexual harassment, threats of injury, abuse of alcohol or drugs, destruction of hospital property as well as physical acts of violence.

I will treat NHS staff, fellow patients, carers and visitors politely and with respect at all times.

I will not consume alcohol or take any form of non-prescribed medication or drugs whilst on any premises of Velindre Trust.

I accept and understand that the Trust is obliged to provide a safe and secure environment for all its staff and to care for their health and safety. I accept and understand that no member of staff has to jeopardise their safety in providing me with information and my relative/friend with care.

</div>

I confirm that I understand that if my behaviour is unacceptable and I do not comply with my responsibilities this can result in the withdrawal of my rights as a visitor as outlined in the Trust's Policy for Management of Violence and Aggression Policy.

Signature of Visitor:	Signature of Velindre Representative:
Print name:	Print name:
Date:	Date:
Witnessed by:	Date:
Print name:	

Visitor Undertaking Letter 1 (Stage 2)

Visitor's name…………………………………
Visitor's address ……………………………..
……………………………………………………
…………………………………………………….
Date:

Dear ………………………..

This is to formally confirm that due to your unacceptable behaviour on………………………………………………… at…………………………………………………
You are now subject to the conditions outlined in Velindre Trusts Visitors Undertaking in order to protect the patient, other vulnerable adults and staff.

The procedure for using a Visitors Undertaking has been applied to you and enclosed is a copy of the Trust's Policy for Handling Violence and Aggression.

Should you, on any occasion in the future, fail to comply with the expected standards of behaviour explained to you by ……………………….... and outlined in the Visitors Undertaking, you will become subject to the next stage of the Procedure which may involve your immediate exclusion from the Trust premises by our security staff/Police. Such an exclusion from Trust premises would mean that you could only attend the Trust premises accompanied by Security or the Police.

Yours sincerely

Senior Manager

Ref: QS26

POLICY FOR DISPLAY SCREEN EQUIPMENT

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety and Performance Committee
Approval Date:	16 January 2024
Date of Equality Impact Assessment:	November 2023
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	January 2027
Version:	6.0

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Links to Forms and information for use with the Policy: Error! Bookmark not defined.

1. Policy Statement

Velindre University NHS Trust (VUNHST) and its hosted organisations are committed to minimising the health and safety risks to staff who use display screen equipment and to complying with the legal obligations placed on it by The Health and Safety at Work etc. Act 1974 and the Display Screen Equipment (DSE) Regulations 2002

2. Scope of Policy

This policy applies to all employees of the Trust and Hosted Organisations, who use DSE for a continuous period of an hour or more (DSE users) whilst on Trust business.   It also applies to workstations provided for use on Trust premises by persons who are not employees, i.e. service users, visitors, volunteers or staff of external bodies located on Trust premises.

Note – This policy refers to **hybrid working**, which is also called **agile working** in the hosted organisations.

3. Aims and Objectives

Aim

This Policy aims to manage so far as reasonably practicable the health and safety risk to staff from using display screen equipment both on VUNHST or hosted organisation premises and if undertaking hybrid working.

Objectives

This policy describes the ways in which VUNHST will comply with the requirements of the Health & Safety (Display Screen Equipment) Regulations 1992.   It also outlines the way that the Trust complies with the Health and Safety Executive (HSE) guidance on hybrid working.

The Regulations require: -

- a DSE assessment is carried out on DSE Users workstations both in the office environment and when staff are working in a hybrid manner.
- risks from DSE workstations are eliminated or reduced.
- eye tests, paid for by the employer, are available if a DSE worker requests one.
- the employer will pay a specified amount for the provision of DSE specific glasses where the provisions of the Regulations apply (see section 6.5)
- DSE specific information and training is provided for DSE users.

4. Responsibilities

4.1 **The Chief Executive** has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

- an Executive Director to be appointed as a lead for health and safety
- the Trust Board and Executive Management Board to be informed as required on health and safety matters affecting employees, patients, donors or others.
- the Trust's policy on the Safe Use of Display Screen Equipment to be implemented
- training and development of staff
- ensuring there are sufficient resources to implement this policy

4.2 **The Executive Director of Strategic Transformation, Planning and Digital** has delegated responsibility at Trust Board level for managing health and safety and is responsible for making sure that systems are in place to ensure:

- this policy is reviewed when appropriate.
- regular updates on issues raised are reported to the Executive Management Board.
- activities are planned, measured, reviewed and audited so that legal requirements are satisfied and risks arising from the use of display screen equipment are minimised.
- information and guidance regarding the safe use of display screen equipment is communicated throughout the Trust.
- training needs for the use of display screen equipment are identified and compliance with training is monitored and reported.

4.3 **The Executive Director of Organisational Development and Workforce** is responsible for ensuring that:

- there is effective induction training that includes safe use of display screen equipment advice and training, which is appropriately monitored and recorded.
- arrangements are in place to support and provide adjustments for employees with musculoskeletal injuries or other health issues that may arise from or be aggravated by the use of display screen equipment.

4.4 **Divisional Directors / Directors of Hosted Organisation**s are responsible for ensuring arrangements are in place for:

- the development and implementation of local procedures and organisational arrangements for the safe use of DSE in line with the Trust policy.

- processes are in place to ensure DSE assessments to be carried out for workplace and hybrid working
- staff receive DSE information and training.
- appropriate DSE equipment is made available to staff in the office and when hybrid working.
- 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 employees complete a homeworking assessment

4.5 **Assistant Director of Estates, Environment and Capital Development** has overall responsibility for the management of the working environment including lighting, temperature and ventilation in the buildings owned by the Trust.

4.6 **Departmental Managers** have responsibility for ensuring that there are arrangements in their department to:

- identify DSE users.
- ensure DSE users' access DSE training and information including information on use of DSE during hybrid working and how to set up a work station at home.
- ensure DSE users complete a DSE assessment in accordance with the arrangements in their division or hosted organisation, including assessments for hybrid working.
- review DSE assessments and ensure that any issues identified are addressed and where necessary escalated to DSE assessors, health and safety advisors or Occupational Health.
- refer people to Occupational Health or expert ergonomic advice for health issues which may be related to or made worse by DSE work, for example musculoskeletal pain or other sensation or numbness in hands, arms shoulders, back or neck or DSE related eye problems, headaches or stress (not an exhaustive list). All referrals to Occupational Health must be accompanied where possible by an up-to-date display screen equipment risk assessment
- ensure that workers who working in a remote manner have been provided with suitable equipment (monitors, laptops, keyboard, mice etc.), requests for additional equipment should be considered on a case by case basis and where appropriate further support and guidance should be sought from DSE assessors, health and safety teams, Occupational Health, Digital, and/or Workforce as required.
- scrutinise and authorise payment for display screen related eye tests and glasses for use with DSE work (see section 6.5)
- ensure that any DSE Equipment, workstations, chairs provided in their areas of responsibility in the office meet the requirements of the DSE Regulations.

- enable work to be organised so that employees are able to take regular breaks and/or changes of activity.
- ensure that Trust, divisional or hosted organisations arrangements for checking equipment are implemented.
- Ensure that hybrid workers complete a home working risk assessment.

4.7 **DSE equipment 'users'** must

- complete the display screen equipment training in the format required by their division (on-line ESR) or by their hosted organisation.
- If they undertake hybrid working, familiarise themselves with the Trust, divisional and hosted organisation information and guidance on hybrid working and setting up a workstation at home.
- complete a DSE assessment for the work station they use in the office and (where applicable) for any workstation they use at home.
- escalate any issues identified by display screen assessment to their manager and where appropriate cooperate with any assessment carried out by a display screen assessor.
- inform their manager of any health issues potentially caused or made worse by DSE work including musculoskeletal pain, eye strain, headaches (not an exhaustive list), including issues that may be related to DSE use as part of hybrid working.
- ensure that any work station they use for home working is safe and without risks to health, set up in accordance with their DSE training and does not constitute a risk to other persons in their home environment.
- adjust any workstation they use whilst agile working/hot desking in accordance with their display screen equipment training.
- review their display screen equipment risk assessment if there is a significant change in working practice or their work station at the office or at home, the environment, the use of different equipment or software or a change in a health condition.
- Cooperate with Trust, divisional or hosted services arrangements for checking equipment.
- Complete a home working risk assessment if they work in a hybrid manner.

4.8 **Health and Safety Teams** - The Trust, divisional and hosted organisation Health and Safety Managers/Advisors will ensure that:

- training and information is available for display screen equipment users
- advice is available with regard to display screen equipment risk assessments
- systems are in place to monitor compliance with this policy as part of the health and safety audit process.

4.9 **Occupational Health** is provided via a service level agreement and includes the provision of advice on DSE related health issues. The service is also able

to offer advice on the design and suitability of DSE Workstations through the Occupational Health Physiotherapy service.

All referrals to Occupational Health must be accompanied where possible by an up-to-date display screen equipment risk assessment.

4.10 **Digital Services** will coordinate the procurement of relevant equipment and software, as determined by departmental / line managers or based on the recommendations from formal DSE and/or Occupational Health assessments.

5.   Definitions

- **Display Screen Equipment** are devices or equipment that have an alphanumeric or graphic display screen and includes display screens, laptops, tablets, touch screens and other similar devices

- **Display Screen Users** are workers who regularly use DSE as a significant part of their normal work (daily, for continuous periods of an hour or more) and include users of Portable Laptops/Notebooks.

- **Hybrid working, Remote working, Agile working** are terms used where time is split between a central workplace (VUNHST or Hosted Organisation premises) and other locations including working at home.

- **Agile** working applies where staff do not necessary have an allocated desk but may work at 'hot desks' at VUNHST or Hosted Organisation or other NHS premises.

6.   Implementation/Policy Compliance

6.1   <u>**DSE Workstation Assessments**</u>

Workers who use DSE continuously for an hour or more a day must complete a DSE assessment for both office and home working where applicable.

Where DSE related risks are identified, steps must be taken to reduce them as soon as reasonably practicable. Users can make straightforward adjustments to workstations themselves following instruction, training and guidance. Managers must review DSE Assessments and request additional advice and guidance from trained DSE assessors, health and safety teams and/or Occupational Health as appropriate where unresolved issues are identified.

Where DSE assessments of home workstations identify issues, which may require additional equipment, managers should consider these matters on a case-by-case basis and obtain further advice from DSE assessors, health and safety teams, Occupational Health, Digital, and/or Workforce as required.

Where workers work at multiple workstations (hot desking) they should use the information, training and guidance they have received to adjust each workstation to meet their needs and to reduce the risk from DSE work.

DSE assessments should be completed when a new workstation is set up, when a new user starts work, when a change is made to an existing workstation or when a user experiences pain or discomfort or other possibly DSE related health effects.

6.2 **Appointment of Display Screen Equipment Assessors**

DSE assessors will be trained and appointed to support the display screen risk assessment processes, and to provide advice and guidance on workstation set up, provision of equipment and working practices. DSE assessors will signpost to additional support such as health and safety teams, Occupational Health, Workforce and Digital as appropriate.

6.3 **Work Routines**

DSE users should organise their work to take regular breaks whether working in the office or at home. Regular breaks, which may involve a change of activity and an opportunity to move around and/or change position. Breaks support musculoskeletal health, allow a break from looking at the screen and support mental wellbeing avoiding extended periods of concentration without respite.

Generally speaking, staff should take short regular breaks (e.g. at least five minutes in every hour) away from the workstation.

6.4 **Training and Information**

Employees will be provided with training, information and guidance about the use of DSE.

6.5 **Eye and Eyesight Tests**

Eye tests will be provided for DSE users, if requested, in line with the requirements of the Display Screen Regulations.

The Trust will pay up to £50 for glasses if the test shows an employee needs special glasses specifically for DSE work. The Trust will not reimburse the cost of glasses where an ordinary prescription is suitable for DSE work. The requirement for a DSE specific prescription must be confirmed in writing by the Optician.

The DSE user must take the Display Screen User Eyesight Request Form authorised by their Line Manager prior to the visit, with them to the appointment for the Optician to complete. The frequency of repeat testing will be at the clinical judgement of the Optician.

Claims for reimbursement must be submitted via the e-expenses portal on the Display Screen User Eyesight Request Form together with relevant receipts.

7. **Hybrid Working**

Guidance on hybrid working can be found in the Trust Hybrid Working Toolkit and in guidance provided by divisions and hosted organisations.

Hybrid working is where an employee splits their time between, the workplace and working remotely either at home or another workplace location. Hybrid working can be undertaken in non-traditional environments through remote and virtual work, hot desking at alternate bases.

Wherever an employee is working , they should use the information provided to them in their DSE training and information to adjust their workstation to avoid discomfort.

When working from home as part of Hybrid working arrangements agreed with their manager, they should make every effort to set up the work space as close to the office provision as possible, remembering posture and the positioning of equipment e.g. laptop, keyboard and mouse, monitor.

Staff are required to complete a display screen assessment for their work station at home as well as for their workstation on VUNHST or hosted organisation premises.

Staff must also complete the Home working risk assessment and ensure that their working area is safe and without risk to health. Further guidance is available in the Hybrid Working toolkit and in guidance provided by the trust, divisions and hosted organisations.

Staff will be provided with training and guidance on basic electrical safety. They must regularly inspect all DSE related equipment provided to them by the Trust or hosted organisation. If it is visibly damaged or shows signs of being defective, they must not use it and must report the issue to their manager and/or Digital Services as appropriate for remedial action to be taken.

8. **Reasonable Adjustments**

DSE assessments completed in the office or hybrid working may identify requirements for reasonable adjustments for persons with a disability as defined

under the Equality Act 2010. Each person must be considered on a case-by-case basis. Managers must seek further advice from health and safety teams, Occupational Health and/or Workforce and Organisational Development as appropriate to ensure the requirements of the Equalities Act 2010 are adhered to.

9.   Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative impact has been identified.

10.   References

Working Safely with Display Screen Equipment – HSE website
Velindre University NHS Trust Hybrid Working Toolkit.

11.   Getting Help

Please approach the Trust, divisional or hosted organisation's health and safety team for additional guidance or advice.

12.   Related Policies

Reference should also be made to the following Trust Policies:

- Health, Safety and Welfare policy PP10
- Workplace Equipment Policy PP17
- Home Working Policy WF45
- Supporting Staff with Specific Needs – disability Guidance
- Hybrid Working Tool Kit .

13.   Related documents and forms

- DSE Assessment and Guidance Form
- Home working assessment
- Home working DSE Assessment and Guidance
- DSE Guidance available on Trust, Divisional and Hosted Organisations' SharePoint pages.
- DSE Training available on ESR
- Annual DSE equipment questionnaire (Trust and divisions only)

14.   Monitoring Arrangements

Completion of the display screen equipment e-learning on ESR will be monitored by divisional and Trust quarterly health and safety meetings.

Compliance with this policy will also be monitored as part of the HSG 65 Health and Safety audit process.

15.   Main Relevant Legislation

This policy supports the legal duties placed on the organisation by the following: -

- Health and Safety at Work etc. Act 1974
- Health and Safety (Display Screen Equipment 1992
- Provision and Use of Work Equipment Regulations 1998
- Workplace (Health, safety and Welfare) Regulations 1992
- The Electricity at Work Regulations 1989

Ref: QS14

SAFER MANUAL HANDLING POLICY

Executive Sponsor & Function:	Executive Director of Strategic Transformation, Planning and Digital
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety & Performance Committee
Approval Date:	16th January 2024
Date of Equality Impact Assessment:	November 2023
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	16th January 2027
Version:	8.0

1. Policy Statement

Velindre University NHS Trust attaches great importance to the health, safety and welfare of its patients, staff and visitors, whilst fulfilling its statutory obligations within the law.

The Trust has a legal obligation under the Manual Handling Operations Regulations 1992 to make a suitable and sufficient assessment of the risk to employees from the manual handling of loads.

The Regulations set out a hierarchy of measures that should be followed to reduce the risks from manual handling which are: -

* to avoid manual handling operations so far as is reasonably practicable,
* to assess the risk in any manual handling operations that cannot be avoided and
* to reduce the risk of injury so far as reasonably practicable

This policy outlines the requirements for safer manual handling within the organisation, in accordance with current legislation and the current All Wales NHS Manual Handling Passport Scheme.

2. Scope of Policy

This policy applies to all staff employed by or contracted to the Trust, including those within Hosted Organisations, that are required to undertake any form of manual handling during the course of their duties.

3. Aims and Objectives

The aim of this policy is to minimise the risk of musculo-skeletal injuries as a result of manual handling by maintaining a structured method of training and risk assessment, to reduce the need to undertake manual handling activities so far as is reasonably practicable.

To achieve this, it is necessary to ensure that adequate arrangements are in place to ensure the effective management of manual handling operations.

The Trust will ensure, so far as is reasonably practicable, an ergonomic approach to the provision of work equipment. Where identified by the risk assessment process, employees will be provided with the appropriate level of training.

The Trust is committed to complying with the standards set by the current All Wales NHS Manual Handling Passport Scheme.

4. <u>Responsibilities</u>

4.1 The Chief Executive

The Chief Executive has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

- an Executive Director to be appointed as a lead for health and safety the Trust Board and Executive Management Board to be informed as required on manual handling issues that affect employees and/or the service users
- the Trust's Safer manual Handling Policy to be implemented
- supporting the training and development of staff
- ensuring that there are sufficient resources for the implementation of this policy

4.2 Executive Director of Strategic Transformation, Planning and Digital

The Executive Director of Strategic Transformation, Planning and Digital has delegated responsibility at Trust Board level for managing health and safety and is responsible for ensuring that:

- the Trust's Safer Manual Handling Policy is reviewed as and when appropriate
- regular updates on manual issues are reported to the Executive Management Board
- activities are planned, measured, reviewed and audited so that legal requirements are satisfied and health and safety risks arising from manual handling activities are minimised
- information regarding safer manual handling is effectively communicated throughout the Trust
- The approach to safer manual handling is both systematic and appropriate

In addition to the delegated responsibilities for managing Health and Safety, the Executive Director of Strategic Transformation, Planning and Digital should ensure that: -

- risks to the health and safety of employees and others from manual handling operations affected by constraints of workplace environments, in property owned or leased by the Trust, are eliminated and / or reduced where possible
- risks to the health and safety of employees and others from manual handling operations affected by constraints of workplace environments, in new build and / or refurbished property owned by the Trust are eliminated / reduced by ensuring that suitable and sufficient space for manual handling operations and equipment is incorporated at the design stage of any new build or refurbishment to Trust property

- manual handling equipment provided as part of a new build or refurbishment scheme is suitable for the work environment and for employees that use the equipment. Work equipment should not pose a risk to the health and wellbeing of employees so far as is reasonably practicable.

4.3   Executive Director of Organisational Development and Workforce

The Executive Director of Organisational Development and Workforce is responsible for ensuring that:

- there is an effective mandatory and induction training programme that includes manual handling advice and training, which is appropriately monitored and recorded
- arrangements are in place for health surveillance, support and counselling for employees with musculo-skeletal injuries.

4.4   Divisional Directors / Directors of Hosted Organisations

Directors have overall responsibility for making sure that arrangements are in place for: establishing a local health & safety group which comprises representatives from all relevant departments and staff representatives, within their service area, where issues or concerns regarding manual handling can be discussed.

- liaising with the Trust Capital Planning and Estates Department
- ensuring that local procedures for the safer manual handling are developed and implemented in line with the overarching trust policy
- preparing and implementing the organisational structure and allocating responsibility for manual handling within the service area and that the identified personnel (e.g. Senior Manager) are aware of their responsibility
- identifying all manual handling risks associated with work and ensuring that associated risk assessments for manual handling activities have been implemented within the service area
- ensuring that employees have access to a level of training appropriate to their role
- any manual handling equipment and manual handling operations to satisfy the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER)
- any manual handling equipment to satisfy the requirements of the Provision and Use of Work Equipment Regulations

4.5   Assistant Director of Estates, Environment & Capital Development

The Assistant Director of Estates, Environment & Capital Development will make arrangements to:

- ensure that competent risk management and health and safety advice is available to all divisions and hosted organisations of the Trust and to support the appointed local lead managers in developing and maintaining their safety management systems and training for manual handling . Competent advice may be sourced both internally and externally, dependant on the nature of the topic.
- provide support to the Executive Director with delegated responsibility for risk and health and safety management across the Trust, divisional directors, operational managers and health and safety leads in the implementation of policy,
- ensure that statistical information is available on health and safety performance throughout the Trust and interpret such information in order to evolve action plans to improve or maintain standards
- investigate incidents and report to senior managers on findings and where necessary provide recommendations

4.6   Departmental Managers

Department managers have overall responsibility for making sure that arrangements are in place within their department to:

- identify any potential concerns arising from manual handling on a day to day basis.
- ensure that a risk assessment is carried out, in line with current legislation and trust policy. The assessment should include sufficient information about the risks that are faced and the preventive / control measures that are required. The risk assessment should be regularly reviewed.
- identify any specific training that may be required by departmental staff via the PADR process and advise the Education and Development Team to ensure that this is reflected within the job profile on the ESR system.
- identify any health surveillance or support that may be required by staff following an incident and liaise with local Workforce personnel to ensure that an appropriate level of occupational health support is readily accessible to staff
- identify any health surveillance or support that may be required by staff that have an existing musculo-skeletal injury / related illness, in order to maintain their safety whilst in work
- have access to specialist advice by liaising with the local Health & Safety lead, specialist advisor or the Trust Capital Planning and Estates Department
- ensure that individuals are aware of their responsibilities for safer manual handling and have access to current information and risk assessments.
- consult and involve staff and safety representatives with local management arrangements and report all manual handling incidents.
- develop and implement a local departmental procedure or safe system of work for safer manual handling which will include

- ensuring that any manual handling equipment and manual handling operations under their management (whether owned, leased or contracted) satisfies the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) e.g.

  ➢ all equipment used for lifting is fit for purpose, appropriate for the task, suitably marked and subject to statutory periodic 'thorough examination'. Records must be kept of all thorough examinations and any defects found must be reported to both the person responsible for the equipment and the relevant enforcing authority.

- ensuring that any manual handling equipment under their management (whether owned, leased or contracted) satisfies the requirements of the Provision and Use of Work Equipment Regulations e.g.

  ➢ the equipment is constructed or adapted to be suitable for the purpose it is used or provided for
  ➢ take account of the working conditions and health and safety risks in the workplace when selecting work equipment
  ➢ work equipment is only used for suitable purposes
  ➢ work equipment is maintained in an efficient state, in efficient working order and in good repair
  ➢ where equipment has a maintenance log, keep this up to date
  ➢ where the safety of work equipment depends on the manner of installation, it must be inspected after installation and before being put into use
  ➢ where equipment is exposed to deteriorating conditions liable to result in dangerous situations, it must be inspected to ensure faults are detected in good time so the risk to health and safety is managed
  ➢ ensure that all people using, supervising or managing the use of work equipment are provided with adequate, clear health and safety information. This will include, where necessary, written instructions on its use and suitable equipment markings and warnings
  ➢ ensure that all people who use, supervise or manage the use of work equipment have received adequate training, which should include the correct use of the equipment, the risks that may arise from its use and the precautions to take
  ➢ that work equipment is provided with appropriately identified controls for starting, stopping and controlling it, and that these control systems are safe
  ➢ where appropriate, provide suitable means of isolating work equipment from all power sources (including electricity)

Following a manual handling incident, the manger will:

- ➢ ensure that the incident is reported in a timely manner into the Datix Risk Management system
- ➢ discuss the incident with the staff member
- ➢ where appropriate investigate the incident
- ➢ ensure the controls are adequate to manage the risk
- ➢ provide a supporting role to encourage staff well being
- ➢ refer staff to occupational health where required
- ➢ seek advice or guidance where necessary
- ➢ identify and escalate any identified risks, in accordance with the Trust risk assessment policy
- ➢ ensure that any outcome e.g. a change in process, further training required, will formally be fed back to the staff member concerned.

4.7   Employees

All employees are expected to:

- act in a responsible manner and treat others with dignity and respect whilst performing their manual handling duties
- comply with policies and procedures developed to protect their health and safety
- report all manual handling incidents and near misses
- discuss any health and safety concerns with their manager that may affect their ability to undertake manual handling duties
- cooperate with their manager in relation to health and safety and risk assessment
- undertake the relevant level of manual handling training

4.8   Occupational Health Departments

The Trust has service levels agreements in place for the provision of Occupational Health which is covered by local procedures. Please seek advice from your Organisational Development and Workforce department, who will be able to direct you to the appropriate service provider. The manager is able to refer staff involved in a manual handling incident where health issues have been identified and a self-referral is available to members of staff that have existing musculo-skeletal injuries that affect their ability to undertake their manual handling duties. For those with access to the Cardiff and Vale University Health Board Occupational Health Service, there is a self-referral pathway for OH physiotherapy.

5. **Definitions**

Terminology used throughout this policy is defined below:-

- **Manual Handling Operation** - Any transporting or supporting of a load, including the lifting, putting down, pushing, pulling, carrying or moving by hand or bodily force.

- **Minimal Handling** - The process by which risks associated with a manual handling operation are reduced as far as is reasonably practicable.

- **Load** - a moveable object, including any person or animal

- **Hazard** - something with the potential to cause harm.

- **Risk Assessment** – The calculation of the likely outcome of the hazards posed by a manual handling operation should they come to fruition weighed against the control measures in place.

- **The Ergonomic Approach**- the matching of the demands of work with the worker's capabilities and limitations.

- **Emergency Situation** - An unforeseeable situation in which an individual must be moved to safety immediately and there is no time to get equipment or plan the move in detail. Risks may have to be taken. It should be appreciated that these situations will be extremely rare.

6. **Implementation / Policy Compliance**

To ensure the effective implementation of this Policy the following local arrangements must be put into place: -

- **Manual Handling Trainers** – An adequate number of trainers will be identified (either internally or externally) to ensure that all members of staff who perform manual handling tasks receive appropriate training. Each trainer will be expected to have the level of training and skills to perform their roles in accordance with the All Wales Manual Handling Training Passport and Information Scheme.

- **Employees** – the training needs of each employee will be assessed in accordance with the requirements of the Core Skills Training Framework and the All Wales NHS Manual Handling Passport Scheme.

- **Agency/Temporary Staff** – All agency/temporary staff must have received adequate training prior to commencing any duties within the Trust. This

instruction must provide them with the basic skills that they will need to fulfil their placement safely.

- **Students/Trainees** – All students/trainees must have been provided with adequate instruction by their training provider prior to commencing a placement with the organisation. This instruction must provide them with the basic skills that they will need to fulfil their placement safely.

- **Volunteers -** All volunteers should also receive adequate training to enable them to undertake any duties within the Trust.

- **Uniforms / Clothing** - The Trust will ensure that uniforms and personal protective equipment provided are compatible with the handling tasks to be undertaken.

Staff that do not wear a uniform must ensure that clothing they wear at work is compatible with the handling tasks they undertake at work. They should ensure that the fit of their uniform/clothing allows them to move freely and adopt positions required for any manual handling task.

Footwear worn by staff that perform a considerable amount of manual handling tasks, or where tasks that are performed require it, should have an enclosed heel and toe, which will help to provide a stable base for the handler.

Where personal protective equipment is required in order to undertake manual handling duties safely, this will be provided by the Trust, without charge.

- **Provision of Equipment** - Appropriate handling equipment should be provided where a risk has been identified. The following should be taken into consideration: -

  - An inventory of handling equipment used within an area should be held locally
  - All equipment must be suitable and fit for the purpose for which it has been provided and a suitable quantity supplied.
  - Any equipment that is/or thought to be faulty must be taken out of use and repaired or a replacement provided.
  - All employees should receive suitable and sufficient instruction and training on all aspects of specific manual handling equipment before use.
  - Local arrangements should outline the role of the manual handling trainer and the role of infection control in the procedure for the purchase of equipment
  - Local arrangements should outline the requirement for maintenance of equipment and inspection in accordance with LOLER 1998.

7. **Equality Impact Assessment Statement**

This policy has been screened for relevance to equality. No potential negative impact has been identified.

8. **References**

[Health and Safety Executive (HSE) Manual Handling At Work](#)
[Health and Safety Executive – Musculoskeletal Disorders (MSDs)](#)
[Health and Safety Executive – Thorough examinations and inspections of lifting equipment](#)
All Wales NHS Manual Handling Passport Scheme

9. **Getting Help**

Advisors for certain aspects of Health, Safety and Risk Management have been incorporated within the Trust structure, to provide specialist advice as outlined below:-

Assistant Director of Estates, Environment and Capital Development	Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ
Health and Safety	**Trust Health & Safety Manager** Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ Tel: WHTN 01875 6522
	VCC Health & Safety Advisor Velindre Cancer Centre Velindre Road Whitchurch Cardiff CF14 2TL Tel: 02920615888
	WBS Health & Safety Advisor Welsh Blood Service Ely Valley Road Talbot Green Pontyclun CF72 9WB Tel: 1797 2356

Occupational Health

Cardiff and the Vale University LHB
Heath Park
Cardiff CF14 4XW
E-mail: occupational.health@wales.nhs.uk
Telephone; 02920743264

Occupational Health provision has been established via formal service level agreements with the above-named local health board. Staff working outside the Geographical region of South East Wales are provided with Occupational Health services via local arrangements with their Occupational Health provider. Where practical, the occupational health provision should cover pre-employment checks, formal health surveillance, health assessments in connection with fitness to work, identification of occupational hazards and risks, along with support and advice for staff.

10. **Related Policies**

Reference should also be made to the following Trust Policies:

- Bedrails Procedure
- Falls Pathway
- VCC Falls Policy
- Enhanced Supervision Policy
- Health, Safety and Welfare policy QS18
- Workplace Equipment Policy QS36
- Medical Devices and Equipment Management Policy QS 24
- Decontamination Policy IPC 04

11. **Information, Instruction and Training**

Currently, there are 3 main levels of training within the Core Skills Training Framework: -

- Level 1a Theory of Inanimate Load Handling, which covers Module A of the All Wales Manual Handling Training Passport and Information Scheme
- Level 1b The practical implementation of Inanimate Load Handling, which covers Module B of the All Wales Manual Handling Training Passport and Information Scheme.
- Level 2 (Client Handling) includes Modules A,B, C plus any other relevant module of the All Wales Manual Handling Training Passport and Information Scheme

It will be for each departmental manager to determine which level of training is required by undertaking a Training Needs Analysis (TNA) for all staff. Where level 2 training contains elements of tasks that are not undertaken, e.g. hoisting, this element of the training will not be required. This should be documented on the appropriate Training Record.

Frequency of training and / or refresher training should be based on competency and should be undertaken as required by the Core Skills Training Framework.

Initial training should take place upon employment with the organisation unless the employee can demonstrate existing compliance by the submission of a current Passport form from their previous NHS employer.

No manual handling operations should be undertaken until training has been completed in accordance with the required TNA.

12. **Main Relevant Legislation**

This policy supports the legal duties placed on the organisation by the following: -

- Health & Safety at Work etc. Act 1974
- Management of Health & Safety at Work Regulations 1999
- Manual Handling Operations Regulations 1992
- Provision and Use of Work Equipment Regulations 1998
- Lifting Operations & Lifting Equipment Regulations 1998
- Workplace (Health, Safety & Welfare) Regulations 1992
- Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 2013

Appendix 1

[Link to the All-Wales NHS Manual Handling Passport   Scheme - Standards](#)

Ref: QS33

POLICY FOR THE CONTROL OF SUBSTANCES HAZARDOUS TO HEALTH (COSHH)

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning, and Digital
	Health and Safety Function
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety and Performance Committee
Approval Date:	16th January 2024
Date of Equality Impact Assessment:	November 2023
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	January 2027
Version:	5.0

Contents **Page**

1. **Policy Statement**

    Velindre University NHS Trust attaches great importance to the health, safety and welfare of its patients, staff and visitors, whilst fulfilling its statutory obligations within the law.

    This policy outlines the requirements for the management and control of substances that are hazardous to health (CoSHH) within the organisation, in accordance with current legislation. It includes the use of and the storage and transportation of any substance that is hazardous to health.

2. **Scope of Policy**

    This policy applies to all staff employed by or contracted to the Trust, including those within Hosted Organisations. It applies to all areas where hazardous substances are used, stored or generated.

    Failure to follow guidance in this policy will increase the risk of hazardous substance related injuries / illness to the user, other staff, patients, donors and visitors.

3. **Aims and Objectives**

    Velindre University NHS Trust intends, so far as is reasonably practicable, to protect its employees and those affected by its undertaking from the harmful effects of substances that may be used in fulfilling its business.

4. **Responsibilities**

    4.1.   Chief Executive

    The Chief Executive has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

    - ensuring that there is an Executive Director appointed as a lead for health and safety
    - ensuring that the Trust Board and Executive Management Board is informed as required on health and safety matters affecting employees and/or the public
    - ensuring that the Trust's CoSHH policy is implemented
    - supporting training and development of staff
    - ensuring that there are sufficient resources for the implementation of this policy

4.2. Executive Director of Strategic Transformation, Planning and Digital

The Executive Director of Strategic Transformation, Planning and Digital has delegated responsibility at Trust Board level for managing health and safety and is responsible for ensuring that:

- the Trust's CoSHH policy is reviewed as and when appropriate
- regular updates on health and safety issues are reported to the Executive
- Management Board

In addition to the delegated responsibilities for managing Health and Safety, the Director of Strategic Transformation, Planning and Digital should ensure that:

- there are appropriate arrangements in place to respond to major incidents and emergencies which could expose people to substances hazardous to health.
- risks to the health and safety of employees and others from workplace environments, in new build and / or refurbished property owned by the Trust are eliminated / reduced by ensuring that precautions for the control of substances hazardous to health are incorporated at the design stage of any new build or refurbishment to Trust property
- work equipment provided as part of a new build or refurbishment scheme is suitable for the work environment and for employees that use the equipment. Work equipment (including the relevant level of personal protective equipment), should not expose employees to any hazardous substance so far as is reasonably practicable.

4.3. Executive Director of Organisational Development and Workforce

The Executive Director of Organisational Development and Workforce is responsible for ensuring that: -

- there is an effective training programme that includes specific CoSHH training where required, which is appropriately monitored and recorded
- reports on work related illness or work-related ill health that is attributable to substances hazardous to health, are submitted to the trust Estates Assurance Meeting.
- pre-employment screening is carried out and provide advice to managers on any pre-existing conditions identified as part of that process
- arrangements are in place for health surveillance of in-service employees and others, such as work experience and students, where there is a specific requirement under CoSHH regulation.

4.4. Assistant Director of Estates, Environment & Capital Development

The Assistant Director of Estates, Environment & Capital Development will make arrangements to: -

- ensure that competent risk management and health and safety advice is available to all divisions and hosted organisations of the Trust and to support the appointed health and safety lead managers in developing and maintaining their CoSHH safety management systems and training. Competent advice may be sourced both internally and externally, dependant on the nature of the topic.
- provide support to the Executive Director with delegated responsibility for CoSHH management across the Trust, divisional directors, operational managers and health and safety leads in the implementation of, and monitoring compliance with, the CoSHH policy.
- ensure that information is available throughout the Trust on the management of CoSHH in order to evolve action plans to improve or maintain standards
- provide support to investigate incidents and report to senior managers on
- findings and, where necessary, provide recommendations

4.5. Health and Safety Manager and Divisional H&S Advisors/Leads

The Health and Safety Manager with the support of Divisional H&S leads is responsible for providing advice and guidance to managers on the effective implementation of this policy and safe working methods.

4.6. Divisional Directors / Directors of Hosted Organisations

Directors have overall responsibility for making sure that arrangements are in place for:

- establishing a local health & safety group which comprises representatives from all relevant departments and staff representatives, within their service area, where CoSHH issues or concerns can be discussed.
- liaising with the Trust Capital Planning and Estates department.
- ensuring that local CoSHH procedures are developed and implemented in line with the overarching trust policy
- preparing and implementing the organisational structure and allocating responsibility for CoSHH management within the service area and that the identified personnel (e.g. Senior Manager) are aware of their responsibility
- ensuring that CoSHH risk assessments have been implemented for all relevant activities within the service area
- ensuring that employees are trained to use, handle and store safely and correctly, any substances used in work activities
- ensuring that they are familiar with and ensure that all employees under their control are aware of:
- any contingency plan involving spillage

- the safe disposal of unwanted substances
- first aid arrangements appropriate to the substances used

4.7. Department Managers

Department managers have overall responsibility for making sure that arrangements are in place within their department to:

- identify any substances hazardous to health that are in use within their department and ensure that the appropriate paperwork is accessible to staff e.g.
- safety data sheets etc.
- ensure that a CoSHH hazard and risk assessment is carried out, in line with current legislation and trust policy. The assessment should detail all exposure scenarios and include all activities to ensure that staff have access to sufficient information about the risks they face and the preventive / control measures that are required. The risk assessment should be regularly reviewed.
- identify any specific CoSHH training that may be required by departmental staff via the PADR process and advise the Education and Development Team to ensure that this is reflected within the job profile on the ESR system.
- identify any health surveillance that may be required for staff and liaise with local Workforce personnel to ensure that an appropriate level of occupational health surveillance is readily accessible to staff, e.g. skin checks, lung function tests etc.
- have access to specialist advice by liaising with the local Health & Safety lead, specialist advisor or the Trust Capital Planning and Estates department
- ensure that individuals are aware of their responsibilities for CoSHH management and have access to current / up to date safety data sheets and risk assessments.
- develop and implement a local departmental CoSHH procedure or safe system of work
- consult and involve staff and safety representatives with local CoSHH management
- ensure that all hazardous substances are used, stored and handled in the prescribed manner

4.8. CoSHH department Leads

Department Managers will designate a member of staff within the department that will have the responsibility to manage the CoSHH arrangements for that particular Department. They will be trained on the use of Sypol the current CoSHH management system. This will ensure that effective CoSHH management system is maintained within the departments that are using the

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hazardous substances. Divisions may rely on divisional safety leads to provide them with advice and guidance appropriate to their service needs.

CoSHH compliance within the department will be monitored by the divisional H&S Managers and will act as the main contact between the division Health & Safety Groups and the Trust Health Safety and Fire Board in order that effective communication is created and maintained.

4.9.   Safety Representatives

Employees who have been formally appointed by their professional organisation or Staff Side organisation, to act as a health and safety representative for their members are entitled to make representation to their managers on general matters affecting the health safety and welfare at work of any employee and investigate potential CoSHH related hazards, dangerous occurrences, causes of incidents and complaints by employees, at the workplace

4.10. Individual Employees

All employees have a statutory duty of care, both for their own personal safety and that of others who may be affected by their acts or omissions.

- all employees are required to co- operate with their Manager/Supervisor to enable the Trust to meet its own legal duties under CoSHH regulation
- all employees are expected, in the course of their employment, to report to their Manager/Supervisor any hazardous situations or defective equipment that could result in exposure to a hazardous substance and to report incidents in line with local reporting procedures
- to follow the guidance contained in CoSHH risk assessments and to follow the risk reduction control measures recommended, e.g. using/wearing safety equipment / devices provided to them
- where appropriate, to attend occupational health medical examinations at the appointed time and give information about their health that may be reasonably required.

4.11. Committees and Management Groups

The following committees / groups will provide advice to the appropriate Executive Director in order to ensure that accountability is being discharged properly and to ensure that the aims and objectives of the Trust are being achieved. Committees include:

- Trust Estates Assurance Meeting
- Trust Infection Prevention and Control Management Group
- Trust Medical Devices and Equipment Management Group and / or relevant sub group
- Trust Water Safety Group

- Trust Research, Development and Innovation Operational Management Group
-

6.   Definitions

6.1.   Hazardous substances include:

- Substances used directly in work activities (e.g. cleaning agents)
- Substances generated during work activities (e.g. fumes from welding)
- Biological agents such as bacteria and other micro-organisms.

Under CoSHH Regulations, there are a range of substances regarded as hazardous to health which include: -

- Substances or mixtures classified as dangerous by law (listed in table 3.2 of part 3, Annex VI of (CLP Regulations). These can be identified by their warning label which will have one or more of the following hazard symbols and the supplier must provide a safety data sheet for them: -

Explosive (Symbol: exploding bomb)	Hazardous to the environment (Symbol: Dead tree and fish)	Corrosive (Symbol: Corrosion)
Flammable (Symbol: flame)	Health hazard/Hazardous to the ozone layer (Symbol: Exclamation mark)	Gas under pressure (Symbol: Gas cylinder)
Oxidising (Symbol: flame over circle)	Serious health hazard (Symbol: health hazard)	Acute toxicity (Symbol: Skull and crossbones)

- Substances with workplace exposure limits are listed in the HSE publication EH40
- Biological agents (bacteria and other micro-organisms), if they are directly connected with the work e.g. exposure to bacteria from an air conditioning system that is not properly maintained).
- Any kind of dust if its average concentration in the air exceeds the levels specified in the CoSHH regulations.
- Any other substance which creates a risk to health, but which for technical reasons, are covered by different legislation including asphyxiates, pesticides, medicines, cosmetics or substances produced in chemical processes.

Substances that are hazardous to health, can take many forms and include liquids, fumes, dusts, vapours, mists, nanotechnology, gases (and asphyxiating gases) and biological agents (germs) that cause diseases such as leptospirosis or legionnaires disease and germs used in laboratories

If the packaging has any of the hazard symbols then it is classed as a hazardous substance.

CoSHH does not apply to: -

- Asbestos, Lead or Radioactive Substances, which have their own legislation
- Biological Agents not directly related to the work environment (e.g. flu)
- Substances which are hazardous only because they are radioactive, at high pressure, at extreme temperature or have explosive or flammable properties (other regulations apply to these risks)

7.   Implementation/Policy Compliance

In order to comply with the CoSHH Regulations, the following action must be taken locally to prevent or reduce workers exposure to hazardous substances: -

- Identify what substances are present, or in use, that would be classed as hazardous to health and find out what the health hazards are;

    Consider the following:

    - What do you do that involves hazardous substances?
    - Can you avoid using a hazardous substance or use a safer process – preventing exposure, e.g. using water-based rather than solvent-based products, applying by brush rather than spraying?
    - Can you substitute it for something safer – e.g. swap an irritant cleaning product for something milder, or using a vacuum cleaner rather than a brush?

- Can you use a safer form, e.g. can you use a solid rather than liquid to avoid splashes or a waxy solid instead of a dry powder to avoid dust?

- decide how to prevent harm to health by undertaking a CoSHH risk assessment;

If you can't prevent exposure, you need to control it adequately by applying the HSE's principles of good control practice.

Minimise emission, release and spread
Consider routes of exposure
Choose control measures proportionate to the risk
Choose effective control options
Personal protective equipment – the final control option
Review the effectiveness of controls
Provide information and training
New measures, new risks

The above principles are all equally important in achieving adequate control. Also, the Principles are not listed in rank order: The first principle is not more important than the last principle, although there is a logical progression in how they are presented and should be considered.

7.1. Risk Assessment

The COSHH Regulations require an assessment of risk to be undertaken for tasks involving the use of hazardous substances (see section 5 for definition of a hazardous substance).

When undertaking the assessment, consideration should be given to the following:

- The hazardous properties of the substance
- Information on health effects provided by the supplier
- The level, type and duration of exposure
- The circumstances of the work, including the quantity used
- The potential routes of exposure, e.g. inhalation, ingestion, injection and absorption
- Activities such as maintenance where there is the potential for a high level of exposure
- Any relevant workplace exposure limit or similar occupational exposure limit
- The effect of preventive and control measures which have been or will be taken
- The results of relevant health surveillance
- The results of monitoring of exposure
- The risk presented by exposure to a combination of substances
- Any additional information needed in order to complete the risk assessment.

The Health and Safety Executive (HSE), in collaboration with the Trades Union Congress (TUC) and the Confederation of British Industry (CBI), have developed a *COSHH Essentials* website and where there is no local access to COSHH risk assessments, this website can be referenced. *COSHH essentials* is a generic risk assessment scheme for a wide range of hazardous substances covered by CHIP and COSHH. It leads users to appropriate control advice for a range of common tasks. *COSHH essentials* can be used as a basis for the recording of the risk assessment. Whilst *COSHH essentials* has been designed to ensure that a precautionary approach is taken towards control it is a generic guide and cannot guarantee that in all circumstances it will lead to full compliance with the Regulations assessment control requirements.

7.2.   Information, Instruction and Training

Following the completion of a COSHH risk assessment the need for information, instruction and training must be considered and appropriate arrangements made by the manager. These might range from a simple instruction to regular formal sessions. Wherever employees are exposed to hazardous substances they must receive information, instruction and, where appropriate, training in the following:

- The risks to health created by their exposure
- The precautions that should be taken
- Control measures, their purpose and how to use them
- How to use personal protective equipment and clothing provided ● Results of any exposure monitoring and health surveillance.

7.3.   Health Surveillance

In certain circumstances it will be necessary to undertake health surveillance for employees. Health surveillance is a systematic process which is required when:

a)   there is an identifiable disease or adverse health effect associated with the work,
b)   there is a reasonable possibility that the effect may occur under the conditions of the work (e.g. if control is dependent on Personal Protective Equipment) and
c)   there is a valid means for detecting the effect before it becomes permanent.

The objective of health surveillance is to:

- Protect the health of individual employees by detecting as early as possible adverse changes which may be caused by exposure to hazardous substances
- Help evaluate the measure(s) taken to control exposure
- Collect, keep up to date, and use data and information for determining and evaluating hazards to health.

Health surveillance will be undertaken via the Occupational Health Service, under local arrangements, as required.

7.4. Emergency Arrangements

Where the risks of a substance escaping are high, or the substance is especially hazardous, the local manager will ensure that emergency arrangements are in place as part of the risk assessment process. Guidance can be found on the supplier's Safety Data Sheet.

7.5. Personal Protective Equipment

Where the risk assessment has concluded that it is necessary to use personal protective equipment (PPE), this shall comply with the provisions of the Personal Protective Equipment Regulations 2002.

The main requirement of the Regulations is that PPE is to be supplied and used at work wherever there are risks to health and safety that cannot be adequately controlled in other ways.

The Regulations also require that PPE

- is properly assessed before use to ensure it is suitable;
- is maintained and stored properly;
- is provided with instructions on how to use it safely; and ● is used correctly by employees.

PPE, including protective clothing, must be

- properly stored in a well-defined place;
- checked at suitable intervals; and
- when discovered to be defective, repaired or replaced before further use.
- personal protective equipment which may be contaminated by a substance hazardous to health must be removed on leaving the working area and kept apart from uncontaminated clothing and equipment. This equipment must be subsequently decontaminated and cleaned or, if necessary, destroyed.

7.6. Engineering Controls

All control measures in use should be visually checked, where possible, at appropriate intervals and without undue risk to maintenance staff. In the case of local exhaust ventilation (LEV) and work enclosures, such checks should be carried out at least once a week.

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Procedures for servicing equipment should specify:

(a) which engineering control measures need servicing;
(b) the work to be carried out on each of them;
(c) when the work should be done;
(d) who is to do the work and who is responsible for it; and (e) how to put right any defects found.

In most circumstances control measures will include defined working procedures. These should be observed regularly to check that they are still being followed. They should also be reviewed periodically to confirm that they are still appropriate and workable and to see whether they can be improved.

Local exhaust ventilation plant (e.g. fume cupboards) must be inspected at least once every 14 months. Where respiratory protective equipment (RPE) (other than disposable RPE) is provided, thorough examination and, where appropriate, testing of that equipment must be carried out at suitable intervals. Records of examinations and tests carried out, and of any repairs carried out as a result of those examinations and tests, must be kept for at least 5 years.

7.7. Exposure Monitoring

Where the COSHH assessment shows it is necessary, valid and suitable occupational hygiene techniques should be used to estimate the amount of employees' exposure to substances hazardous to health. For airborne contaminants, this measurement will normally involve collecting a sample of air from the employee's breathing zone using personal sampling equipment. It may also, where appropriate, involve sampling the air at the workplace periodically or continuously, using static sampling equipment.

Where air sampling techniques alone may not give a reliable indication of exposure, e.g. where there is skin absorption, ingestion or where RPE is being used to adequately control exposure, biological monitoring is often a useful complementary technique to air monitoring.

7.8. Monitoring and Auditing

As part of the Health and Safety Audit process, evidence will be required to demonstrate that assessment of the use of Hazardous substances has looked at: -

- Investigation into whether there is a less hazardous alternative for the particular hazardous substances in current use.
- Any concerns in relation to occupational exposure to hazardous substances
- Confirmation that risk assessments have been either completed or reviewed and that all staff have been made aware of any associated risks through Sypol.

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- The availability of current Safety Data Sheets for all hazardous substances in use within their remit.
- Confirmation that engineering controls such as LEV are inspected and maintained to schedule and that records are kept for the required 5 years
- The above information will be provided via Sypol.

7.9.   General Housekeeping

It is vitally important that all chemicals that are used, handled and stored, are kept within their original packaging as far as reasonably practicable. This will ensure that the necessary information / hazardous nature of the chemical is available and visible to all. If the safety data sheet requires a specific method of storage e.g. locked cabinet, then this should be available prior to the procurement of the hazardous substance. Suitable spill kits should be readily available for use, along with PPE required to control or clear a spillage, as required by the safety data sheet. Decontamination procedures should be utilised as appropriate and appropriate measures in place to dispose of any spillage.

7.10. Procurement

Procurement have a role to play in ensuring that any potentially hazardous materials that they may procure or assist with procuring are as safe as possible for use.

This involves ensuring that Safety Data sheets can be obtained from the supplier and that the least harmful alternative is available / considered.

They would need to be aware of legislation such as REACH that may apply to certain chemicals and pass this information on to the end user.

Where necessary Procurement would need to pass on information that they are sent from the supplier, relating to the hazards of the chemical, to the end user.

8.   Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative impact has been identified.

9.   References

- The Health and Safety Executive provides access to a wide variety of guidance and information via its website
- The Control of Substances Hazardous to Health Regulations 2002 (as amended). Approved code of practice and guidance
- Working with substances hazardous to health - What you need to know about COSHH
- HSE COSHH Essentials Website
- Personal Protective Equipment relevant to CoSHH Regulations

- [EH40/2005 Workplace Exposure Limits: Containing the list of workplace exposure limits for use with the Control of Substances Hazardous to Health Regulations 2002 (as amended)](#)
- [The European Regulation (EC) No 1272/2008 on classification, labelling and packaging of substances and mixtures](#)

10. <u>Getting Help</u>

Advisors for certain aspects of Health, Safety and Risk Management have been incorporated within the Trust structure, to provide specialist advice as outlined below:-

Assistant Director of Estates, Environment and Capital Development	Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ
Health and Safety	**Trust Health & Safety Manager** Velindre NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ Tel: WHTN 01875 6522
	VCC Health & Safety Advisor Velindre Cancer Centre Velindre Road Whitchurch Cardiff CF14 2TL Tel: 02920615888
	WBS Health & Safety Advisor Welsh Blood Service Ely Valley Road Talbot Green Pontyclun CF72 9WB Tel: 1797 2356
Fire (precautions and training)	**Trust Fire Safety Advisor** Velindre University NHS Trust Headquarters 2 Charnwood Court Heol Billingsley, Parc Nantgarw Cardiff CF5 7QZ Tel: WHTN 01875 6522

Infection Prevention and Control	Senior Infection Control Nurse
	Velindre Cancer Centre
	Whitchurch
	Cardiff CF14 2TL
	Tel: WHTN 01875 6129
Occupational Health	Cardiff and the Vale University LHB
	Heath Park
	Cardiff CF14 4XW
	E-mail: occupational.health@wales.nhs.uk
	Telephone; 02920743264

Occupational Health provision has been established via formal service level agreements with the above-named local health boards. Staff working outside the Geographical region of South East Wales are provided with Occupational Health services via local arrangements with their Occupational Health provider. Where practical, the occupational health provision should cover formal health surveillance and health assessments in connection with identification of occupational hazards and risks, along with support and advice for staff.

11. Related Policies

There are numerous policies which should be considered alongside this policy. They are available via the trust's intranet page.

12. Information, Instruction and Training

See sections 4.7, 4.8, 6 & 6.2.

13. Main Relevant Legislation

- The Health and Safety at Work etc., Act 1974
- The Control of Substances Hazardous to Health Regulations 2002 (as amended). Supported by the control of substances hazardous to health (L5) sixth Edition, published 2013, Approved Code of Practice and Guidance ● See also section 8 – "References"

Ref: QS09

POLICY FOR THE MANAGEMENT OF LATEX AND LATEX ALLERGY

Executive Sponsor & Function:	Executive Director of Strategic Transformation, Planning and Digital Health and Safety Function
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety and Performance Committee
Approval Date:	16th January 2024
Date of Equality Impact Assessment:	November 2023
Equality Impact Assessment Outcome:	This policy has been screened for equality. No potential negative impact has relevance been identified
Review Date:	January 2027
Version:	7.0.

Contents   **Page**

1. Policy Statement

The Health and Safety Executive (HSE) advise that Natural rubber latex (NRL) proteins have the potential to cause asthma and urticaria. More serious allergic reactions, such as anaphylaxis, are also possible. NRL proteins are substances hazardous to health under COSHH (Control of Substances Hazardous to Health Regulations).

Velindre University NHS Trust attaches great importance to the health, safety and welfare of its patients, donors, staff and visitors, whilst fulfilling its statutory obligations within the law.

This policy outlines the requirements for the management of Latex and Latex Allergy, within the organisation, in accordance with current legislation and should be read in conjunction with the Trust Policy QS33 Policy for the Control of Substances Hazardous to Health (CoSHH).

2. Scope of Policy

This policy applies to all staff employed by or contracted to the Trust, including those within Hosted Organisations. It applies to all areas where products containing NRL are used or stored.

Failure to follow guidance in this policy will increase the risk of NRL related allergies to the user, other staff, patients and visitors.

3. Aims and Objectives

Velindre University NHS Trust intends, so far as is reasonably practicable, to protect its employees and those affected by its undertaking from the harmful effects of NRL that may be used in fulfilling its business. Every effort has been undertaken to ensure that all gloves used and purchased by the organisation are now latex free. However, there may be other products in use that may contain NRL. It is also recognised the NRL may be in products within other NHS organisations or in the community, where staff undertake their duties.

The policy includes sections relating to the management of staff or service users with known or suspected latex allergy and for the management of those considered to be at increased risk.

4. Responsibilities

4.1 Chief Executive

The Chief Executive has overall accountability for health and safety within the organisation, making sure that arrangements are in place for:

- ensuring that there is an Executive Director appointed as a lead for health and safety
- ensuring that the Trust Board and Executive Management Board is informed as required on health and safety matters affecting employees and/or the public
- ensuring that the Trust's policy on the Management of Latex and Latex Allergy is implemented
- supporting training and development of staff
- ensuring that there are sufficient resources for the implementation of this policy

4.2 Executive Director of Strategic Transformation, Planning and Digital

The Executive Director of Strategic Transformation, Planning and Digital has delegated responsibility at Trust Board level for managing health and safety and is responsible for ensuring that:

- the Trust's policy on the management of Latex and Latex Allergy is reviewed as and when appropriate
- regular updates on health and safety issues are reported to the Executive Management Board

4.3 Executive Director of Organisational Development and Workforce

The Executive Director of Organisational Development and Workforce is responsible for ensuring that: -

- there is an effective training programme that includes specific CoSHH training where required, which is appropriately monitored and recorded
- reports on work related illness or work-related ill health that is attributable to substances hazardous to health, are submitted to the Trust Estates Assurance Meeting.
- pre-employment screening is carried out and provide advice to managers on any pre-existing conditions / allergies identified as part of that process
- arrangements are in place for health surveillance of in-service employees and others, such as work experience and students, where there is a specific requirement under CoSHH regulation.

4.4 Assistant Director of Estates, Environment & Capital Development

The Assistant Director of Estates, Environment & Capital Development will make arrangements to: -

- ensure that competent risk management and health and safety advice is available to all divisions and hosted organisations of the Trust and to support the appointed health and safety lead managers in developing and

maintaining their CoSHH safety management systems and training. Competent advice may be sourced both internally and externally, for expert advice on NRL allergy.

- provide support to the Executive Director with delegated responsibility for CoSHH management across the Trust, divisional directors, operational managers and health and safety leads in the implementation of, and monitoring compliance with, the policy on the management of Latex and Latex Allergy.
- ensure that information is available throughout the Trust on the management of Latex and Latex Allergy in order to evolve action plans to improve or maintain standards
- provide support to investigate incidents and report to senior managers on findings and, where necessary, provide recommendations

4.5 Health and Safety Manager and Divisional H&S Advisors/Leads

The Health and Safety Manager with the support of Divisional H&S leads is responsible for providing advice and guidance to managers on the effective implementation of this policy and safe working methods.

4.6 Divisional Directors / Directors of Hosted Organisations

Directors have overall responsibility for making sure that arrangements are in place for:

- establishing a local health & safety group which comprises representatives from all relevant departments and staff representatives, within their service area, where NRL information or concerns can be discussed.
- liaising with the Trust Capital Planning and Estates Department
- ensuring that local CoSHH procedures are developed, which include reference to NRL, and implemented in line with the overarching trust policy
- ensuring that NRL health assessments have been implemented for all relevant staff and service users where required

4.7 Department Managers

Department managers have overall responsibility for making sure that arrangements are in place within their department to:

- ensure that general NRL risk assessment is undertaken with regard to work and clinical activities within their areas of responsibility. Specific individual risk assessments will be required where service users or staff are identified as allergic to NRL.
- identify and implement any action/control required following the NRL risk assessment, (further advice may be sought from Occupational Health).

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- ensure that staff are given the necessary information, instruction and training to enable them to manage NRL allergy and comply with this policy, including the need for reporting:
- report NRL allergic reactions suffered by patients via the critical incident reporting mechanism.
- report symptoms suggestive of NRL allergy in staff to the Occupational Health Department.

4.8   CoSHH Departmental Leads

Department Managers will designate a member of staff within the department that will have the responsibility to manage the CoSHH arrangements for that particular Department They will be trained to use Cypol our CoSHH Management system. This will ensure that effective CoSHH management system is maintained within the departments that are using the hazardous substances. Divisions may rely on divisional safety leads to provide them with advice and guidance appropriate to their service needs.

CoSHH compliance within the department will be monitored by the divisional H&S Managers and will act as the main contact between the division Health & Safety Groups and the Trust Health Safety and Fire Board in order that effective communication is created and maintained.

CoSHH leads should ensure that CoSHH assessments consider NRL and be able to provide managers and staff with safety data sheets for products containing NRL.

4.9   Individual Employees

All employees have a statutory duty of care, both for their own personal safety and that of others who may be affected by their acts or omissions.

Having been provided with information, instruction and training, staff will comply with this policy and follow safe systems of work for their area(s) of work and responsibility.

4.10   Committees and Management Groups

The following committees / groups will provide advice to the appropriate Executive Director in order to ensure that accountability is being discharged properly and to ensure that the aims and objectives of the Trust are being achieved. Committees include but are not limited to:

- Trust Health Safety and Fire Board

5. Definitions

The Health and Safety Executive (HSE) advises that Natural rubber latex (NRL) is a milky fluid obtained from the Hevea brasiliensis tree, which is widely grown in South East Asia, and other countries. NRL is an integral part of thousands of everyday consumer and healthcare items.

As with many other natural products, natural rubber latex contains proteins to which some individuals may develop an allergy.

NRL is not only contained within single-use disposable gloves, but can also be found in a number of medical products, such as catheters, elasticised bandages, wound dressings etc. It is also in the packaging for a number of medical products. While these may pose a low risk of sensitisation, they can pose a significant risk (e.g. anaphylactic shock) to sensitised individuals, either patients or healthcare workers.

The majority of healthcare products containing NRL are 'medical devices' as defined by the Medical Devices Regulations 1999. Therefore, their manufacture and provision are regulated by the Medicines and Healthcare Products Regulatory Agency (MHRA)

6. Implementation/Policy Compliance

6.1 Responsibilities to Employees

Existing staff need to be aware of the following: -

6.1.1 Diagnosis

Employees who think they may have latex allergy can self-refer to the Occupational Health Department, but ideally they should go through their managers who can arrange a quick referral through the Organisational Development and Workforce department and also arrange for the appropriate actions to be taken. The Department of Occupational Health will be able to undertake all necessary measures to diagnose Type 1 latex allergy. Appropriate advice is available on any work-related medical conditions.

6.1.2 Management

Advice regarding latex avoidance will be given. The Department of Occupational Health will review latex allergic employees after avoidance advice has been given to ensure symptom control. If necessary the Trust will support the employee by redeployment and retraining in the case of allergic reactions unresponsive to avoidance precautions. In some cases, ill-health retirement may be appropriate where the aforementioned options fail or are not possible.

New employees must complete a Pre-employment health pre-placement questionnaire. The questionnaire asks about known allergies it includes

questions regarding possible latex allergies. These staff will usually include all those working in clinical areas or in contact with service users in the community.

If latex allergy is identified and confirmed in a prospective employee the Occupational Health department will advise management and the employee of any adjustments needed to the working practices or workplace to accommodate the employee. The Trust will consider any reasonable adjustments necessary to comply with this advice. The Department of Occupational Health will review latex allergic employees after avoidance advice has been given to ensure symptom control.

6.2   Responsibilities to Service Users

6.2.1 Screening for Risk of Allergy

Careful history taking from patients, should identify the high-risk groups. These include:

- atopic allergic disease / known allergies, including but not limited to eczema, hay fever and asthma
- patients with spina bifida,
- health care workers,
- Service users with a history of multiple surgical procedures.

Specific questioning will be included in the routine nursing procedures for units where the possibility exists for mucosal exposure to latex (for example, patient undergoing selectron treatment). Service users will be questioned regarding a history of immediate reaction to skin rubber contact such as:

- following dental surgery,
- blowing up rubber balloons,
- wearing of rubber gloves,
- any history of immediate allergic reaction to fruit, especially banana and kiwi fruit.   The issue of latex sensitivity will be raised at relevant departmental meetings on a regular basis to ensure that all new staff are made aware of this problem.

6.2.2 Diagnosis

Service users giving a history of atopy (A hereditary disorder marked by the tendency to develop immediate allergic reactions to substances such as pollen, food, dander, and insect venoms and manifested by hay fever, asthma, or similar allergic conditions. Also called *atopic allergy*) and of adverse reaction to fruit, or those giving a history of immediate adverse reaction to rubber contact should have their surgery deferred if possible. An IgE RAST test to latex protein should be carried out and a referral made to the dermatology department for further diagnosis and investigation.

6.2.3 Latex Avoidance

For service users who are confirmed as having latex protein sensitivity, or in those in whom it is suspected from the history, but emergency treatment is unavoidable, appropriate alternative equipment packs will be made available. The risk of adverse reaction during clinical examinations including manual pelvic examinations will be brought to the attention of appropriate staff.

6.2.4 Anaphylaxis

Education in the recognition and management of anaphylactic reactions must be facilitated by each division. Each division must have an Anaphylaxis policy/SOP, if possible backed up by posters in the appropriate areas.

6.2.5 Management of Non-Life-Threatening Reactions

A service user suffering from milder reactions which do not compromise the airway or lead to cardiovascular collapse should be managed with intravenous antihistamine followed by oral antihistamine therapy. Referral to the dermatology department may be considered appropriate if the cause of reaction is unclear. A service user suffering from milder reactions away from a hospital environment should be transferred to an appropriate place of treatment.

6.3 Responsibilities of the Procurement Department

It will be the responsibility of the procurement department to monitor all products which have the potential to contain NRL by liaising with manufacturers and advise management of their findings and to provide advice on the availability of alternative products.

6.3.1 Use of low protein devices

Sensitisation can be prevented by the use of devices low in protein. Currently, the accepted method for assaying protein in latex devices is the Modified Lowry assay.

The Surgical Materials Testing Laboratory carries out testing of medical devices for the All Wales Contracts. Part of this work includes assaying protein levels in medical devices. Reports are available from SMTL on request and on their Internet site which documents protein levels in various medical devices, including gloves and urinary catheters.

Devices used especially gloves must be those on the All Wales Welsh Health Supplies contract.

6.3.2 Use of Non-Latex Devices

The use of non-latex devices is recommended in situations where staff or patients have a known latex allergy and contact with the device is unavoidable. All divisions must identify where latex free devices are available and identify a person who will be responsible for maintaining this equipment.

6.4   Responsibilities of the Occupational Health Service

Where covered by an appropriate Service Level Agreement (SLA), Occupational Health Departments, have a responsibility to: -
*   Ensure staff (or prospective staff) with NRL allergy and their managers, are advised of any necessary adjustments or restrictions to their work activities, using an evidence and risk assessment-based approach
*   Provide guidance to staff and managers on suitable and safe working environments for NRL sensitised employees.
*   Facilitate investigation of staff suspected of having NRL allergy.
*   Provide statistical and other relevant information concerning NRL allergy in staff to the Trust Estates Assurance Meeting, whilst maintaining individual confidentiality.

6.5   Housekeeping

Good housekeeping practices should be followed to remove latex-containing dust from the workplace. Areas potentially contaminated with powder from latex devices should be identified for frequent cleaning. Ventilation filters and vacuum bags should be changed frequently in these identified areas

7. Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative impact has been identified.

8. References

*   The Health and Safety Executive provides access to a wide variety of guidance and information via its website
*   The Control of Substances Hazardous to Health Regulations 2002 (as amended). Approved code of practice and guidance
*   Working with substances hazardous to health - What you need to know about COSHH
*   HSE COSHH Essentials Website
*   Personal Protective Equipment relevant to CoSHH Regulations Latex allergies in health and social care

9. **Getting Help**

Advisors for certain aspects of Health, Safety and Risk Management have been incorporated within the Trust structure, to provide specialist advice as outlined below:-

Assistant Director of Estates, Environment and Capital Development

Velindre NHS Trust Headquarters
2 Charnwood Court
Heol Billingsley, Parc Nantgarw
Cardiff CF5 7QZ

Health and Safety

Trust Health & Safety Manager
Velindre NHS Trust Headquarters
2 Charnwood Court
Heol Billingsley, Parc Nantgarw
Cardiff CF5 7QZ
Tel: WHTN 01875 6522

VCC Health & Safety Advisor
Velindre Cancer Centre
Velindre Road
Whitchurch
Cardiff CF14 2TL
Tel: 02920615888

WBS Health & Safety Advisor
Welsh Blood Service
Ely Valley Road
Talbot Green
Pontyclun CF72 9WB
Tel: 1797 2356

Occupational Health

Cardiff and the Vale University LHB
Heath Park
Cardiff CF14 4XW
E-mail: occupational.health@wales.nhs.uk
Telephone; 02920743264

Occupational Health provision has been established via formal service level agreements with the above-named local health boards. Staff working outside the Geographical region of South East Wales are provided with Occupational Health services via local arrangements with their Occupational Health provider. Where practical, the occupational health provision should cover formal health surveillance and health assessments in connection with identification of occupational hazards and risks, along with support and advice for staff.

10. Related Policies

This policy should be read in conjunction with, or reference made to, the following trust documents: -

Health, Safety and Welfare Policy	QS18
Control of Substances Hazardous to Health (COSHH)	QS33
Incident Reporting and Investigation Policy	QS 01
Medical Devices Equipment Policy Final	QS 24

11. Main Relevant Legislation

- The Health and Safety at Work etc., Act 1974
- The Control of Substances Hazardous to Health Regulations 2002 (as amended). Supported by the control of substances hazardous to health (L5) sixth Edition, published 2013, Approved Code of Practice and Guidance

Appendix 1

Health and Safety Executive – About Latex Allergies

What is Natural Rubber Latex?

Natural rubber latex (NRL) is a milky fluid obtained from the Hevea brasiliensis tree, which is widely grown in South East Asia, and other countries. NRL is an integral part of thousands of everyday consumer and healthcare items.

As with many other natural products, natural rubber latex contains proteins to which some individuals may develop an allergy.

What is the cause of Natural Rubber Latex Allergy?

The introduction of Universal Precautions in the late 1980s mandated that healthcare workers protect themselves against the risk of cross-infection from blood-borne pathogens such as HIV and Hepatitis B. This demand led to an unprecedented demand for NRL gloves, which was met by changes in some manufacturers' practice (i.e. high protein [allergen] examination gloves coming onto the market place) and is believed to be the primary cause of the increased number of healthcare workers with NRL allergy. At the same time there has been an unrelated and dramatic rise in incidence of atopic allergic disease in the past 30 years, which is also thought to be a major factor.

Who is most at risk?
- Healthcare workers (some studies have reported that up to 17% are at risk of reactions to NRL)
- Individuals undergoing multiple surgical procedures (some studies have reported that up to 65% of Spina Bifida children are sensitised to NRL)
- Individuals with a history of certain food allergies, such as banana, avocado, kiwi and chestnut
- Individuals with atopic allergic disease (estimated at some 30 - 40% of the UK population)
- Individuals exposed to NRL on a regular basis e.g. workers in the car mechanics, catering and electronics trades

Around 1-6 % of the general population is thought to be potentially sensitised to NRL although not all sensitised individuals develop symptoms.

Are all latex allergies the same?

There are two Types of allergy related to natural rubber latex, one caused by the natural proteins, the other by chemicals that are used to convert the NRL to a usable item. They are respectively called Type I and Type IV allergy.

Some people may experience an irritant reaction when using products made from natural rubber latex, which is known as irritant contact dermatitis. This is not, however, a true allergy.

Type IV allergy

Some people react to the chemicals used in the manufacturing process, mostly accelerators. The chemicals most likely to cause a reaction are thiurams, dithiocarbamates and mercaptobenzothiazoles (MBT). This is a delayed hypersensitivity reaction which occurs 6 - 48 hours post-exposure.

Symptoms of Type IV allergy

☐ Red itchy scaly rash, often localised to the area of use, i.e. wrists and forearms with glove use, but which may spread to other areas

Management of Type IV allergy

Occupational Health or medical advice should be sought and avoidance of the specific chemicals in future use.

Type 1 allergy
- Type I natural rubber latex allergy is an immediate allergic reaction to NRL proteins and is potentially life threatening.
- Deaths have occasionally been reported due to latex allergy.

Symptoms of Type I allergy
- Urticaria (hives) and hay fever Type symptoms, asthma.
- Though rare, more severe symptoms such as anaphylaxis (a condition where there is a severe drop in blood pressure leading to possible loss of consciousness or severe breathing difficulty)

Months or even years of exposure without symptoms may precede onset of clinical symptoms of Type 1 NRL allergy. In many cases symptoms become progressively more severe on repeated exposure to NRL allergens, so it is important for sensitised individuals to avoid further contact with NRL proteins.

NRL allergens attach to corn starch used in powdered gloves. This powder acts as a vehicle making the NRL proteins airborne when these gloves are used, enabling the allergens to be inhaled. This means that NRL allergic individuals may experience symptoms of an allergic reaction, by being in a room where powdered NRL gloves are used even though they are not in contact with these gloves directly.

Management of Type 1 allergy

Avoidance of the allergen is the best treatment option. There is no cure for NRL allergy, but medications are available to treat symptoms of NRL allergy once it develops.

Natural rubber is found in many thousands of consumer and medical products. There are two Types of natural rubber products. Dipped or stretchy NRL products (e.g. gloves, balloons, condoms, rubber bands) are a more frequent cause of allergic reactions to latex proteins than dry rubber products (e.g. tyres, tubing). Reactions to dry rubber products are less common and only experienced by severely sensitised individuals.

How are allergies diagnosed?

There is currently no completely reliable investigation for Type 1 NRL allergy, and diagnostic practice varies across the country. In general, the diagnosis is made on the basis of clinical history plus either positive allergen specific IgE blood test or skin prick / glove challenge test. Type IV allergy is diagnosed by standard patch testing.

Use of Medical equipment.

Many items contain NRL but are often not usually labelled to warn of NRL content. Because a much more serious reaction may occur when these items contact internal body surfaces, e.g. mucosal, parenteral and serosal contact, it is very important for sensitised patients to inform healthcare providers of their allergy so that only NRL-free medical equipment is used.

How can sensitised individuals avoid NRL?

- Avoid contact with NRL gloves or products where possible
- Inform employers and healthcare providers of NRL allergy
- Avoid areas where inhalation of powder from NRL gloves worn by others or from balloon displays may occur
- Recommend use of Medic-Alert bracelet, stating natural rubber latex allergy

How is NRL used?

Gloves are the single most widely used device containing natural rubber latex. The Health and Safety Executive has stated that, "Single use disposable natural rubber latex gloves may be used where a risk assessment has identified them as necessary. When they are used they must be low-protein and powder-free".

In many situations a risk-assessment will suggest that in the presence of a risk of bloodborne pathogen transmission, for example surgery and body fluid contact, NRL is the safest choice of material provided the worker and patient are not sensitised to this. If a person is sensitised to NRL proteins, NRL-free gloves and equipment must be used.

Not all NRL-free gloves afford the same protection against blood-borne pathogens so care must be taken in the choice of substitutes. Some gloves may only be suitable for nonclinical tasks as they may not afford the same level of protection against transmission of blood-borne pathogens. If there is doubt suppliers can be asked to provide test data proving the glove's suitability.

NRL gloves are also often used in catering, domestic services, motor industry, hairdressing and other professions and trades where, if there is no contact with blood or body fluids, they should be substituted by an alternative non-latex product.

Why use NRL?

NRL is a widely used and cost-effective material, which for the majority of the population is not a clinical risk. The importance of risk-assessment is to make an informed decision as to whether an alternative is effective for the task.

NRL has many benefits which are yet to be equalled where there is a requirement for specific tactility and dexterity qualities, for example in surgical practice. Where it is used, the gloves must be low protein (<50mcg/g) and powder free.

Products containing NRL

There are many medical and consumer products that contain natural rubber latex. Healthcare providers must ensure that latex-free medical supplies are available for use on or by sensitised individuals. Here are some examples of products that may contain natural rubber latex:

Medical Equipment

Examination and Surgical gloves	Dental dams
Oral and Nasal airways	Wound drains
Endotracheal tubes	Anaesthesia masks
Intravenous tubing	Blood pressure cuffs
Surgical masks	Syringes
Rubber aprons	Stethoscopes
Catheters	Tourniquets
Injection ports	Electrode pads
Bungs and needle sheaths on medicines	
Consumer items	
Erasers	Rubber bands
Balloons	Condoms
Contraceptive Cap	Hot water bottles*
Baby teats	Swimming cap and goggles
Stress balls	Carpets
Washing-up gloves	Tyres *
Adhesives	Shoe soles*
Underwear elastic	Calculator/remote control buttons
Sports equipment (e.g. hand grips and gym mats)	* dry rubber

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30th January 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR DISCUSSION

1. PURPOSE

This paper is to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on the 16th January 2024.

2. BACKGROUND

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

3. **HIGHLIGHTS FROM THE MEETING HELD ON 16th JANUARY 2024**

3.1 *Triangulated themes*

The following triangulated themes were identified:

- Increasing demand on both divisions and complexity with delivery being impacted by workforce deficits / challenges

Eg PERFORMANCE

- WOD initiatives - Impact / outcome on KPIs
- Operational and workforce issues / incidents
- Agency / bank – access and use of for small teams / high vacancy areas
- Establishment reviews
- Incidents – themes / lessons learnt

3.2 *Further Information*

Board members who are not members of the Committee and require further detail are able to access the agenda and papers for the November 2023 Quality, Safety & Performance Committee meeting at: https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-committee-2023/public-quality-safety-performance-committee-16012024/

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	**Workforce Supply and Shape & Associated Finance Risks** The Committee discussed in detail the workforce supply and shape paper that provided an overview of the key workforce risks and the actions and interventions being undertaken to mitigate these. The risks were: - Recruitment and retention - Service and workforce planning - Keeping our valued staff and supporting wellbeing

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A recruitment & retention and workforce planning audit has been undertaken, one recommendation was for the Trust's People Strategy to be communicated more widely and this has been actioned through a number of communication events and regular newsletters. Robust monitoring is in place via monthly Workforce and Organisational Development dashboard reporting to senior leadership teams to highlight any issues around recruitment and retention, vacancies and turnover are regularly monitored and hotspots focused on accordingly.

- Assurance was provided that the Trust is designing its workforce around patient/donor needs and not using nonregistered nurses as substitutes. This is being closely overseen through the 6-monthly establishment reviews.
- The Committee requested (in line with recent audit reports) that reports to QSP focus on the outcomes/ impact made from the range of initiatives that are clearly in place.

Speaking Up Safely Framework – Implementation Update

The Committee received the paper which gives an update into implementation of the Speaking Up Safely Framework, part of the Trust's key strategic driver towards a Healthy and Engaged Workforce. Following a self-assessment against the Welsh Government Speaking Up Safely Framework some gaps in delivery were identified, particularly in the following areas:

- Communication
- Processes
- Governance around Speaking up Safely

A programme of work and action plans had subsequently been developed and agreed at Executive Management Board to reduce these gaps and mitigate any associated risks.

Finance Report for the period ended 31st November 2023

The Committee received the Finance Report which outlines the financial position and performance for the period to the end of November 2023. The following was highlighted:

- Financial targets - the three KPIs are still forecasting a revenue breakeven position. Public sector performance is well above the targeted 95% with anticipation of sustaining this, and the Capital

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expenditure limit is expected to be brought within the expenditure budget although Welsh Government approval of funding the new Velindre Cancer Centre (nVCC) project costs is awaited.

- A risk was identified in the Integrated Medium-Term Plan which suggested that the growth in activity levels may not be sufficient to cover the costs of the investment made in the additional capacity, however November activity performance and associated marginal income more than covers the £3.5M invested in the additional capacity and a small amount of headroom for further investment is anticipated.
- Investment Support - £2M of additional cost savings to be delivered by the end of the year to provide financial support re the all-Wales NHS financial pressures, alongside the £1.8M savings target previously signed off as part of the IMTP Financial Plan which is also anticipated to be fully delivered.

With regards to the £500K emergency reserve which the Trust has not needed to draw on this year due to other non-recurrent funding, the Committee **ENDORSED** for Board approval the option that any reserves not required to deliver the Trust revenue breakeven position may be offered to support the NHS Wales position on a non-recurrent basis.

Welsh Blood Service (WBS) Quality, Safety & Performance Report

The WBS Quality, Safety and Performance report which gives details of activity for the period August to November 2023 was discussed in detail. The following was highlighted:

- Supply chain - the Service has experienced a difficult, almost unprecedented period, particularly during November, with 10% sickness, vacancies and the need to train a number of cohorts of staff which has significantly affected capacity. This resulted in Blue Alert being declared for blood group o negative that has been in place for six weeks.

Mutual aid was sought from Northern Ireland and NHS BT. The Committee were advised of UK-wide challenges and the mitigating actions were outlined.

Formal thanks were extended to all WBS staff across for their additional support during this particularly difficult period.

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- The Summary of incidents reported to the Medicines and Healthcare products Regulatory Agency (MHRA) was discussed. Four of the ten reported instances were one-off incidents, however six were related to issues around donor screening. This is a national trend across all UK blood services and discussions are being held at national level to look at how the screening criteria could be presented in a different, more logical manner. A full root cause analysis of each has been undertaken.

Integrated Quality & Safety Group Highlight Report

The Integrated Quality & Safety Group highlight report covered the outcomes and activities of the group up to the 19th December 2023. The following was highlighted:

- Mortality Governance - the Trust is meeting its legislative responsibilities in relation to reviewing inpatient mortality. There remain data validity issues preventing robust mortality metric monitoring, the digital team are actively working to resolve this. In addition, work is underway following external benchmarking to agree mechanisms for reviewing post SACT and Radiotherapy deaths.
- A good number of Quality & Safety Framework actions have been delivered. Some have been delayed and the Committee had oversight of revised delivery dates. An external peer review of the framework has been undertaken and the outcome will inform the framework refresh.
- There remains work to do in respect of the Quality & Safety Tracker to be able to provide robust assurance in respect of delivery of all Quality and Safety related actions. Targeted work is required in respect of the Brachytherapy Peer review improvement plan. The Committee were advised that this work was being progressed.

The Committee discussed the *Cancer Service Patient Administration and Process Improvement Plan*, which summarises the high-level improvement actions being undertaken to address the five patient administrative process themes that have been identified through analysis of incidents and concerns:
- Patient referral processes
- SACT Booking
- General Booking Processes
- GP/patient letters post appointment.
- Response to patient telephone calls into Velindre Cancer Service

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The Committee were advised that there are detailed action plans behind each section of the high level action plan shared with the Committee.

Trust Infection Prevention Management Group (IPCMG) Highlight Report

The IPCMG highlight report from the meeting held on the 6th December 2023 was discussed and the following highlighted:

- There has been a 100% increase in Klebsiella Bacteraemia cases compared to the same period in 2022/2023. A look back exercise and genomics confirm that there are no links between any of these cases.
- The Group had oversight of the unresolved Infection Prevention & Control and decontamination issues in respect of the new Velindre Cancer Centre design. The Group will continue to have oversight of these matters and escalate if required.
- Bare Below the Elbow - The compliance with staff in uniform/staff in clinical areas being consistently bare below elbows was highlighted. Targeted and general communications have been undertaken and the role of managers to reinforce standards reinforced.

Nurse Staffing Levels (Wales) Act 6-Month Report

The Committee received the 6-month report which provides assurance to the Committee in relation to how the Trust is meeting its responsibilities the Nurse Staffing Levels (Wales) Act. Attention was drawn to the detailed information around Sections 25A and 25B. The following was highlighted:

- The Trust is meeting the legislative requirements in respect of the establishment within the 25B ward (first floor ward). There was no impact on patients due to staffing levels on the ward. .

- Three 25A areas do not have the required 26.9% headroom built into establishments which is affecting ability of staff to receive required training and impacts on patient care delivery during periods of absence (SACT, Clinical Nurse Specialist Team & Assessment Unit). These are being actively reviewed currently and will feature in the 2024 IMTP.

The Committee **ENDORSED** the paper and the need to review the establishment of the 25A areas detailed.

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ASSURE	**Digital Risks Overview** The Committee received a detailed overview of digital risks and how these are being managed/mitigated, in particular the risks associated with legacy systems. The recently appointed Head of Data and Insight brings a wealth of experience and will be an important addition to our capacity, capability and knowledge. The need to further map through the clinical digital risks was highlighted. **Freedom of Information Act/Environmental Information Regulation Report Quarter 1 to 3 2023/2024** The report identified overall compliance with requests of 73.75%. Compliance has recently improved following the appointment of a permanent Freedom of Information and Compliance Officer. The Committee were assured that in the majority of cases the delay beyond response deadline was only 2-3 days and improved compliance in line with the latest month (within the report) are now anticipated to continue. There were exemptions applied for 44% of requests. The reason for each was detailed. It was agreed that benchmark against other organisations would be undertaken. **Trust Risk Register** The Committee received the Risk Register Report, the structure of which has changed significantly following feedback from this Committee and other Trust governance fora. The Committee advised that positive changes had been made resulting in positive assurance. Progress against Risk 3215 was discussed. The Committee noted that although the action was proposed to be closed, the Executive Management Board had requested it remain open until further assurance of compliance with all required standards is received. The associated action plan is to be reviewed by the Executive Management Board prior to resubmission to the March QSP Committee. **Trust Assurance Framework** The updated Trust Assurance Framework (TAF) which contained the eight agreed strategic risks was discussed in detail. It was the first time that TAF07 and TAF08 had been received by the Committee.

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- TAF07: although significant work had been undertaken, further refinement is required including mapping current Datix risks into submission and strengthening actions. This will be completed in advance of the Board in January.

- TAF08: Picks up the broader financial risk that includes the longer-term financial situation across the NHS and risks this poses to the Trust and the Value Based Healthcare agenda.

The Committee subsequently **ENDORSED** the Trust Assurance Framework for Trust Board approval pending further development of TAF07.

Trust Performance Management Framework Report and Supporting Analysis - November 2023/24
The Committee received the paper which reports on the Trust's performance for the month of November 2023. The following key points were noted:

VCS
- Consistency of performance against targets in Radiotherapy remains despite fragility of equipment and workforce challenges. Equipment utilisation continues to be high and continued improvements can be seen as a result of moving through IRS (Integrated Radiotherapy Solution) implementation.
- SACT delivery remains a challenge, primarily linked to pharmacy capacity to support chemotherapy treatment. Work being undertaken with both the pharmacy and nursing teams to look at options available to support an increase in capacity as quickly as possible.
- There has been little patient impact as a result of the recent industrial action due to the hard work and support provided by all departments. Some activity was displaced.
- SACT data: six patients had waited for more than 28 days and two patients waited more than 36 days. The Committee was assured by the Director of Velindre Cancer Service that a harm review process has been undertaken alongside a daily prioritisation process to ensure that all patients are seen within an appropriate clinically required timescale.
- Patient experience feedback: the current two different ways of capturing feedback (short friends and family and longer national survey) was discussed and both had satisfaction levels below 95% target. The Committee were advised that the areas with lowest

	satisfaction rates were SACT appointments, general appointments and waiting times. Improvement work is underway in respect of outpatients and SACT booking. • There had been a seven-point improvement in the SPC chart on patient falls. Assurance was provided in respect of the falls reduction improvements that had been made through the monthly falls Scrutiny Panel, including work to ensure appropriate risk assessments and fall reduction plans are in place. **Welsh Blood Service Performance Report** • All quality and safety measures are within tolerance. • Satisfaction remains consistently high for the service. • Efficiency markers very good. SPC charts show consistent improvement in red blood cell wastage and positive performance in terms of platelets.
INFORM	**Welsh Blood Service (WBS) - Donor Story** The Committee received a video story that provided some insight into some of the actions being taken at WBS to recruit 4000 new bone marrow donors, including: • Patient engagement • Community outreach • Interacting with key groups • Structured pathways **Recruitment and Retention Audit and Action Plan** The paper outlined the four recommendations made following an Internal Audit of recruitment and retention: • Developing an implementation plan for the People Strategy - been completed and is moving through the appropriate governance cycle. • Communication of the strategy through the Trust - as part of the Trust-wide enabling strategies, the People strategy is subject to the existing communication mechanisms in place since the latter part of 2023. • Performance measures and effectiveness of recruitment and retention initiatives - Further work required to determine these.

	Trust Policies for Approval
	The following policies were **APPROVED** by the Committee:
	Health and Safety Policies • Management of Violence & Aggression Policy • Safe Use of Display Screen Equipment (DSE) Policy • Safer Manual Handling Policy • Control of Substances Hazardous to Health (COSHH) Policy • Policy for Management of Latex and Latex Allergy
	Trust Policies for Endorsement
	The following policies were **ENDORSED** by the Committee:
	Organisational Development & Workforce Policies • All Wales NHS Dress Code • Annual Leave Policy • Redundancy and Security of Employment Policy • Recruitment and Selection Policy
	Future Committee Cycle of Business
	It was agreed that a full review of the Committee's cycle of business was required to ensure the Committee is as effective as possible. Committee members were all asked to inform this review and identify the opportunities the Integrated Quality & Safety Group provides by further amalgamating reporting through to the Committee.
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 16th January 2024.

TRUST BOARD

AUDIT COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30/01/2024

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, Acting Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
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1. **PURPOSE**

   This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 19 December 2023.

   Key highlights from the meeting are reported in Section 2.

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

1

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Audit Committee held on the 19 December 2023:

ALERT / ESCALATE	There was nothing to be alerted or escalated to Trust Board.
ADVISE	**TRUST ASSURANCE FRAMEWORK** The Committee **NOTED** the Trust assurance Framework. The Committee discussed that it would be helpful to have time at a Board Development Session to focus on strategic objectives included in the Integrated Medium-Term Plan (IMTP) and the mapping process across to the TAF. The Committee felt there should be discussions at Board to pick up Strategic objectives, the Integrated Medium-Term Plan (IMTP) and Strategic risks and how they all map across to each other and then the Trust Assurance Framework. **AUDIT ACTION TRACKER** The AUDIT Committee **AGREED** the requested extension dates and **AGREED** to formally closing the 17 green/complete actions and these being changed to blue status. **AUDIT POSITION UPDATE:** The Committee were informed that the 2022-2023 audit work was complete in terms of the Trust accounts and in the New Year, Audit Wales will be contacting Officers in relation to the 2023-2024 audit. Audit Wales are currently undertaking the audit of charity fund accounts and are on track to compete that work by the end of January 2024. The Audit Plan will be taken to the Charitable Funds Committee in January 2024 at the same time as the accounts audit report. **2023/24 INTERNAL AUDIT PROGRESS UPDATE:** The Committee **NOTED** the report and **AGREED** to the cancelling of the nVCC Enabling Works 2023/2024 audit as there was still work continuing on the 2022/2023 audit on the same issue.
ASSURE	**TRUST RISK REGISTER** The 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 the on-going developments of the Trust's risk framework. The Committee were assured that if the risks are below 12 or 15, they are being managed through the overall Trust Risk Management Framework approach making sure risks are identified at the appropriate level of management as part of the normal review and monitoring process. The Committee recognised that the update format was helpful with the ongoing management of the Risk Register, now giving updates and likely timescales to reduce the risk score.
INFORM	**INTERNAL AUDIT REPORTS** The Committee received the following internal audit reports, all of which reported a reasonable level of assurance: • Continuity Audit Report • Recruitment & Retention Audit Report

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	• nVCC Approvals Audit Report • nVCC Panning Audit Report **OTHER BUSINESS:** The Committee received an oral update on the Private Patient agenda items and agreed that a comprehensive plan should be prepared in relation to Private Patient services which would be presented at an extraordinary Audit Committee meeting, which should take place ahead of the next scheduled Audit Committee meeting. The Committee also received written reports under the following agenda items: • Counter Fraud Progress Report Quarter 2 23/24 • Losses and Special Payments Report • Procurement Compliance Report The Committee **APPROVED** the Capital Management Procedure.
APPENDICES	**NONE**

3. RECOMMENDATION

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

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

<table>
<tr><td colspan="2" align="center">**TRUST BOARD**</td></tr>
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<tr><td colspan="2" align="center">**HIGHLIGHT REPORT FROM THE CHAIR OF THE
STRATEGIC DEVELOPMENT COMMITTEE**</td></tr>
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DATE OF MEETING	30/01/2024

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

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
		Choose an item.

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee 18th January 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	There were no items identified to advise the Trust Board.
ASSURE	**2.1 Trust Values** The Committee received an updated paper, proposing a refreshed set of organisational values designed to complement Destination 2033. Once adopted, these will shape how people act in the course of their work and be the foundation for people policies and practices. A structured programme of engagement and dialogue with stakeholders took place in two phases, July to October 2022 and August to November 2023, leading to a discussion at a Board Development Session on 20th December 2023. Taking account of the feelings and ideas gathered during this engagement, including the views of the Trust Board, the proposed values were further refined. These were then considered at Executive Management Board on the 2nd January 2024, followed by a further Board Briefing Session on the 11th January 2024 during which Board Members agreed on the final versions of the values and supporting statements. Following consideration of the paper, the Strategic Development Committee **Endorsed** the Trust Values for Trust Board approval. **3.1 Integrated Medium Term Plan – Update** Formal guidance has been received from Welsh Government which is being worked through with colleagues. Allocation letters have been received. Draft versions of service plans have been received from Welsh Blood Service and Velindre Cancer Services. These are being worked through with support functions with particular focus on digital capability issues. The quality impact assessments are being developed. These will be brought through Executive Management Board for review.

	A financial plan is being developed alongside the service priorities. There will be a constraint of what additional funding is allocated from our commissioners. The Strategic Development Committee **NOTED** the Integrated Medium Term Plan update. **4.1 Trust Assurance Framework** The Trust Assurance Framework was endorsed at Quality, Safety and Performance Committee on Tuesday 16th January subject to the comments circulated by Vicky Morris, Independent Member via email. It was agreed for Lauren Fear to circulate the email with comments from Vicky Morris with an PDF version of the Trust Assurance Framework as not all colleagues attend Quality, Safety and Performance Committee. It was confirmed, the Trust Board on 30th January will be given the opportunity to review and approve all eight risks as part of the Trust Assurance Framework. Due to an administration delay, the Strategic Development Committee have not had adequate time to review the Trust Assurance Framework fully. Subject to the comments circulated by Vicky Morris the Strategic Development Committee **ENDORSED** the Trust Assurance Framework.
INFORM	There were no items to inform the Trust Board.
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30/01/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
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1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Charitable Funds Committee at its Public meeting held on the 12th December 2023.

Key highlights from the meeting are reported in Section 2.

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

1

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Charitable Funds Committee (CFC) held on the 12th December 2023:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**FUNDRAISING CASE STUDY – CRAIG MAXWELL, VIEW FROM A FUNDRAISER** The Committee received a presentation from Craig Maxwell who is Tenby-born and a former WRU Commercial Director. Craig Maxwell has had a terminal cancer diagnosis and is currently undergoing trial treatment. The Committee were informed by Craig Maxwell of how Velindre Trust has helped give himself, his wife and children purpose and hope, and expressed the amazing support received form the Fundraising Team. The Committee noted that Craig plans to complete a 780mile Wales coastal walk with celebrities during February 2024 which will run for 26 days from Chester to the Principality Stadium for the Wales versus France Game, and the Welsh Rugby Union are providing the match ball to accompany Craig on the walk, and will then run a Principality Stadium event later in the year. The Committee expressed that they were inspired by Craigs journey and the work he is doing to raise funds to support cancer care in Wales. **FUNDRAISING** The Committee **NOTED** the following: • The recruitment to three posts within the Fundraising Team and that the Team is working well together, with remaining vacant posts being recruited to. • Morocco Trek cancelled due to impact of earthquake and reset for July 2024. • Rhod Gilbert comedy event was very successful, just waiting for the final evaluation. • France bike ride successful, lessons to learn from some event delivery issues, currently undertaking an evaluation. • Key West bike ride is full, and the Charity President is likely to take part. • Patagonia Trek now full, with a list of 20 reserves. • Wear Red campaign being arranged. • Christmas messages, thank you messages to staff and fundraisers will run up to Christmas Eve. • Legacies received to date are £960,000, with a further £550,000 due this financial year and one legacy still to legally process. • Terms and Conditions for Challenge Events have been updated and are being reviewed by legal advisors to assess if they are fit for purpose.

2

- All Charitable Funds Committee Policies have passed their review dates. These Policies remain extant, and the CFC will go through a review cycle going forward.

The Committee **SUPPORTED** renewal of the NHS Charities Together Membership for one year which will now incur a small fee of c£3.6k, during which the benefits and value would be reviewed.

FINANCIAL POSITION

The Charitable Funds Committee **NOTED** the financial performance of the Charity for the period ending 31st October and the current position and performance of the Charity's investment portfolio as at 31st October 2023.

Income, Expenditure, Funds & Investment Performance:
- Income for period ending 31 October totalled c£2.978 million.
- £525k of the overachievement is against unrestricted funds and primary driver of the overachievement is the £300k funding drawn down from Moondance for Advancing Radiotherapy Cymru (ARC).
- Expenditure position is lower than planned at £1.296 million for period ending October.
- Significant proportion of the slippage relates to the RD&I Integrated bid of roughly £720k and slippage against the Advancing Radiotherapy Fund (ARF) of £247k.
- Indicative forecast for overhead cost is £188k, roughly a £52,000 reduction to the plan due to the in-year vacancy of the Charity Director post.
- Funds held at 31 October have increased to £10.004 million.
- Expecting net income £377k. Expecting an out turn fund balance £10.213 million.
- The overall value of the investment portfolio has fallen by about 12.85%. The Fund investment strategy is designed to provide long term growth in value, so expect the Investment value to recover in the future.
- Holding cash balances £4.442 million.
- Onboarding with new Investment Managers is currently progressing and when complete will discuss potential cash management options. Expecting the return on cash held to be roughly 5%.

Reserve Policy:
- The Trust is currently overachieving by about £4.593 million against the target reserve. This is expected to reduce over next few years with significant commitments made being implemented.

Forecast Commitments:
- Target reserve at March 2024 is expected to be about £2.356 million with an expected over performance of about 1.8 times that value. Should have a balance of about £4.2-4.3 million.

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- 2025/2026 reserve balance expected to shrink £2.644 million.
- £1.5 million reduced charge is expected to be drawn next financial year.

Investments:
The Committee were advised that the Charitable Investment Performance Review Sub Committee has discussed the investment performance in some detail with its Advisors. The next meeting is due to be held in February 2024.

Under the revised delegated financial limits from £5k up to £25k the CEO and Finance Director committed expenditure between the two Committee meetings on one order relating to an approved Event for £5,600.

BUSINESS CASE AND EXPENDITURE PROPOSALS
The Committee **APPROVED** one Business Case and Expenditure proposal:

- **Update on Implementing the Cancer R&D Ambitions – An Integrated Business Case 2023-2026 –including an overview of recruitment and request for funding arrangements.**

The Charitable Funds Committee **APPROVED** the proposed change of the funding timing in relation to the Clinical PhD in Precision Oncology post for which 50% funding was included in the approved RD&I bid and 50% funding from the Stepping Stone Fund. The timeframe of the agreed RD&I funding doesn't align with the PhD post term which runs until October 2026. The Committee agreed with the plan to draw money from the Charitable Funds first to cover 100% of the costs and then from the Stepping Stone Funds for 100% of costs in the later period to make sure funds continue to the October 2026 deadline.

BUSINESS CASE ANNUAL EVALUATIONS
The Charitable Funds Committee **APPROVED one** Business Case Annual Evaluation:

- **2021-05 Building Capacity in Research through the establishment of a small grants scheme**

The Committee were content with the outcomes achieved.

The Committee requested the two applicants who were not able to take up the research opportunity due to workforce pressures should be asked to resubmit their bids. The Charity in the new calendar year, following discussion with the Division SLT.

4

	APPROVED BUSINESS CASE – NON STARTER REVIEW • **2023-17 Business Case for Co-Funding (25%) of a Clinical Research Fellow (Brain Radiotherapy) from the Headfirst Appeal/Brain Research Sub Fund** The Committee **APPROVED** the non-starter review on the funding for this post which has not been used within the timeframe and noted that work is being undertaken to agree the best way to use the funds for a different post. Once a Job Description for a different post has been finalised this will come through the Charitable Funds Committee as a new funding request. **WIG SERVICE AND SOP PRESENTATION** The Committee **AGREED** to sign-up to the All-Wales wig Contract and with reference to the paper presented to the Committee previously by Steve Coliandris that this will be funded going forward fully from Charitable Funds so that VAT exemption will apply.
ASSURE	There were no items required to report for assurance to the Trust Board.
INFORM	The Committee would like to inform Trust Board on the items below: The Committee **APPROVED** the Charitable Funds Policy Review – Scheme of Delegation and Stages for the Purchasing and Authorisation of Goods and Services The Committee **NOTED** the discussions and updates from the Charitable Funds Investment Performance Review Sub Committee. The next Charitable Funds Investment Performance Review Sub-Committee will be held 02 February 2024. The Committee **NOTED** the Noddfa Report and the funds awarded through the NHS Charities Together (Captain Toms) for the scheme to provide a Wellbeing Coordinator and capital expenditure on equipment and furniture.

3. RECOMMENDATION

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

5

TRUST BOARD

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

DATE OF MEETING	30th January 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 23rd November 2023.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Trust Board.
ADVISE	There were no items to advise to the Trust Board.
ASSURE	There were no items to assure to the Trust Board.
INFORM	**TCS Programme Finance Report** The year-to-date spend for the TCS Programme is £11.576m Capital and £0.460m Revenue, with a forecast expenditure for the current financial year of £17.928m Capital and £0.785m Revenue against budgets of £14.778m and £0.744m respectively. It was confirmed the funding for the Full Business Case phase of the nVCC Project for £3.140m has been set aside by Welsh Government. The funding letter will be received soon. It is hoped the finance report for the December TCS Programme Scrutiny Sub-Committee will show a break even position because the funding has been received. The following additional Capital Projects commenced in October 2023: • Advanced Design Development Agreement – Capital funding of £3.882m approved in October 2023 • Whitchurch Hospital Site – Capital funding to be secured from Welsh Government as part of the Enabling Works Full Business Case addendum The TCS Programme Scrutiny Sub-Committee **NOTED** the financial position for the TCS Programme and Associated Projects for 2023-24 as at 31st October 2023. **Programme Director's Report** The TCS Programme Director and TCS Associate Director of Programmes reviewed TCS Programme's current performance for the reporting period 5th October – 9th November 2023 and concluded an **Amber status**.

	There is currently 10-12week delay on the original programme because of the ground issues experienced with the Satellite Radiotherapy Unit. The TCS Programme Scrutiny Sub-Committee **NOTED** the Programme Directors Report.
APPENDICES	None.

TRUST BOARD

**HIGHLIGHT REPORT FROM THE CHAIR OF THE
LOCAL PARTNERSHIP FORUM**

DATE OF MEETING	30.01.2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Sarah Morley, Executive Director of OD and Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	
LPF	Local Partnership Forum
SLT	Senior Leadership Team
VCC	Velindre Cancer Centre
OCP	Organisational Change Policy
WBS	Welsh Blood Service
RCN	Royal Collage of Nursing

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 19th December 2023.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to escalate
ADVISE	Nothing to advise
ASSURE	Nothing to assure
INFORM	**Workforce Performance Report** The Local Partnership Forum received an update on the details highlighted by the Workforce Performance Report, of note in the report was the Trust's intention to meet an interim internal Trust target, as the national target of 3.54%, set by Welsh Government, cannot be changed not met in the short term due to the challenging operational context.Hotspot areas in the Trust have been highlighted, the Workforce Team are working with managers to address any issues. **Partnership Working and Next Steps for Recruitment** The Local Partnership Forum noted an update in respect of the Social Partnership and Procurement Act and the recruitment, as agreed with Trade Union colleagues, to appoint to the role. The job description is in development, and will strengthen partnership work. The Executive Management Board will support the approach and it is anticipated that trade union colleagues will assist in partnership to jointly recruiting to the role.

International Recruitment

The Local Partnership Forum noted the update in respect of international recruitment being run by NWSSP. There are continuing gaps of around 20% in nursing, which the Trust has not been able to recruit to and therefore has undertaken recruitment internationally.

The Trust has been successful in recruiting 15 whole time equivalent nursing staff, some of who are oncology trained. The Workforce Team are working on cultural induction and support for international recruits. The new recruits will start in February 2024 to start OSCE training

Speaking Up Safely

The Local Partnership received an update on the Speaking Up Safely work, which is a key strategic driver to develop a healthy and engaged workforce, looking to develop a culture in the Trust to speak up safely, ensuring psychological safety. Staff engagement and feedback are key to the success of this work.

Trust Values Project

An update was shared with the Local Partnership Forum detailing that 500 people have contributed to the engagement programme, including patients and donors. The work is concluding and will be fed through the Speaking Up Safely work programme.

Staff Survey

The Local Partnership Forum were informed that the response rate in the Trust for the staff survey was 34% response rate, which was higher than the 20% response rate nationally. Final Trust results will be available in February 2024.

Development and Retention Plan

The Local Partnership Forum were informed that as part of the non-pay deal agreed there were some elements around Trust retention plans and retention as a whole. An All Wales Nurse Retention plan has been established and an appointment has been made into lead nurse retention role. This work will be rolled out and expanded to other areas of work, beyond nursing.

APPENDICES	

**WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 21 NOVEMBER 2023**

The Welsh Health Specialised Services Committee held its latest public meeting on 21 November 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
[2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)](#)

1. Minutes of Previous Meetings
The minutes of the meetings held on the 19 September 2023 were approved as a true and accurate record of the meeting.

2. Action log & matters arising
Members noted the progress on the actions outlined on the action log.

3. Financial Savings Update
Members received a presentation on **WHSSC's saving plan forecast.**

Members noted the presentation.

4. Draft Integrated Commissioning Plan (ICP)
Members received a report and a presentation offering assurance regarding the development of the 2024/2025 Integrated Commissioning Plan (ICP) and the approach to its development within the wider NHS Wales situational context.

Members noted the report and the presentation.

5. **Chair's** Report
Members received the Chair's Report and noted:
- Chairs Action **– the Chair's Action taken on 25 October 2023 to appoint Mrs Elizabeth Kathleen Abderrahim, as Chair to the WHSSC Individual Patient Funding Request (IPFR) Panel from 1 November 2023 for a period of up to 3 years; and**
- Key Meetings attended.

Members (1) Noted the report, (2) Ratified **the Chair's action taken on 25 October 2023 to appoint Mrs Elizabeth Kathleen Abderrahim, as Chair to the WHSSC Individual Patient Funding Request (IPFR) Panel.**

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

- Cochlear Implant and Bone Conduction Hearing Implant – Update - The Designated Provider process has been initiated to implement the model agreed by the Joint Committee. A letter inviting Expressions of Interest to become the specialist auditory implant device hub with an outreach service was sent to all the Health Boards (HBs) in the South East Wales, South West Wales and South Powys region in July 2023. WHSSC received two responses: CVUHB submitted an Expression of Interest in becoming the specialist auditory implant device hub with an outreach service; and SBUHB confirmed that they wished to work in partnership with CVUHB to develop the outreach support. The remaining elements of the Designated Provider process are in progress to ensure that the HB is able to meet the service criteria. The results of the full process will be received by the Management Group for scrutiny before a formal recommendation is made to the Joint Committee; and

- Welsh Healthcare Financial Management Association (HFMA) Innovation, Digital & Data Award - Congratulations to James Leaves, Interim Director of Finance, WHSSC and Sandy Tallon, **Head of Information, WHSSC on winning the 'Innovation, Data and Digital' HFMA Wales Branch award in October 2023. James, Sandy** and their teams have been working on the financial costs and effects of the new Cystic Fibrosis drug called 'Kaftrio'. WHSSC were instrumental in arranging for the drug to be prescribed to Welsh patients from the autumn 2020. Digital Health and Care Wales (DHCW) data was used to analyse inpatient, outpatient and emergency attendances of the Kaftrio patient cohort, comparing information before and after their first prescription of the new drug.

Members noted the report.

7. Paediatric Surgery Update
Members received a report which considered the short term and longer term transformational changes for Paediatric Surgery and Paediatric Intensive Care in 2024/25 following a Joint Committee Workshop held on 17 November 2023. The neonatal service issues will be considered in more detail by the Joint Committee in January 2024. The report also made a recommendation to continue outsourcing paediatric surgery in **2023/24 (previously included in WHSSC's Financial Improvement** Options).

Members (1) Noted the report and the steps taken to date,
(2) Approved the continued outsourcing of paediatric surgery cases in 2023/24, (3) Did not Support the principle of outsourcing the backlog of patients in 2024/25 to support a waiting list position of 36 weeks, with

the detail to be considered in the agreement of the WHSSC Integrated Commissioning Plan (ICP) 2024/25, but did support the ambition to do so; and (4) Supported the transformational programme of work for paediatric surgery and paediatric intensive care for inclusion in the WHSSC ICP 2024/25.

8. Individual Patient Funding Request Policy (IPFR) and WHSSC Terms of Reference (TOR)

Members received a report presenting the outcomes from the engagement process with key stakeholders to review the All Wales Individual Patient Funding Request (IPFR) Policy and to seek support for the proposed changes to the policy prior to being shared with Health Boards for final approval. The updated WHSSC IPFR Terms of Reference (ToR) were also presented for approval.

Members (1) Noted the report, (2) Noted the feedback from the WHSSC IPFR engagement process with key stakeholders, (3) Supported the proposed changes to the All Wales IPFR Policy prior to being submitted to each Health Board (HB) for final approval, (4) Noted that the proposed changes in the revised Policy have been developed jointly by the Policy Implementation Group and WHSSC, and have taken into consideration, where appropriate, the comments and suggestions received from the Kings Counsel (KC), (5) Noted that once the revised policy has been approved by the Health Boards (HBs) it will be shared with Welsh Government prior to adoption, (6) Noted that a Task & Finish Group have discussed and agreed some further updates to the WHSSC ToR; and (7) Approved the proposed changes to the WHSSC IPFR Panel ToR.

9. Delivery and Assurance Commissioning Arrangements for Operational Delivery Networks

Members received a report proposing revised arrangements for commissioning, performance management and delivery assurance for Operational Delivery Networks (ODNs) commissioned by WHSSC and the respective services where they sit within WHSSC's remit.

Members (1) Noted the report, (2) Approved the revised arrangements for commissioning, performance management and delivery assurance for Operational Delivery Networks (ODNs) commissioned by WHSSC and the respective services where they sit within WHSSC's remit; and (3) Approved the new Terms of Reference (ToR) that have been prepared for the South Wales Trauma Network (SWTN) and the South Wales Spinal Network (SWSN) Delivery Assurance Groups (DAGs).

10. Gender Identity Services for Children and Young People Update

Members received a report providing an update on the progress of the NHS England (NHSE) Transformation programme for gender services for Children and Young People. The report aims to provide an update on the

development of regional services, options for Welsh patients and identify any potential financial risks.

Members (1) Noted the information presented in the report regarding the NHS England Transformation Programme for children and young people with gender incongruence, (2) Noted the mobilisation timescale and the risk of increased waiting times for children and young people as a result, (3) Supported **WHSSC's commissioning position of continuing to work** with NHS England to progress services in line with the recommendations of the Cass Review, (4) Noted the information in the report regarding the financial risks linked to the NHS England mobilisation costs and potential **revised tariff that are likely to present an 'in year' risk to WHSSC in 2024-25**, (5) Supported inclusion of the proposal for funding for the provision of waiting list support in the WHSSC triangulated risk assessment process which will inform the 2024/25 Integrated Commissioning Plan (ICP).

11. Audit Wales – WHSSC Committee Governance Arrangements Update

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

Members (1) Noted the report, (2) Noted the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, (3) Noted the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and (4) Approved the updated audit tracker for submission to Audit Wales and to HB Audit Committees for assurance in early 2024.

12. WHSSC Integrated Performance Report – August 2023

Members received a report providing a summary of the performance of **WHSSC's** commissioned services. Further detail including splits by resident Health Board (HB) was provided in an accompanying Power BI Dashboard report.

Members noted the report.

13. Financial Performance Report – Month 6 2023-2024

Members received the financial performance report setting out the financial position for WHSSC for month 6 2023-2024. The financial position was reported against the 2023-2024 baselines following approval of the 2023-2026 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2023.

The year to date financial position reported at Month 6 for WHSSC was an

underspend against the ICP financial plan of (£5.171m), the forecast year-end position was an underspend of (£9.076m).

Members noted the contents of the report including the year to date financial position and forecast year-end position.
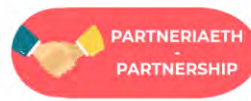
14. Corporate Governance Matters
Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members (1) Noted the report; and (2) Approved the WHSSC Annual Report 2022-2023.

15. 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 (QPSC); and
- Welsh Kidney Network (WKN).

Reporting Committee	Emergency Ambulance Services Committee
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	21 November 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.
An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: https://easc.nhs.wales/the-committee/meetings-and-papers/november-2023/   The minutes were confirmed as an accurate record of the Joint Committee meeting held on 19 September 2023 subject to one updated clarification.   The Welsh Ambulance Services NHS Trust (WAST) provider report at EASC 23/093 (last bullet point). Jason Killens updated the Committee that no decisions had been made and WAST continued to be in discussion with the provider (SALUS) which was expected to conclude in the next week or so. Discussions were progressing well and a more substantial update would be provided at the next meeting.
PATIENT STORY - the first time at an EASC meeting   Professor David Lockey introduced a video with a patient story 'A step too far - Donna's story'.   Members noted: • EMRTS provides a national service with four bases that respond across Wales   • the service is coordinated from the EMRTS Critical Care Hub with each 999 call screened and triaged to identify the need for the highly specialised advanced care provided   • in the patient story, the crew from the nearest base at Caernarfon was already busy and therefore the Welshpool crew came straight to the patient from Ysbyty Gwynedd where they had just handed over a patient   • not all incidents relate to high trauma such as road traffic accidents, this was a fall from standing at home in the garden   • the patient had a severe lower limb open fracture and a fractured arm   • that the triage decision making for resource dispatch was based on the information the public are providing from scene   • the service provided advanced decision making, early antibiotics, advanced analgesia, sedation and a direct flight to definitive care   • the patient was taken to the Stoke Major Trauma Centre for restoration of the blood supply to the limb and for the open fracture to be dealt with, this required orthopaedic and plastic surgery

- the work of the EMRTS Patient Liaison service was identified, which provides support to patients and relatives, including follow-up visits at varying intervals during recovery. The aim of liaison is to provide explanations about what has happened at the scene whilst giving emotional support to both patient and relative. Also, information gained helps to improve the service provided.

Members noted the reduction in terms of hours for the patient to receive definitive care when attended by the service.

The Chair thanked David Lockey for leading the session and reflected on the powerful story about an incident which could happen to anyone.

On behalf of the Committee, the Chair also thanked Donna for sharing her story to help others understand how the service works and explaining the life and limb saving benefits for patients.

PERFORMANCE REPORT

The Performance Report was received which included the Ambulance Service Indicators and the EASC Action Plan. In presenting the report, Stephen Harrhy highlighted a number of key areas. Members noted:
- 999 call volumes in September 2023 were slightly lower than the same period last year but with an increase in the number of incidents responded to
- work to "shift left" as much as possible with hear and treat at a higher rate than the same period last year, with WAST working with colleagues from the Six Goals for Urgent and Emergency Care Programme to progress opportunities identified
- work to re-categorise calls, with some amber calls moving to the red category
- disappointing performance against the 8 minute standard
- amber incidents in September 2023 were 5.6% higher than the same period last year
- the increased acuity of incidents presenting to the system
- the IMTP commitments in terms of ambulance handover delays not being met, with total hours lost increasing since June.

Members agreed:
- the historical data indicated an increased demand to come over the next period which was concerning
- the recent Chief Executive meeting had discussed ensuring WAST had access to any Same Day Emergency Care services across Wales
- the need for WAST staff and Emergency Department staff to continue to work collaboratively, this included access to diagnostic services and ensuring the early release of patients who did not require further treatment
- the need to focus on the role of clinical hubs and progressing the opportunities identified
- to focus efforts on the 4hour red lines, these had increased significantly in some areas
- to monitor the above over the next 6-8 weeks with the EASC Team providing more regular updates including site by site and regional perspectives.

Members noted:
- concern at the level of red calls and the recent increase in these and the variability in the amount of ambulance handover hours lost
- that these increases did not reflect the number of patient admissions
- the importance of SDEC (and access to the services for WAST staff) and other alternatives to ED
- the need to consider what could be done for the large number of elderly people within the population to improve the quality of the service
- the pending Christmas season and the need for preparation of the post-Christmas period
- Cardiff & Vale UHB were a net exporter of ambulance resources to other parts of south east Wales; whilst this was good in terms of patient safety, there was a need to address the balance as patient flow improves
- there was a need to reflect the actions and opportunities being taken across the system in the Integrated Commissioning Action Plan (ICAP) process
- the red incidents verified incidents was shared by Jason Killens – with breathing difficulties increasingly significant in recent weeks and the impact of this on the system
- increased WAST resource hours available across all resource types, more total hours, less overtime, less abstractions and the work undertaken by WAST to sustain higher levels of production in readiness for winter.

Members agreed:
- the increase of red calls relating to breathing difficulties and the need to consider progressing a respiratory plan at pace
- to progress discussions with the Primary Care and the Six Goals for Urgent and Emergency Care National Programmes regarding virtual wards for acute respiratory illness / infection
- to review the work undertaken in England that identified an over-triage rate in relation to respiratory and the opportunity to include conversion to conveyance and admission rates in relation to respiratory red calls
- to consider alternatives to the medical model at the front door, a nurse/therapy model was suggested.
- Stephen Harrhy agreed to send a note following the meeting in relation to the points raised above. This would include the areas for specific focus over the coming months, monitoring and reporting arrangements, the escalation process and use of the ICAP process to coordinate these efforts.

QUALITY AND SAFETY REPORT

The Quality and Safety Report was received. In presenting the report, Stephen Harrhy highlighted the presentation of the revised quality report in light of the requirements of the Duty of Candour and Duty of Quality.

Members noted:
- The WAST plan for complainants to receive a reply within 30 days to improve their performance against the 75% target in coming months
- 7 cases identified by WAST as requiring joint investigation in September 2023
- An increased number of patients were waiting over 12 hours for an ambulance response in September 2023 compared to July and August 2023

- The return of spontaneous circulation (ROSC) rates was 22.1% which was felt to reflect the impact of the CHARU service
- The number of patients that self-presented at ED with a high triage category, with 323 patients self-presenting at a category 1 triage level (concern re missing earlier intervention)
- The Review of Remote Clinical Services; the recommendations had been accepted by WAST and the Review had been presented at EASC Management Group. An implementation plan for the recommendations would be presented at the next EASC Management Group meeting and an update provided at future EASC meeting.

Members raised:
- The timing of the work between WAST and HB colleagues to understand the level of harm within the system and to develop additional processes to assure the Committee, it was confirmed that this would be presented in early 2024.
- The need to work together in order to consider prevention of future death notices received from the HM Coroner and the different approaches of different HM Coroners, this required an all-Wales review and including HM Coroners themselves. The EASC Team would coordinate and present findings to a future meeting of the Committee.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received. Matthew Edwards presented the report and Members noted:
- EASC Commissioning Frameworks – the delay in progressing the development of a long-term strategy for the Non-Emergency Patient Transport Service (NEPTS) Commissioning Framework due to the resourcing requirement of the EMRTS Service Review over recent weeks
- The formal approval of the EASC Integrated Medium Term Plan (IMTP) and the need for quarterly updates against progress
- The progress against each of the IMTP commitments as set out in the IMTP Tracker
- The Quarter 2 Update against the EASC Commissioning Intentions 2023-24 as presented at the EASC Management Group meeting in October.

UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW

The update report on the EMRTS Service Review was received. Lee Leyshon presented the report and gave an overview of work to date in the phased approach.

Noted:
- The second Phase of engagement closed on 12 November 2023 (it had been extended for an additional week)
- A reminder that following receipt of the EMRTS Service Development Proposal in November 2022, Members asked the CASC and the team to undertake further scrutiny of the work.
- In December 2022, it was agreed that the work start afresh led by the Chief Ambulance Services Commissioner (CASC)
- The (then) Community Health Councils (now Llais) asked for a formal engagement process for at least 6 weeks.
- The engagement process has been delivered in three phases

1. Phase 0, from October 2022 to March 2023
2. Phase 1, took 14 weeks, from March 2023 to June 2023
3. Phase 2, which reported back information as promised at the public meetings (in Phase 1). This phase presented factual information and took 5 weeks from 9 October to 12 November 2023 and utilised a number of ways to engage with the public.

- Phase 2 engagement comprised in-person drop-in sessions, in person large public meetings and online or virtual public meetings.
- The in-person sessions and meetings were supported with a comprehensive set of bilingual engagement materials which were available on the EASC Website. These included presentations, FAQs, plain language or easy read versions, and also included the full technical details as requested in Phase 1.
- The large public meetings were held using the same format as Phase 1, the CASC gave a short presentation which gave an overview of the work and then held a comprehensive question and answer session until all present had asked what they needed to
- Phase 2 provided factual information which was not assessed or interpreted – it was stressed throughout the process that no decision had been made, although members of the public were very sceptical about this
- All in-person drop-in sessions had bilingual members of staff present to assist and explain the work to date
- Accessible public venues had been chosen, many high schools with the supporting audio-visual equipment readily available.
- Simultaneous translation into Welsh was provided at every session and the meetings were professionally recorded for note taking purposes
- Meetings took place, led by the CASC with various stakeholders including elected representatives at national, regional and local levels; with staff groups, the Wales Air Ambulance Charity and health board Stakeholder Reference Groups
- Swansea Bay UHB raised concerns in relation to the process followed at the EASC Management Group on 19 October 2023; an initial response had been sent with a follow up meeting planned for late November
- Attendance by CASC at the BCUHB Board meeting on 26 October 2023 and a planned meeting with Powys at the end of November 2023
- Ongoing discussions had taken place with Llais with the approach to Phase 2 discussed in July 2023. Llais staff also attended some of the large meetings and drop-in sessions held
- The public were also asked to evaluate the sessions provided to ensure effectiveness in how the process was delivered
- Communications packs were provided to all health boards and NHS Trusts and Local Authorities in Wales and included the organisers of the social media campaign groups and all media sources
- All media requests had been obliged and statements to all media enquiries made.

Current position and next steps:
- Responses had been provided from members of the public and they were being replied to and themes captured
- The options developed would be shortlisted and assessment undertaken using the previously agreed evaluation Framework.

It was proposed that:
1. EASC Members nominate staff to undertake the assessment of options using the factors and agreed weightings with an aim to provide additional information for the December meeting of EASC.
2. That the recommendation presented to EASC in December would be taken back to respective health boards for individual consideration before a joint Committee decision was made.

Members noted:
- Work was continuing with the All-Wales Communications, Engagement and Service Change leads in health boards; information had also been shared with the Directors of Governance / Board Secretary peer group and updates provided to Llais
- All bilingual information had been updated and managed on the EASC website and regular stakeholder updates were being distributed
- Risks identified included the significant concerns from the public particularly for those living close to the Caernarfon and Welshpool bases
- Emails had been received from Llais notifying that they had concerns about the process although no formal information had yet been received
- The Equality Impact Assessment had been updated, processed by CTMUHB and was available on the website.

Comments from Members included:
- Thanking the CASC and the EASC Team for the substantial work undertaken
- Interest in the position of Llais and would welcome an update at the next meeting
- Welcoming the opportunity to take information back to health boards for further consideration before any decision made at EASC.

The Chair wanted to record that the work to deliver the EMRTS Service Review had taken a lot of time and effort by a small team of staff; the CASC and the EASC Team were thanked for the comprehensive way they had undertaken the formal engagement process and their approach in appearing in front of audiences for many weeks, it was felt that this would pay dividends as the work drew to a close. In terms of the efforts made, it would be hard to say that any views had not been taken fully into consideration.

WELSH AMBULANCE SERVICES NHS TRUST REPORTS

The Welsh Ambulance Services NHS Trust (WAST) Provider Report was received with Members noting that the key headlines of the report had already been covered in earlier discussions.

Jason Killens introduced a presentation on WAST's Integrated Medium Term Plan (IMTP) Ambitions / Strategy. In presenting, Rachel Marsh highlighted a number of key areas.

Members noted:
- Timely to look ahead now, thinking of next year's WAST IMTP and updating and refreshing the WAST strategy document
- Range of ambitions including providing the right care or advice, in the right place, every time
- Patients at the centre
- Series of enablers focussing on staff, innovation and technology and collaboration

- Fundamentals including quality, clinical led and delivering exceptional value
- System pressures driving the need for change and impacting on patient and staff safety
- Innovative staff group, looking to do more
- The WAST offer to transform care and improve the current model
- Partnerships as a fundamental part
- Alignment with Six Goals for Urgent and Emergency Care Programme
- Indicative impact of the changes included in the WAST offer including reduced cancellations, increased closure of more calls; meeting patient needs closer to home, more patients treated at home of referred to community services, protected emergency response for critically ill patients, better staff experience and ultimately more timely service for patients to reduce harm
- The next steps included seeking support from commissioners for pump-prime funding to increase the pace of change; and enablement of the integration of WAST with health board community services to achieve the potential of a once for Wales approach.

Members agreed:
- There was scope to do more outside of the hospital department, this would need to a joined up clinically-led approach and clinically designed. It would also involve digital solutions to ensure the right mechanisms to make the required significant stepped change for the benefit of patients (and staff)
- WAST were heavily involved in the work to develop the 'Safe at Home' model in C&VUHB, there were lots of lessons from this that would be helpful for the system including the use of technology and therefore the need to work closely with digital leads. It was noted that Connected Support Cymru working with Welsh Government and DHCW colleagues could help in this regard
- The need for local buy-in
- To consider how commissioning could enable more of this; a legacy issue for the new NHS Wales Joint Commissioning Committee.

Members noted:
- The WAST meeting with BCUHB Executive Team on Wednesday 22 November 2023 would consider how to progress the potential opportunities and ensure the right structure was in place to facilitate and progress the issues identified. Similar discussions could be arranged with other Executive Teams to consider the more local approach to change
- The importance of a coordinated approach to get the balance correct across the system.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received and was presented by Stephen Harrhy. The report highlighted key areas which included:

- Meetings with Welsh Ambulance Services NHS Trust (WAST)
- Meeting with Health Boards
- Six Goals for Urgent and Emergency Care Programme
- Resource Capacity
- Connected Support Cymru

- Transfer, Discharge and Repatriations
- NEPTS Vision (Strategic Direction)
- Commissioning Intentions 2024-25
- Review of National Commissioning
- Data linking.

Members particularly noted:
- Connected Support Cymru – including the IT requirements and also staff working for St John Cymru who could report back from the scene (when with a patient) and, if unable to access the right community service, develop options to stay with the patient until the service was available. This work would be evaluated and had been extended to the end of March 2024.
- Transfer, Discharge and Repatriation – an appropriate task and finish group would be developed to further this work including ambulance and the Adult Critical Care Transfer Service to develop into the future
- Commissioning Intentions for 2024 would be developed, building on the existing versions but adapting in line with the resource envelope (the same as for health boards) and would work with the 111 Service to ensure a combined arrangement
- The letter from the Welsh Government highlighting the expectation that the functions of the Chief Ambulance Services Commissioner would be including within the structure of the team supporting the new Joint Commissioning Committee.

EASC FINANCIAL PERFORMANCE REPORT MONTH 7 2023/24

The EASC Financial Performance Report at Month 7 in 2023/24 was received. Stacey Taylor presented the report and Members noted no variances within the plan; the position showed £21k underspend. Members noted ongoing work with WAST in relation to ongoing arrangements on recruitment and overtime.

Further discussions would take place with the Welsh Government on financial options and Members recognised the huge opportunities in the new Joint Commissioning Committee to explore further the utilisation of resources and value-based healthcare. Further information would be shared and developed in due course.

SUMMARY OF THE EASC MANAGEMENT GROUP MEETING HELD IN AUGUST 2023

Members noted the Chair's summary of the EASC Management Group meeting which took place on 19 October 2023.

EASC SUB-GROUPS CONFIRMED MINUTES

Approved: EASC Management Group notes 22 June 2023

EASC GOVERNANCE

The report on EASC Governance was received. Gwenan Roberts presented the report and highlighted the following key areas:
- EASC Risk Register
- EASC Assurance Framework

- Closure of the Welsh Language Commissioner investigation
- EASC Key Organisational Contacts
- Assurance Report Audit and Risk Committee at Cwm Taf Morgannwg UHB 24 October 2023.

Noted that:
- The Risk Register had five red risks in total, three scoring the highest level at 25.
- The EASC Assurance Framework had been updated in line with the changes above to the risk register, the framework utilised the host body's risk management approach and assurance framework.
- The Welsh Language Commissioner was satisfied with the approach taken and had closed the investigation
- The latest EASC Key Organisational Contacts report was presented and Members asked to review their organisational representatives at EASC and its sub groups
- The short summary (for assurance) of the latest Audit and Risk Committee meeting which took place on 24 October 2023.

FORWARD LOOK AND ANNUAL BUSINESS PLAN
The Forward Look and Annual Business Plan was received and approved.

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

- Red and amber performance - Note to be sent to capture key issues during the meeting to include the areas for specific focus over the coming months, monitoring and reporting arrangements, the escalation process and use of the ICAP process to coordinate the efforts
- Handover delays (and the monitoring of handover improvement plans in HBs with trajectories) and the impact on services provided to HB local communities and to WAST – through the ICAP process
- In relation to the EMRTS Service Review, EASC Members were asked to nominate staff to undertake the assessment of options using the factors and agreed weightings with an aim to provide additional information for the December meeting of EASC. Anticipated that the recommendation presented to EASC in December would be taken back to respective health boards for individual consideration before a joint Committee decision was made.

Matters requiring Board level consideration

- To acknowledge the continued significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours – especially in relation to the quality of services patients receive
- Output from the EASC meeting in December for further discussion at the Board prior to decision making at EASC.

Forward Work Programme and Annual Business Plan

Considered and agreed by the Committee.

Committee minutes submitted	Yes		No	√
Date of next meeting	21 December 2023			

Reporting Committee	Emergency Ambulance Services Committee
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	21 December 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.
An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: https://easc.nhs.wales/the-committee/current-and-past-papers/december-2023/ The minutes were confirmed as an accurate record of the Joint Committee meeting held on 21 November 2023.
PERFORMANCE REPORT The Performance Report was received which included the latest published Ambulance Service Indicators. In presenting the report, Ross Whitehead highlighted a number of key areas. Members noted: • 999 call volumes in October 2023 were 7.7% lower than October 2022 • 7.4% reduction in incidents in October 2023 compared to October 2022 • Hear and Treat levels were 2.3% higher in October 2023 compared to October 2022 • Red incidents in October 2023 were 7.8% higher compared to October 2022. • Amber incidents in October 2023 were 6.1% higher compared to October 2022. • Ambulance handover lost hours in October 2023 were 19.8% lower compared to October 2022. Some improvements had been made on a number of metrics, % of patient handed over in 15 min and patient handovers over 4 hours had been seen in 2023. However, between September 2023 and October 2023 there had been a 18.4% increase in handover lost hours. Members noted: • Challenging performance picture in October • Progress had been made during the course of the year but finding improvements in performance were still difficult • The growth in red and amber demand • Slightly lower handover delays but the total hours lost was very challenging for health boards and WAST • Impact of funding and overtime on units of hours produced • Discussions also taking place in the wider system and at the NHS Leadership meetings

- Specific requests had been made (of EASC) in relation to the Integrated Commissioning Action Plans (ICAPs):
  - A specific focus on a minimum of two priority actions from HB plans
  - all Members asked to confirm their actions to Stephen Harrhy as soon as possible for coordination
  - common actions to be identified and opportunities for all Wales actions
  - actions to be prioritised locally
  - identification of system indicators to use and add to the EASC Team weekly dashboard for wider sharing.

Members agreed:
- commitment had been given by all at the NHS Leadership Board to ensure these actions were implemented.

Nick Wood, Deputy Chief Executive of NHS Wales reiterated discussions held, and commitments made, at the NHS Wales Leadership Board and the actions from the existing health board ICAPs. The identification of 2 or 3 actions and ensuring the delivery on a consistent basis and the commitment to provide assurance that this was the case. The CEOs or Chief Operating Officers in HBs would be asked for confirmation this and also for confirmation from WAST about the actions detailed in the Winter Plan and also from those areas where working together was essential.

Nick Wood also reminded Members of the clear policies and procedures which had been developed in the system but were potentially not being implemented or utilised. These included:
- Same Day Emergency Care (SDEC) services and the referral of patients through the 999 route or conveyance routes. The numbers of patients referred would be monitored and variation should be avoided; there needed to be a consistent pathway for access into the SDEC services
- Clinical Advice Hubs, most HBs had versions of these and would need to be fully implemented (including ensuring consistent access)
- Immediate diagnostic front door pathways with the expectation that HBs and WAST would work together for access particularly for issues like direct admission and timely handover arrangements and for specific illnesses such as stroke and fractured neck of femur.

Members noted that the weekly CEO meeting would monitor progress and performance indicators would be developed to measure progress on the key actions identified. Nick Wood asked Members to work with the CASC to identify issues and provide assurance that the actions had been initiated and were consistent in the system in order to mitigate any unacceptable patient safety risks.

Members agreed:
- To provide responses in relation to local plans and commitment by the first week of January 2024 to the CASC for ongoing coordination and embedding into ongoing processes, this would be a blended approach across HBs and WAST.

The Immediate Release Report was discussed. A meeting had been arranged by the EASC Team between HBs and WAST in particular to look at the data and also the consistency of the approach. The key issues had been captured, recommendations had been made and subsequently endorsed by the EASC Management Group.

Further work would take place to streamline the process and improve compliance and understanding across the system.

Information had been presented in draft using the Statistical Process Control (SPC) as requested by Members. Comments had been requested and it was agreed that they would be integrated as part of the information for future meetings.

Stephen Harrhy highlighted specific information from the SPC Charts including:
- The improvements in the units of hours produced for emergency ambulances
- The Cymru High Acuity Response Units (CHARU) and their positive impact on the system (particularly as recruitment was increasing) and the important impact on quality of services received by patients.

- AGREED THE NEXT STEPS
  - The EASC Performance Report and the Quality and Safety Report would continue to be presented as the first agenda items at each meeting of the Emergency Ambulance Services Committee
  - the SPC charts would be included in future dashboards.

QUALITY AND SAFETY REPORT

The Quality and Safety Report was received. In presenting the report, Ross Whitehead highlighted a number of key areas.

Members noted:
- The significant challenge at WAST for complainants to receive a reply within 30 days to improve their performance against the 75% target in coming months, it is currently 21% (October)
- 16 cases identified by WAST as requiring joint investigation in October 2023. This joint process had been implemented in the last 12 months and would be reviewed in 2024
- 51 National Reportable Incidents had been made by WAST to date; this was raised with Welsh Government official at the Quality and Delivery meeting
- An increased number of patients were waiting over 12 hours for an ambulance response in October 2023 (677) compared to July 425, August 554, Sept 609
- Clinical indicators and compliance increased e.g. Stroke care bundle achieved for 76.4%
- Work has commenced on data outcomes and the data linking work would accelerate this; work to link to the deprivation index was also continuing and more information would be provided to Members, including the variation in services
- The return of spontaneous circulation (ROSC) rates was 17.1% which was believed to reflect the impact of the CHARU service
- The number of patients that self-presented at ED with a high triage category, with 314 patients self-presenting at ED with a category 1 triage level (concern re missing earlier intervention)
- Falls the biggest reason for a 999 call in October.

Members noted:
- The request from the CASC for comments to support the further development of the Quality & Safety Report

- The action to work with HM Coroners to ensure a consistent national approach and a meeting was due to be arranged
- The work would continue to be reported to Directors of Nursing and Quality
- The ongoing work on data linking and the impact.

Members raised
- Issues related to the new escalation process in Hywel Dda UHB and cohorting at the 2 hour level. The internal quality assurance team were working to ensure this was being closely monitored in terms of mortality and morbidity in as close as possible to real time. It was suggested it could be helpful to align the work being led by the EASC Team with this new area of work at HDUHB, especially in view of the impact of system pressures. It was agreed that Ross Whitehead would work with HDUHB to identify if any wider system learning could be identified and coordinated and specifically to include the whole patient waiting time.

- AGREED THE NEXT STEPS
  - The EASC Performance Report and the Quality and Safety Report would continue to be presented as the first agenda items at each meeting of the Emergency Ambulance Services Committee.
  - The EASC team would continue to work with WAST and HB colleagues to understand the level of harm within the system and to develop additional processes for the committee to assure itself that it is discharging its statutory responsibilities for the planning and securing of emergency ambulances
  - Specific work with Hywel Dda UHB.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received. Matthew Edwards presented the report and Members noted:
- The emphasis on the collaborative approach to the development of the EASC Commissioning Intentions for 2024 to 2025.

Members noted:
- The EASC Team would work with WAST and Emergency Medical Retrieval and Transfer Service (EMRTS) colleagues to further develop the draft Commissioning Intentions, these would be presented at a future meeting for approval
- WAST and EMRTS would have an opportunity to comment on the draft versions
- The need to consider the inclusion of other issues, for example mental health as appropriate
- Intentions would be developed to reflect the interdependencies with other programmes of work across the system, e.g. Six Goals for Urgent and Emergency Programme and how the system would work together to deliver against these
- Intentions would be developed to confirm the actions for health boards, health boards and WAST and WAST itself
- Trajectories would be developed against the agreed actions
- The need to consider funding bids to support delivery of the agreed actions if required
- The CASC would attend the meeting of the Directors of Planning in January to discuss.

- AGREED THE NEXT STEPS
  - The EASC Team would consider comments received on the Commissioning Intentions from members of the EASC Management Group and NEPTS and EMRTS Delivery Assurance Groups
  - The EASC Team would discuss intentions with WAST and EMRTS colleagues
  - Commissioning Intentions would then be submitted for approval by the EASC Committee
  - The Commissioning Intentions would be issued to each of the commissioned services.
  - The EASC team would continue to work with Members to enact the priorities of the Committee for the HB populations, with benefits delivered to patients and the Welsh public, Welsh Government, Clinical Networks, Health Boards and other elements of the NHS Wales system.
  - This would include the different elements of the collaborative commissioning approach including:
    - EASC Commissioning Frameworks
    - Integrated Commissioning Action Plans
    - EASC Integrated Medium Term Plan (including the IMTP Performance Improvements and Enablers Tracker)
    - EASC Commissioning Intentions.

UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW

The update report on the EMRTS Service Review was received.
Lee Leyshon presented the report and gave a detailed overview of work to date according to the phased approach.

Noted:
- The approach taken in Phases 1 and 2 of the 19 week engagement process
- The number of responses received and the wide-ranging emergent themes from the most recent engagement in Phase 2
- The CASC had attended Board sessions in both Betsi Cadwaladr University Health Board and Powys Teaching Health Board over recent months
- The CASC had been in contact with Llais throughout the process; since Phase 2 has been underway queries had been raised by some Llais members and these had been informally addressed
- Correspondence from Llais was received by the CASC on 29 November 2023 formally raising concerns about the next steps of the Review and recommending that this Review was taken to a formal public consultation
- Queries initially raised by Swansea Bay University Health Board (SBUHB) at the EASC Management Group in October had been responded to and a follow-up meeting with SBUHB colleagues had taken place.
- EASC had received a further communication from SBUHB reiterating the same points which would be responded to alongside the Llais recommendation
- A letter had been received from the Wales Air Ambulance Charity setting out the impact that a delay would have on them and requesting that the extensive process was brought to a conclusion as soon as possible

- Health Board representatives had been nominated to participate in the evaluation process originally scheduled for 14 December, this had been rearranged in light of Llais' letter and the recommendation being considered by the Committee.
- EASC had previously endorsed the proposal that the preferred and recommended option going to EASC would be taken back to each respective health board for individual board consideration before a collective Joint Committee decision was made. It was proposed that this remained the case
- The Options Appraisal, using the agreed evaluation framework, with nominated health board representatives would take place in early January
- The outcome of the Options Appraisal (i.e. shortlisted options) would be shared with Llais and developed into Phase 3 documents
- The shortlisted options – to include a preferred option – would be shared with the public and stakeholders
- Phase 3 would last for 4-weeks, online during February 2024 and in order to address the needs of the digitally excluded in the population, health board engagement teams would provide local opportunities for their populations to be supported to contribute to this important process
- The following range of bilingual documents would be developed as a minimum:
  - Updated equality impact assessment
  - Phase 3 document focusing on the impacts and pros and cons and costs with an opportunity to comment
  - A plain language or easy read version
- The aim of the documents would be to meet the principles for 'consultation' to ensure that sufficient reasons were put forward for any proposal to permit 'intelligent consideration'. This would include data where possible with as much explanation (and costs) as possible to continue the work of Phases 1 and 2.
- The shortlisted options – to include a preferred option would be simultaneously considered by each health board
- The public and stakeholder feedback would be considered by the CASC; Llais would also have an opportunity to comment
- Each health board would need to provide their respective board views to the CASC by 29 February 2024
- A preferred option would be recommended by the CASC for the Committee to make a final decision on, expected to be at the planned meeting of EASC on 19 March 2024.

Members noted:
- The comprehensive update provided, reflecting the breadth of the public responses received, including in relation to rural communities
- The recent conversation with Alyson Thomas, Chief Executive of Llais and noted that Llais were content with the approach put forward for a 4-week Phase 3 of the public engagement process, building on Phases 1 and 2 allowing the public opportunity to comment on the options which would include additional detail and costs
- That Llais referenced service development (rather than service change) and it had been confirmed that Llais wanted the public across Wales to be able to comment on the options shortlisted
- The support required from health board communication, engagement and service change leads during the engagement period to ensure the consistent approach across Wales

- All health boards are impacted by the EMRT service as there are patients in every area who do not currently receive a service (unmet need)
- The need to complete the process correctly, building on the comprehensive approach undertaken to date, but also mindful of the impact on others (Charity) in a timely manner
- The CASC would respond to Llais on behalf of the Committee (and would share a copy with Members)
- The concern of the Wales Air Ambulance Charity in respect of further delays to the process.
- The CASC expressed his thanks to the Charity for staying with the process, despite the delay causing the Charity potential difficulties.

The Chair thanked Members for their support, reiterating that this had been an extremely comprehensive process. It was helpful to receive the Members support for the next phase and there was a need to work together to complete the process to arrive at a decision in March and prior to the development of the new Joint Commissioning Committee.

- AGREED THE NEXT STEPS
  - Following the meeting on 21 December, the Commissioner would to send a formal response to Llais on behalf of the Committee confirming the agreed EASC position and clarifying the adjusted timeline for the Review going forward.
  - Issue a public communication confirming the Committee's agreed position and next steps for the EMRTS Service Review including any adjusted timeline.
  - Make operational arrangements to deliver the EASC agreed next steps of the process.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received and was presented by Stephen Harrhy. The report highlighted key areas which included:

- WAST Stakeholder Briefing
- Winter Ambulance Improvement Plan

Members particularly noted:
- The WAST Stakeholder Briefing sent by WAST at the start of December which had raised some concerns regarding timing and content, and noting that a formal response would be prepared by the CASC on behalf of the Committee. It was agreed that the CASC would share a draft response to health boards for comment before formally responding to WAST.

- AGREED THE NEXT STEPS
  - Once responses are received on the recent WAST briefing, before, at the meeting or following a response would be sent. This would be shared in advance with Members
  - Commissioners had an opportunity to input actions for the Winter Ambulance Improvement Plan and these would be forwarded to Welsh Government as soon as possible.

FORWARD LOOK AND ANNUAL BUSINESS PLAN
The Forward Look and Annual Business Plan was received and approved.

Key risks and issues/matters of concern and any mitigating actions
- Red and amber performance – Members agreed to provide responses in relation to local plans and commitment by the first week of January 2024 to the CASC for ongoing coordination and embedding into ongoing processes, this would be a blended approach across HBs and WAST.   - Handover delays (and the monitoring of handover improvement plans in HBs with trajectories) and the impact on services provided to HB local communities and to WAST – through the ICAP process   - In relation to the EMRTS Service Review, due to the requirement of Llais, the Option Appraisal workshop had been postponed - it would now take place in mid January 2024

Matters requiring Board level consideration
- To acknowledge the continued significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours – especially in relation to the quality of services patients receive   - Output from the EASC meeting in January for further discussion at the Board prior to decision making at EASC in relation to the EMRTS Service Review.

Forward Work Programme and Annual Business Plan
Considered and agreed by the Committee.

Committee minutes submitted	Yes	√	No	
Date of next meeting	16 January changed to 30 January 2024			

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	23 November 2023
Summary of key matters including achievements and progress considered by the Committee and any related decisions made.	

Matters Arising

- *Payroll Modernisation Update* – A presentation was given by the Deputy Director of Employment Services and the Head of Payroll. This covered improvements to identifying and monitoring progress with overpayments and improvements to the Staff Movements process. The presentation also highlighted that annual number of pay runs is currently 159 and reductions in this number would produce significant administrative savings. The presentation concluded with the following recommendations which the Committee were content to support:
    o The use of the Overpayments Portal by Health Boards and Trusts to help reduce the occurrence of overpayments;
    o Greater use of the Management Self-Service function in ESR; and
    o Establishing a task and finish group to look at payroll runs frequency.

- *IMTP* – The Director of Planning, Performance and Informatics updated the Committee on progress with the development of the IMTP for the period 2024-27. The NHS Planning Framework has not yet been published but is expected imminently. It is anticipated that ministerial priorities will be consistent with the current year and NWSSP has a key role in supporting NHS Wales organisations to deliver against these priorities. Progress to date includes a World Café event for all NWSSP Directorates in mid-October and the development session with the Committee in November. Going forward, the aim is to bring the IMTP to the January 2024 Committee for formal approval. The plan will be underpinned by the overarching principles of doing the basics well, being financially sustainable, embedding the Duty of Quality, and looking after the welfare of our staff. Whilst the financial climate across NHS Wales imposes severe challenges, it may also provide the opportunity for NWSSP to implement measures on an all-Wales basis that give the potential for significant savings within Health Boards and Trusts.

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Chair's Report

The Chair referred to a number of meetings that she had attended including the Welsh Risk Pool Committee and the Audit Committee. She also welcomed the opportunity to meet regularly with the Minister with other chairs which she found invaluable. The development session held with SSPC members earlier in the month had been very successful and she thanked those who attended for giving up their time, and for the contributions that they made to the event.

The Committee NOTED the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- Conversations continue with Hywel Dda UHB over the closure of the Glangwili Laundry site and the commencement of discussions regarding the TUPE arrangements for the remaining staff within the Cwm Taf Laundry to transfer across to the NWSSP Laundry Service;
- The NWSSP SLG recently endorsed the anti-Racist Action Plan which demonstrates our commitment to being an anti-racist organisation and sets out our plan to address the actions contained in the plan produced by Welsh Government and in meeting the requirements of the Welsh Workforce Race Equality Standard;
- The development of the first phase of a Solar Farm at IP5 where we are currently tendering for the infrastructure works having secured additional capital funding from Welsh Government as part of the decarbonisation agenda;
- The Medical Examiner Service will attain a statutory footing from April 2024 with the relevant legislative amendments being passed in October. The agreed approach allows us to ensure both equity and equality in service delivery across the whole of Wales;
- NWSSP has been accredited with the Corporate Customer Service Excellence Award making it the first organisation within NHS Wales to achieve the highly valued UK Government Standard;
- NWSSP were shortlisted for a number of awards in three different categories and were successful in being the winners of the Evolution award at the recent UK Shared Services Forum Conference in Liverpool; and
- Following publication of the scope of Module 5 (Procurement) of the UK COVID Public Inquiry, and after consultation with our barristers, NWSSP has applied for core participant status for this module.

The Committee NOTED the update.

Items for Approval

Brecon House Patients Medical Relocation – the paper related to a business case that was approved by the SSPC in 2022. Following the discovery of Reinforced Autoclaved Aerated Concrete (RAAC) in the existing building (Brecon

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House), new accommodation had to be secured urgently for the safety of the staff and the secure storage of the records. This required the signing of a lease for the Du Pont building on the same site and owing to the need to sign this urgently, approval was given through a Chair's Action for both the SSPC and the Velindre Trust Board. The Committee RATIFIED the approval.

Primary Care Services – Provision of Multi-Functional and Professional Printing Devices – the Committee APPROVED a three-year contract for the replacement of the existing devices.

Contract Award for Replacement Leased HGVs for Supply Chain and Laundry - The Committee APPROVED the contract award for the lease of 15 heavy goods vehicles.

Speaking Up Safely Action Plan – The Committee APPROVED the Speaking Up Safely Action Plan which formalises a mechanism to ensure concerns raised in relation to Inclusivity and Belonging are captured, reported on, and learnt from.

All-Wales Supply of Electricity – The Committee APPROVED the recommendation of the Welsh Energy Group to secure Zero Carbon for Business electricity source for the supply period 01.04.2024 to 31.03.2025.

South-East Wales Radiopharmacy Business Case - The Committee APPROVED the business case for an immediate capital investment in preparative radiopharmacy facilities in the Southeast Wales region. The preferred option site is IP5.

Items for Noting

International Recruitment

The Committee was provided with an update on the delivery of the All-Wales International Recruitment Programme supporting the safe and ethical recruitment of International Healthcare Workers, embedding a strategic "Once for Wales" approach and maximising opportunities for collaborative working across organisational boundaries.

Phase 2 of the commercial agency pipeline commenced in December 2022 with the first cohort of Internationally Educated Nurses (IENs) arriving in March 2023. As at 31st October, a total of 248 IENs have been onboarded. All Health Boards now have a proportion of Phase 2 candidates either arrived or in progress.

In addition to the commercial agency route, NWSSP has continued to support the recruitment and onboarding of a direct pipeline of nurses recruited via a partnership with an agency of the state government of Kerala, India. That route has already provided 29 candidates who have been successfully on-boarded following a visit to Kerala in May 2023, and a further visit was undertaken in November. The in-country delegation were successful in recruiting a total of 96 registered nurses, plus 16 Junior and Senior Clinical Fellows supporting General

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Medicine and Oncology services.

An important milestone was achieved recently when NWSSP were recognised as an official sponsorship organisation for the General Medical Council, for doctors of all grades and all specialties.

The Committee NOTED the update.

Procure to Pay (P2P) Update

Since 2016, the Finance Academy All-Wales P2P Forum had been successful in the approval and delivery of several P2P initiatives, all of which were underpinned by the Once-for-Wales principles e.g. No PO No Pay Policy, standardisation of Invoice tolerances in Oracle. However, in recent years, the All-Wales P2P Forum has struggled in agreeing, supporting, and taking forward P2P initiatives. As a consequence, the Finance Academy Board agreed to close the All-Wales P2P Forum in September 2023. There is, however, still a need for a Forum or Committee to provide effective governance covering the P2P arrangements and agree future work plans.

The Committee NOTED the update and AGREED to take over the governance arrangements for P2P.

Southeast Accommodation Proposal

The previous option of moving from Companies House to the Welsh Government offices in Cathays Park is now no longer considered viable due to increasing costs, and restrictions on parking and access. We have therefore informed Welsh Government that we will not be pursuing this option. An alternative building has been identified on the Nantgarw estate which would accommodate staff from both Companies House and the existing HQ building in Nantgarw, providing significant annual savings. This is now the preferred option and is being actively investigated on either a lease or purchase basis.

The Committee NOTED the update.

All-Wales E-Scheduling Procurement

E-Scheduling software enables the District Nursing workforce in Wales to access a mobile app to schedule their visits, avoiding paper or spreadsheet-based systems.

The all-Wales contract (two year plus one) commenced with Civica (formerly Malinko) on 1st April 2021. The year extension was implemented in April 2023 with the entire contract due to expire on 31st March 2024. Following extensive consultation, and subject to Welsh Government approval, the intention is to re-tender the contract with expected contract award early in 2024.

The Committee NOTED the update.

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Finance, Performance, People, Programme and Governance Updates

Finance –We continue to forecast a break-even financial position for 2023/24 dependent upon a number of income assumptions relating to pay award funding, the continued demand for and the costs to support increased transactional activity, IP5 running costs and transitional funding for TRAMS. Confirmation that Welsh Government will fund UHBs for the laundry energy cost pressure in 2023/24 has reduced our risk in respect of this. We are anticipating an element of savings achieved to date will be required to support the transitional and removal costs relating to the transfer of significant volumes of medical records to new premises.

People & OD Update – Sickness absence remains low and statutory and mandatory performance is good. PADR rates are below target and the position has slightly worsened over recent months.

Performance – The in-month September performance was generally good with 36 KPIs achieving the target against the total of 41 KPIs. However, five KPIs did not achieve the target and are considered Red/Amber. These relate to Recruitment (2), Procurement, Digital Workforce and Student Awards Services. Professional influence benefits amount to £83M at end of September.

IMTP Q2 Progress Report - 81% (124) of our objectives are on track. 11 objectives are at risk of being off track to complete in 2023-24. All have targeted actions to complete in Quarter 3 and 4 with a view to bringing them back in line. Reporting on objectives remains on a self-assessment basis by the divisional Heads of Service, scrutinised through the Quarterly Review process.

Project Management Office Update – There is only one project currently rated as red, relating to the TrAMS project and particularly the affordability of the proposed solution as part of the wider capital programme. This compares with three red-rated projects reported to the last Committee.

Corporate Risk Register – There are currently five red risks on the Corporate Risk Register, compared with eight reported to the last Committee. These include Brecon House, TrAMs, the impact on the Single Lead Employer Team of proposed Junior Doctors Industrial action, and the limitations imposed by the overall financial climate.

The Committee NOTED the above Reports.

Papers for Information

The following items were provided for information only:
- Audit Committee Assurance Report;
- PPE Stock Report; and
- Finance Monitoring Returns (Months 6 and 7).

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AOB	
N/a	
Matters requiring Board/Committee level consideration and/or approval	
• The Board is asked to NOTE the work of the Shared Services Partnership Committee.	
Matters referred to other Committees	
N/A	
Date of next meeting	Thursday 18th January 2024 10am – 12pm

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TRUST BOARD

TRUST SEAL REPORT: 22ND NOVEMBER 2023 – 30TH JANUARY 2024

DATE OF MEETING	30 January 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	FOR NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	The contents of the Trust Board Seal Register have been approved by the Chair (or Vice Chair in the Chair's absence) and the Chief Executive Officer of the Trust at every Seal Request **(period 23rd November to 30th January 2024).**

RECOMMENDATION / ACTIONS	The Trust Board is requested to NOTE the contents of the Trust Board Seal Register included below as **Appendix 1.**

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

7 LEVELS OF ASSURANCE – N/A

APPENDICES
Appendix 1 – Seal Register

1.   SITUATION/ BACKGROUND

1.1   The contents of the Trust Board Seal Register have been approved by the Chair (or Vice Chair in the Chair's absence) and the Chief Executive Officer of the Trust at every Seal Request **(period 23rd November to 30th January 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	☒

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	Timely	☒
	Effective	☒
	Equitable	☐
	Efficient	☒
	Patient Centred	☐

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* https://www.gov.wales/socio-economic-duty-overview	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx	Not required.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair (or Vice Chair in the Chair's absence) and the CEO of the Trust at every Seal request.

4 RISKS

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

Appendix 1 – Seal Register

Date	Document Details	Signed
30th November 2023	Lease relating to Ground Floor, Cwmbran House, Mamhilad Park Estate, between Johnsey Estates UK Limited and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO

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Date	Document Details	Signed
30th November 2023	Lease relating to 4a and 4b Dupont Building, Mamhilad Park Estate, Pontypool, Torfaen, between Johnsey Estates UK Limited and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
30th November 2023	Counterpart Lease relating to Units 4/5 Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff, CF15 7QZ, between Treforest Trustee (Jersey) Limited and Treforest Nominee (Jersey) Limited as Trustees of the Treforest Unit Trust (as Landlord) and Velindre University NHS Trust (as Tenant).	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
30th November 2023	Lease relating to First Floor, Cwmbran House, Mamhilad Park Estate, between Johnsey Estates UK Limited and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
12th December 2023	Access agreement relating to the laying of electricity apparatus at Whitchurch Hospital, between (1) Cardiff and Vale University Health Board and (2) Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
9th January 2024	Deed of Variation (Land at Whitchurch Hospital) Cardiff & Vale University Health Board and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO

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TRUST BOARD

Nurse Staffing Levels (Wales) Act Update

DATE OF MEETING	30th January 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	Anna Harries, Head of Nursing, Professional Standards & Digital
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	This 6-month report is to provide assurance to the Trust Board in relation to how the Trust is meeting its responsibilities the Nurse Staffing Levels (Wales) Act. Key highlights are: • ***There has been no reported impact on patient care on First Floor Ward due to nurse staffing levels (Trusts 25B area).*** • Nurse staffing levels are being recorded and reported appropriately in line with the Nurse Staffing (Wales) Act. • There have been occasions when the required roster on First Floor Ward (25b Ward) has not been met due to sickness absence and the need to provide cover in other areas where there are deficits such as SACT. Every effort has been made to fill any gaps in the roster utilising reasonable steps. The ward is rarely at full bed occupancy, therefore no impact on care delivery, however this has impacted on staff moral.

	- The nursing establishment on First Floor Ward is sufficiently funded and appropriate to provide the required roster identified through triangulated establishment reviews that include professional judgement. - The establishment reviews conducted in October 2023 identified three 25A areas where it was deemed that the establishment was insufficient to provide sensitive care to patients at all times. These were: SACT, Assessment Unit and Clinical Nurse Specialist Team. This is under review and agreement made to include the requirements in this year's IMTP.
RECOMMENDATION / ACTIONS	To **NOTE** the compliance with the Nurse Staffing Levels (Wales) Act in relation to the 25B area and **APPROVE** the proposal to include 26.9% headroom in the establishment of three 25A areas at Velindre Cancer Service that currently does not contain headroom.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	
Professional Nursing Forum	10.11.2023
Executive Management Board	04.12.2023
Quality, Safety and Performance Committee	16.01.2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS *ENDORCED*	
All Groups noted the proposal and endorsed the work to add headroom into the establishment of the 25 A areas identified.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

APPENDICES	
Appendix 1	Annual Presentation of Nurse Staffing Levels to the Board

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 25A of the Act 'the overarching responsibility to have regard to providing sufficient nurses in all settings.'

Section 25B of the Act - requires organisations 'to calculate and take reasonable steps to maintain the nurse staffing level in all acute adult medical and surgical wards' and 'to inform patients of the nurse staffing level'.

Since the 1st of April 2021 the Executive Management Board/Trust Board agreed that the inpatient Ward at Velindre Cancer Service fell within the wider definition of a medical ward. The First Floor Ward is therefore subject to the full reporting requirements of the Act 2016. All remaining areas that deploy nurses across the Trust are subject to 25A.

Through establishment reviews of all nursing areas, a triangulated approach to each area has been considered despite not requiring national reporting this information is vital to quality indicators. The full detailed report will follow however part of this is considered in the assessment/summary below.

2. ASSESSMENT

2.1 Nurse Staffing Levels (Wales) Act 2016 Reporting

National reporting is yearly and 3 yearly, however an interim 6-month report is also required following acuity and establishment reviews. Mandatory reporting is required for first floor ward as a 25B ward with a summary of themes from non 25B areas. The Nurse Staffing Levels report using the required national template is attached in *Appendix 1*. This report tells us that while the establishment for first floor is sufficient to provide sensitive care to patients, the level of support the ward is being required to provide to SACT services is a risk to this. The support to date has also not impacted on patient care as the numbers of occupied beds have been below capacity. There is no action to change establishment as deemed as sufficient.

2.2 National Acuity Review – First Floor only

Acuity data is entered daily as a standard, however in January and June each year this data is reported and presented through visualiser format. The June 2023 visualiser was fully populated, and through the discussion that took place at the establishment review, the recorded acuity level appeared accurate. Visualiser available via Nicola Williams if required. The acuity data reveals that patients are predominantly scoring a level 3 (complex care). Level 4 (urgent care) scores have significantly reduced which appears to be mainly attributable to the rollout of refresher training for staff on the Welsh Levels of Care Tool. Level 5 (on to one care) patients have also reduced from 6.5% to 0.5%.

2.3 Establishment Reviews

Following each acuity and nurse staffing audit the Executive Director of Nursing, AHP & Healthcare Science and the Divisional Head of Nursing undertake formal establishment reviews across all patient / donor areas who deploy nurses across both divisions. The reviews for Spring and Autumn 2023 have both been completed. Each establishment review details:
- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of Roster
- Patient Feedback (CIVICA)
- Audits (Tendable)
- Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
- KPI review
- Quality Indicators (25B ward)
- Service plans or Clinic Templates as applicable (not all areas)

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In summary of the areas reviewed with nursing workforce, evident knowledge of areas data and information available. No incidents or complaints effecting care linked to staffing were reported. PADR compliance good and in some areas 100% with plans for those that are below. Training was good with reference to specific training focus and working at top of license. Discussions also held around consideration of Band 4 Practitioners based on NHS Wales agreed standards. It was, however, noted that staff moral has been impacted with the ongoing support ward staff are providing to maintain SACT services.

There were areas where the reviews identified that the establishments within Velindre Cancer Service were deemed not currently sufficient to provide sensitive care to patients/donors and urgent work was required to enhance/review establishments. These were:

- ***Clinical Nurse Specialist (CNS) Team*** – The triangulated establishment review identified that overall, the CNS Team is under established in line with what the team are required to deliver including ability to fulfil the key worker role. There is currently no headroom built into establishment resulting in considerable CNS service gaps (gaps in services to patients) when there is annual or unplanned leave. Nationally agreed nursing headroom level is 26.9% - covers annual leave, study leave, sick leave and other (maternity, compassionate etc). Although the recent CNS review has identified a number of efficiencies the workforce is insufficient. After the headroom is factored into the establishment a further establishment review would be conducted.

- ***Assessment Unit*** - The triangulated establishment review identified that the afternoon staffing of the Unit did not meet the patient demand and that an additional Advanced Nurse Practitioner on the afternoon shift would be advantageous. The is also a requirement to add in headroom. There are efficiency opportunities through amalgamating responsibilities and coalescing services such as the Assessment unit, Ambulatory care, Immunotherapy services etc.

- ***Systemic Anti-cancer Therapy (SACT)*** - There was overall professional concern in relation to the SACT Nursing establishment. The establishment does not have the required support infrastructure to allow the registered nurse to do what only they can do. The support resources identified through the previous SACT workforce review have not all been enacted i.e. ensuring two band 3 healthcare support workers per unit per shift and unit reception cover. There are challenges with recruiting into vacancies, high levels of maternity leave and protracted timescales for

new staff being signed off as competent to deliver all SACT as the trainers have been filling SACT delivery gaps. In addition, SACT trained nurses across the cancer centre are being moved regularly to provide SACT which is impacting on morale and staffing levels across the wider cancer service.

Since the end of October 2023, the SACT trainers have been protected to prioritise SACT Competency sign off for those nurses who had not been signed off.

Discussions are underway with finance, VCS and corporate nursing team in relation to quantifying the financial requirement and including in this year's IMTP.

3.5 *Implementation of SafeCare Module*

The SafeCare module of RLDatix has assisted in facilitating automated Act reporting through Velindre University NHS Trust and to NHS Wales in line with National Nurse Staffing Act reporting requirements. Velindre University NHS Trust has completed its integration into a first floor and is now recording acuity and staffing levels data twice a day in line with the All-Wales Standards of Practice for SafeCare. This replaces use of Healthcare monitoring system and continue to allow organisations to report acuity in a similar way to the old system.

The implementation of SafeCare has provided a platform to bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients being cared for at Velindre Cancer Centre, however, there is still work to be done in securing and developing an All-Wales data infrastructure to enable the smooth and efficient retrieval and reporting of meaningful visual data.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐

• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety		
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**		
	Safe	☒	
	Timely	☒	
	Effective	☒	
	Equitable	☒	
	Efficient	☒	
	Patient Centred	☒	
	The Nurse Staffing Levels (Wales) Act covers all aspects safe, timely and effective care. Rostering of staff against demand and acuity enables the delivery of equitable and efficient patient centred care.		
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required		
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health		
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.		
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required		
	Not required as report is for noting purposes.		

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ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*SACT Vacancy factor impacting on First Floor ward. Staff moral impacted but not patients as bed occupancy lower than capacity*
WHAT IS THE CURRENT RISK SCORE	9
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*Plans in place to reduce vacancy with international recruitment and student streamlining*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	March/April 2024 for recruitment (International and Students)
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Retention of staff is vital. *Attrition rates for international recruitment*
All risks must be evidenced and consistent with those recorded in Datix	

Annual Presentation of Nurse Staffing Levels to the Board						
Health Board/Trust	Velindre University NHS Trust					
Date of annual presentation of Nurse Staffing Levels to Board	4th December 2023					
Period Covered	**01 October 2022 to 30 September 2023**					
Number and identity of section 25B wards during the reporting period. • **Adult acute medical inpatient wards** • **Adult acute surgical inpatient wards** • **Paediatric inpatient wards**	Section 25B of the Nurse Staffing Levels (Wales) Act applies to one ward (First Floor) in Velindre Cancer Centre. There has been no primary change to the ward structure during the last year. Bed capacity has remained at full capacity of 32 beds during the last 12-month period. The bi-annual audit cycle took place as planned in both January and June 2023. The calculated Whole Time Equivalent (WTE) Registered Nurse for first floor is 29.69 (inclusive of the ward manager. Previously the ward co-ordinator was included in the figures hence the slight variation in the figures from October 22 and May 2023. WTE for Health Care Support Worker (HCSW) is 14.21, both figures are inclusive of the 26.9% headroom based on 32 bed occupancy.					
	Adult acute medical inpatient wards		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (October 2022)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	30.95	14.21	NA	NA	NA	NA
TE of required establishment funded (October 2022)	30.95	14.21				
Staffing requirements following Spring Cycle (May 2023)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (May 2023)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	30.95	14.21	NA	NA	NA	NA
WTE of required establishment funded (May 2023)	30.95	14.21	NA	NA	NA	NA
Staffing requirements at end of reporting period (September 2023)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	

Required establishment (WTE) calculated (September 2023)	RN	HCSW	RN	HCSW	RN	HCSW
	28.42	14.21	NA	NA	NA	NA
WTE of required establishment funded (September 2023)	28.42	14.21	NA	NA	NA	NA
WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but excluded from planned roster)	1		NA		NA	
Required establishment (WTE) calculated and WTE of required establishment funded	Yes – fully funded					
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards	The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels on First Floor. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews have taken place bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. Patient acuity is scored twice a day using the Welsh Levels of Care Toolkit. The ward manager and band 6 nurses measure patient acuity in a consistent manner using the Welsh Levels of Care lay descriptors and then clinical descriptors if required. The acuity data reveals that patients are predominantly scoring a level 3. Level 4 scores have significantly reduced from 46.7% to 19.2% which appears to be mainly attributable to the rollout of refresher training for staff on the Welsh Levels of Care Tool. Level 5 patients have also reduced from 6.5% to 0.5%.					

WLOC Level	2022-2023	Last 6 months	Trend
Level 5	6.5%	0.5%	↓
Level 4	46.7%	19.2	↓
Level 3	43.8%	57.1	↑
Level 2	3.1%	21.8	↑
Level 1	0.02%	1.5	↑

Level 5	One to One Care - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day
Level 4	Urgent Care - The patient is in a highly unstable, unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	Complex Care - The patient may have a number of identified problems, some of which interact, making it difficult to predict the outcome of individual treatment
Level 2	Care Pathways - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	Routine Care - The patient has a clearly identified problem, with minimal other complicating factors.

There have been instances where the planned roster has not been met, however, professional judgement has been utilised and it was deemed safe due to the reduced number of beds, skill mix and patient acuity levels. Occasionally the planned roster has not been met due to staff sickness and unavailability of bank staff to fill the shift at short notice, all reasonable steps are considered to help deliver sensitive care on these occasions for instance, on rare occasions the ward manager has been required to work in the numbers due to sickness absence or increased acuity.

SafeCare has assisted in avoiding the over or under use of staff and helps in assuring that there is an appropriate and safe nursing skill mix. SafeCare has brought together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients at Velindre Cancer Centre. It aims help to ensure consistency in recording and reporting data across organisations and support the Once for Wales Approach, however, there are issues with data retrieval and reporting. SafeCare has enabled us to collate, review and report numerical data to demonstrate the extent to which the planned roster has been maintained but this is not a simple task and until a national approach for data retrieval is developed it remains an extremely labour-intensive task.

Finance and workforce implications

The establishment review identified that the first-floor ward establishment included the required 26.9% headroom to account for sickness, study leave and annual leave. It was deemed that 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.

There is a professional concern that staff from first floor are having to provide significant support for the SACT service. Having to release staff to cover SACT is impacting on the wards ability to provide effective care to patients and is also affecting staff morale.

	After undertaking a review of the current funded nursing establishment against the required establishment for First Floor ward, the directorate is of the opinion that the current establishment is sufficient to manage and deliver care sensitively to patients. First floor is carrying 6.58 registered nurse vacancies, however, there is a robust plan in place to recruit into these vacancies. Velindre University NHS Trust has joined student streamlining for the first time and is in the process of recruiting 6 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. VCC have successfully recruited 15 registered nurses from Kerala, India, and are, for the first time employing new registrants through the student streamlining process.
Conclusion & Recommendations	
	Conclusion • Nurse staffing levels are being recorded and reported appropriately in line with the Nurse Staffing (Wales) Act. • First floor is open to full capacity of 32 beds, average bed numbers were 19 for the last three months. Five beds have been allocated to SACT. • There have been occasions when the required roster has not been met due to sickness absence. Every effort has been made to fill any gaps in the roster utilising reasonable steps. • Currently there are 6.59 registered nurse vacancies on first floor which are due to be filled via student streamlining and international nurse recruitment. • 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. • There has been no change in the nurse staffing establishment in the last 12 months. **Recommendations** • Continue plans with student streamlining and international recruitment to improve whole Trust vacancy figures. • Consideration of Band 4 Assistant practitioners to again improve vacancy and top of licence working. • Reduce impact of SACT services on the First floor Ward.