Public Trust Board

Thu 27 March 2025, 10:00 - 13:00

Velindre University NHS Trust Headquarters

Professor Donna Mead OBE, Chair

Agenda

10:00 - 10:15
15 min

1. STANDARD BUSINESS

1.1. Welcome and Apologies

Professor Donna Mead OBE, Chair

1.2. In Attendance

Professor Donna Mead OBE, Chair

1.3. Declarations of Interest

Professor Donna Mead OBE, Chair

1.4. Minutes of the Public Trust Board meeting held on 30th January 2025

Professor Donna Mead OBE, Chair

1.4.0 Unconfirmed minutes of Public Trust Board 30.01.2025.pdf (13 pages)

1.5. Public Action Log

Professor Donna Mead OBE, Chair

1.5.0 PUBLIC TRUST BOARD ACTION LOG - MARCH 2025.pdf (2 pages)

1.6. Matters Arising

Professor Donna Mead OBE, Chair

10:15 - 10:25
10 min

2. KEY REPORTS

2.1. Chair's Report

Professor Donna Mead OBE, Chair

2.1.0 Chair's update Trust Board 27.03.2025 FINAL.pdf (6 pages)

2.2. Chief Executive's Report

David Donegan, Chief Executive Officer

2.2.0 CEO's Update Trust Board 27.03.2025.pdf (6 pages)

10:25 - 10:25
0 min

3. INTEGRATED GOVERNANCE

**There are no items for discussion.

10:25 - 11:40
75 min

4. QUALITY, SAFETY & PERFORMANCE

4.1. Performance Management Framework (January 2025)

Lauren Fear, Director of Transformation (interim), Anne Carey, Chief Operating Officer, Matthew Bunce, Executive Director of Finance, Susan Thomas, Deputy Director of Organisational Development & Workforce

- 4.1.0 Trust Board 27.03.25 JAN PMF 2025 FINAL Cttee Format version 036.pdf (46 pages)

4.2. Financial Report (January 2025)

Matthew Bunce, Executive Director of Finance

- 4.2.0 Month 10 Finance Report Cover Paper - TRUST BOARD 27.03.25.pdf (12 pages)
- 4.2.0a Appendix 1 - M10 VELINDRE NHS TRUST FINANCIAL POSITION TO JANUARY 2025 - TRUST BOARD 27.03.25.pdf (29 pages)

4.3. VUNHST Risk Register

Non Gwilym, Director of Corporate Governance (interim)

- 4.3.0 TRUST BOARD TRR 27.03.2025 V06.pdf (7 pages)
- 4.3.0a TRR - APPENDIX 1 -TRUST BOARD - 27.03.2025 -V01.pdf (6 pages)

4.4. Trust Assurance Framework

Non Gwilym, Director of Corporate Governance (interim)

- 4.4.0 TAF Cover Paper - TRUST BOARD- 27.03.2025 V01.pdf (11 pages)
- 4.4.0a V73 TAF DASHBOARD.pdf (27 pages)

4.5. Trust Values Culture Report

Susan Thomas, Deputy Director of Organisational Development & Workforce

- 4.5.0 Bi-Annual Trust Values and Culture Report.pdf (11 pages)

4.6. Staff Survey Results

Susan Thomas, Deputy Director of Organisational Development & Workforce

- 4.6.0 NHS Staff Survey 2024 18.3.25.pdf (11 pages)
- 4.6.0a Appendix 1 VUNHST NHS Staff Survey Report 2024.pdf (31 pages)
- 4.6.0b Appendix 2 NHS Staff Survey Group Terms of Reference3.3.25.pdf (2 pages)

11:40 - 12:15
35 min

5. PLANNING AND STRATEGIC DEVELOPMENT

5.1. Integrated Medium Term Plan (IMTP) 2025-2028

Lauren Fear, Director of Transformation (interim)

- 5.1.0 IMTP Cover Paper - TB.pdf (5 pages)
- 5.1.0a IMTP Master - 23.3.25 - TB Tracked Changes.pdf (52 pages)
- 5.1.0b IMTP - 2025-8 - Cross Reference to Guidance -Trust Board.pdf (22 pages)

5.2. Strategic Planning Update

Lauren Fear, Director of Transformation (interim)

- 5.2.0 Strategic Planning Update - March Board.pdf (4 pages)
- 5.2.0a Appendix 1 - TB - Regional Cancer Programme Update 20.02.25 vfinal.pdf (6 pages)

5.3. Strategic Development Committee Highlight Report (20/02/2025) - oral item

Alert *Lindsay Foyster, Independent Member and Chair of the Strategic Development Committee*

12:15 - 12:45
30 min

6. CONSENT ITEMS

6.1. CONSENT FOR APPROVAL

Professor Donna Mead OBE, Chair

6.1.1. Chair's Urgent Action Report

Non Gwilym, Interim Director of Corporate Governance

6.1.1 PUBLIC Chairs Urgent Action Report MARCH 2025 v2.pdf (4 pages)

6.1.2. Amendments to Model Standing Orders and Reservation and Delegation of Powers for NHS Trusts

Non Gwilym, Director of Corporate Governance (interim)

6.1.2 Amendments to Trust Model SOs_MAR 2025_Cover Report Trust Board v1.pdf (6 pages)
6.1.2a APPENDIX 1 - GC02 v41 SOs Excluding Schedules_MAR 2025.pdf (45 pages)

6.2. CONSENT FOR NOTING

Professor Donna Mead OBE, Chair

6.2.1. Public Strategic Development Committee Highlight Report (05/12/2024)

Stephen Harries, Vice Chair and Chair of the Strategic Development Committee

6.2.1 TRUST BOARD HIGHLIGHT REPORT FOR PUBLIC SDC 05.12.2024.pdf (5 pages)

6.2.2. Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports (17/10/2024, 19/12/2024, 23/01/2025 & 20/02/2025)

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

6.2.2a TRUST BOARD PUBLIC TCS HIGHLIGHT REPORT 17.10.2024 v2.pdf (4 pages)
6.2.2b TRUST BOARD PUBLIC TCS HIGHLIGHT REPORT 19.12. 2024_ (003.pdf (6 pages)
6.2.2c TRUST BOARD PUBLIC TCS HIGHLIGHT REPORT 23.01.2025 v2_SH.pdf (6 pages)
6.2.2d TRUST BOARD PUBLIC TCS HIGHLIGHT REPORT 20.02.2025.pdf (6 pages)

6.2.3. Public Quality, Safety & Performance Committee Highlight Report (13/03/2025)

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

6.2.3 Public QSP Highlight Report 13th March 2025 (VM).pdf (8 pages)

6.2.4. Public Charitable Funds Committee Highlight Report (23/01/2025)

Professor Donna Mead OBE, Chair of the Charitable Funds Committee

6.2.4 TRUST BOARD PUBLIC CFC Highlight Report 23 January 2025 v2.pdf (4 pages)

6.2.5. Trust Seal Report

Non Gwilym, Director of Corporate Governance (interim)

6.2.5 Trust Seal Report 30.01.2025-20.03.2025.pdf (3 pages)

6.2.6. Trust Wide Policies Approved Update

Non Gwilym, Director of Corporate Governance (interim)

- 6.2.6 TRUST WIDE POLICIES APPROVED UPDATE MAR 2025 v2.pdf (5 pages)
- 6.2.6a Appendix 1 QS17 All Wales Consent to Treatment Policy QSPC 13.03.25.pdf (100 pages)
- 6.2.6b Appendices 2-6 IPC Policies.pdf (105 pages)
- 6.2.6c Appendix 7 RD01 Intellectual Property (IP) Policy v7 February 2025.pdf (18 pages)

12:45 - 12:45
0 min

7. ANY OTHER BUSINESS

Professor Donna Mead OBE, Chair

*Prior approval required by Chair

- Vice Chair

12:45 - 12:45
0 min

8. DATE OF NEXT MEETING

Professor Donna Mead OBE, Chair

Thursday, 22nd May 2025

12:45 - 12:45
0 min

9. CLOSE

Professor 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).

12:45 - 12:45
0 min

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

Stephen Harries, Acting Chair

- Minutes of previous private Trust Board meeting
- Action log
- Velindre Cancer Service Structure Update
- MIM Governance Protocol
- nVCC Project Scheme of Delegation and Governance Framework
- Commitments of Expenditure Exceeding CEO Limit
- Private Committee Highlight Reports

MINUTES PUBLIC TRUST BOARD MEETING – PART A
VELINDRE UNIVERSITY NHS TRUST LIVE STREAMED
30th JANUARY 2025 AT 10:00AM

PRESENT	
Professor Donna Mead OBE	Chair
Stephen Harries (SH)	Independent Member *(remotely)*
Professor Andrew Westwell (AW)	Independent Member
Vicky Morris (VM)	Independent Member
Gareth Jones (GJ)	Independent Member *(remotely)*
Lindsay Foyster (LLF)	Independent Member
Hilary Jones (HJ)	Independent Member *(remotely)*
David Donegan (DD)	Chief Executive Officer
Carl James (CJ)	Executive Director of Strategy & Planning / Deputy CEO (interim)
Nicola Williams (NW)	Executive Director of Nursing, Allied Health Professionals & Health Scientists
Dr Jacinta Abraham (JA)	Executive Medical Director
Matthew Bunce (MB)	Executive Director of Finance
Lauren Fear (LF)	Director of Transformation (interim)
Sarah Morley (SM)	Executive Director of Organisational Development & Workforce
ATTENDEES	
Anne Carey (AC)	Chief Operating Officer (interim)
Carl Taylor (CT)	Chief Digital Officer
Non Gwilym (NG)	Director of Corporate Governance (interim)
Kyle Page (Secretariat)	Business Support Manager

1.0.0	**STANDARD BUSINESS**	
1.1.0	**Welcome and Apologies** The Chair welcomed attendees to the meeting, in particular David Donegan, to his first meeting as Chief Executive Officer. The following apologies were noted: • Alan Prosser, Director, Welsh Blood Service • David Cogan, Patient Representative	
1.2.0	**In Attendance** The Chair extended a warm welcome to the following additional attendees: • Bethan Davis, Simultaneous Welsh Interpretation Service (HEIW) • Rachel Hennessy, Interim Director of Velindre Cancer Service *(remotely)* • Katrina Febry, Audit Lead, Audit Wales • Peter Groves, Chair, Health Technology Wales (for item 4.7.0) *(remotely)* • Lisa King, Senior Programme Manager, Health Technology Wales (for item 4.7.0) *(remotely)*	

Unconfirmed

	• Paige Jennings-Brooksby, Management Graduate *(observing)*	
1.3.0	**Declarations of Interest** There were no declarations of interest pertinent to today's agenda.	
1.4.0	**Minutes of the Public Session held on 28th November 2024** The Board confirmed that the minutes of the meeting held on the 28th November 2024 were an accurate reflection of proceedings.	
1.5.0	**Action Log** The Board was content to close all actions marked as 'propose to close'. The Chair advised that in relation to action ***2.1.0 (28/11/2024) (Action 18),*** communication had been sent to Colonel Simon Lawrence by the Chair upon being notified of his achievement and had therefore been actioned prior to the meeting. The status of open actions was reviewed as follows: ***7.1.4 (23/05/2024) (Action 3) –*** It was advised that revisions to Schedule 3 of Trust Standing Orders are dependent on the Corporate Governance Manual, which has not been sighted at / approved by Audit Committee to date. Non Gwilym assured the Board that an alternative route would be explored to avoid further delay. Action to remain open. ***4.1.0 (28/11/2024) (Action 19 and 23) –*** While improvements to the Trust Risk Register were acknowledged, a review of the timescale for achieving **target rating** alongside action 23 in relation to the Trust Assurance Framework was advised from next reporting cycle. ***4.1.0 (28/11/2024) (Action 20) –*** Update on dates for actions had been conducted by divisional Directors prior to January meeting, in addition to renewed emphasis on management of SMART actions as part of Risk Management Training. It was agreed to close the item. ***6.1.2 (28/11/2024) (Action 30) –*** Anne Carey advised that the discrepancy in the dates within the report resulted from misalignment with WBS procurement and a national procurement. NHS Wales Shared services has confirmed the discrepancy, and alignment will be achieved via a 'bridge' procurement. This is to be governed via the Board and the action is to remain open until circulated and approved. The Trust Board accepted the position and updates noted above.	**NG** **NG** **Secretariat** **AC/ Secretariat**
1.6.0	**Matters Arising** There were no matters arising for discussion.	
2.0.0	**KEY REPORTS**	
2.1.0	**Chair's Report** Professor Donna Mead OBE, Chair The report provided an overview of the Chair's activity since the previous meeting of the Trust Board.	

Unconfirmed

	The Chair wished to formally record congratulations to all colleagues recognised in the King's New Year's Honours and advised that all recipients had been contacted individually on behalf of the Board. There were no queries and the Trust Board **NOTED** the content of the Chair's Update Report.	
2.2.0	**Chief Executive's Report** David Donegan, Chief Executive Officer The report provided information to the Board on a number of key matters for the period December 2024 to January 2025. Chief Executive, David Donegan welcomed the ongoing support of patients and services across Wales by staff across the divisions and wider organisation, commending the willingness to engage to continue to improve services and performance. There were no queries and the Trust Board **NOTED** the content of the Chief Executive's Update Report.	
3.0.0	**INTEGRATED GOVERNANCE**	
	There were no items for discussion at today's meeting.	
4.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
4.1.0	**VUNHST Risk Register (including update on current January 2025 position)** Non Gwilym, Director of Corporate Governance (interim) The report summarised the current position of risks scoring 12 and above for Quality / Safety and 15 and above for all other domains, allowing the Board effective oversight and assurance regarding the reporting and managing of risks across the Trust. The Chair acknowledged and welcomed the development of the Register since the last board meeting, which had resulted in a more informative report. The Board noted the removal of areas of duplication, in addition to work currently being undertaken by the team to include SMART actions in future iterations. Non Gwilym thanked colleagues for their contribution to achieving the current position. The assurance rating remained at level 2 as further work on the Register is still required. Anne Carey advised that detailed work had been undertaken by Rachel Hennessy to provide the most up to date position (1 week prior to the meeting) regarding Velindre Cancer Service (VCS) risks to the Board, which was welcomed. However, the previous reporting process had remained in place for the Welsh Blood Service (WBS), therefore reporting a mid-December position. It was advised that the VCS reporting process would be extended to WBS upon confirmation that the Board was content and this was agreed. Significant discussion regarding specific risks followed: **Risk 2249 (22)** – Risk level of 16 should appear in the first column. **Risks 3270 (10) and 3332 (11)** - The most recent update is shown as November and capture of these risks in the new process is required.	**NG** **NG**

Unconfirmed

	Risk 3270 (10) (additional) –the chair requested assurance that all outpatient slots were being used. It was noted that while gaps remain within outpatients slots, regular audits are undertaken to ensure correct utilisation of these. It was confirmed that while all slots are available Monday – Friday, the focus is on increasing use of Wednesday and Friday afternoons which tend to receive fewer patients. **Risk 3543 (21)** – Gareth Jones queried the reason for the reduction in the risk as this wasn't included in the cover paper. Anne Carey indicated that this had been included within the appendix and will be picked up in both papers in the future. **Risk 2187 (2)** – Gareth Jones queried the narrative within the risk stating "workforce plan completed Q3, but currently on hold", querying the reasons for the pause. As a further risk (**Risk 2249 (22)** relating to a financial issue) also related to Workforce, it was suggested that a report specific to Workforce risks would provide additional assurance; Sarah Morley agreed to facilitate this. Vicky Morris welcomed the improvements to the Risk Register but noted a number of static risks. It was suggested that a benchmarking exercise could be undertaken to address this. Non Gwilym advised that this is already underway and that learning sessions are undertaken with the Senior Leadership Team to ensure improved risk reporting and it is anticipated that these risks will improve as a result. **Risk 3542 (20)** – Andrew Westwell expressed concern that this risk had been closed due to its connection with another open risk **(3541 (19))**. It was suggested that a single, merged risk should be created to capture the information from both. This was agreed. **Risk 3448 (13)** – The Chair suggested that the wording of this risk indicated focus on process rather than patient harm. Jacinta Abraham advised that active discussion was underway to recruit a second consultant, however, there is a need to develop the service beyond 2 Consultants. The Trust has reached out to Aneurin Bevan as a potential additional provider. The Chair requested that a paper be presented to the Strategic Development Committee regarding the development of the leadership role, recognising a broader issue than this single risk alone. **Risk 3468 (15)** – Advertisement for Sarcoma Consultant on Twitter / X; David Donegan advised that the NHS Welsh Confederation had taken an active decision to move away from X as a medium for conducting business. Non Gwilym is currently exploring the overall Wales position, which will influence next steps; the Board will be updated on findings. The Trust Board **NOTED:** • The risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above; • The ongoing development of the Trust's Risk Framework; • The work underway to improve organisational management of risk reporting and the targeting of continued improvements.	**NG** **SM** **NG** **JA** **NG**
4.2.0	**Trust Assurance Framework (TAF)** Non Gwilym, Director of Corporate Governance (interim) The report summarised the latest position of the Trust Assurance Framework, providing the Board with the opportunity to review updates and	

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	actions planned for the coming period. Non Gwilym advised that the document did not align with the new risk and new report on risk, which would be the focus going forward following approval of the work in relation to the new TAF by Executive Management Board and Strategic Development Committee. The following specifics were addressed: While the work to date was applauded, Vicky Morris noted that further development is required to ensure translation of actions into controls and assurances, which will inform the Board regarding impact and delivery of strategic objectives. **TAF07** – Lindsay Foyster queried whether both 2nd and 3rd lines of defence should be internal processes. Jacinta Abraham suggested referencing benchmarking / quality standards and it was agreed that this would be addressed for the next publication. Lindsay Foyster suggested it may be more appropriate to use the 7 levels of assurance for assurance rating purposes. It was agreed that this would be taken on board when mapping out assurance for the next year (to be brought to the May 2025 meeting of the Board). **TAF03 action 03.12 (Nurse Retention Plan)** – While the action notes the current draft status of the Nurse Retention Plan, Nicola Williams advised that the plan had been signed off by Executive Management Board. However, due to its complexity, implementation of this would be delivered by April 2026. Lauren Fear advised that actions to address strategic risks would be included within the IMTP and as a result, only one set of actions would be included in the new report as of the next financial year. Cover paper amendments raised: • Amendment of date from April 2026 to 2025 (in relation to TAF04 action 03.12) within the cover paper. • Amendment of date from Feb 24 to Feb 25 (at top of page 6 of cover paper relating to paper due at SDC). • **TAF06 action 06.06** – amend from 'activity ongoing, no firm date for completion' to include further information. Anne Carey advised that benchmarking is ongoing, with quarterly reporting; this wording will be included. The Trust Board **NOTED** the current status and ongoing development of the Trust Assurance Framework and **NOTED** that an amended format would be received from the beginning of the next financial year.	**JA / NW** **NG** **NG** **NG** **AC / NG**
4.3.0	**Performance Management Framework (November 2024)** Lauren Fear, Director of Transformation (interim), Anne Carey, Chief Operating Officer (interim), Matthew Bunce, Executive Director of Finance and Sarah Morley, Executive Director of Organisational Development and Workforce The Framework provided an update and supporting analysis on the performance of the Trust for the month of November 2024 against a number of targets. Lauren Fear advised that a theme of development activity in relation to the framework has focused on the creation of a 'pyramid of reporting', with the adoption of exceptional reporting during the last cycle. Two further developments had been included in this cycle (the inclusion of	

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levels of assurance for each part of the report and the introduction of an explicit decision to escalate matters to the Quality, Safety & Performance Committee). The Committee was content that performance exceptions and items escalated were being dealt with by the relevant Directors.

The new format for reporting was welcomed and the Board noted that the improved narrative enabled focused discussions on key issues.

The Chair queried the significant discrepancy between unvalidated and validated performance data in relation to SACT waiting times (noting that this had been reported incorrectly as percentage differences as opposed to percentage *point* differences). The accuracy of the initial data was also questioned. Anne Carey explained that a 16-week programme is currently being undertaken to design a Cancer Patient Tracking List to facilitate closure of the discrepancy between both sets of data.

Sarah Morley advised that the three Key Performance Indicators relating to Workforce, Wellbeing & Organisational Development remained stable and a number of key pieces of work are ongoing:

- Staff sickness stood at 5.15% to the end of January 2025 and a 'deep dive' had been undertaken to identify hotspots; these will be focused on in collaboration with relevant management colleagues to implement targeted interventions in these areas.
- Development of the Trust's new PADR policy; paperwork is currently being trialled to improve conversations, outcomes, and compliance with the Trust's target. Early feedback is positive.

Andrew Westwell queried other NHS Organisations' position and the availability of comparative data. Sarah Morley advised that a national dashboard is published monthly and the Trust's overall position is positive; the focus will now be on benchmarking beyond Wales.

Gareth Jones queried whether the key issues and risks noted in this section correlate with the action / mitigation underway. It was agreed that the description would be improved, but that the actions / mitigations referred to directly correlate with how Managers manage their staff and fundamental training would achieve a position of knowledge, capacity and confidence to assume Line Management activities effectively.

Hilary Jones noted that the Trust is not on target in relation to Cyber Security in a number of areas (in particular the number of significant IT Business Continuity incidents), querying action currently being taken to improve in this area. Carl Taylor advised that while the Cyber plan is being delivered, it was recognised that updates are infrequent. Compliance against Cyber Security is measured annually using the NHS Wales method of measuring as opposed to the "10 steps to Cyber Security" and a change in score should be evidenced as a result.

Additionally, compliance with Cyber Security statutory & mandatory training currently stands at 82% and the importance of staff being up to date with Information Governance and Cyber Security training was reiterated. It was noted that Information Governance training is currently targeting high-risk areas.

Carl Taylor advised that the issue of IT Business Continuity incidents had been discussed at the Quality, Safety & Performance Committee, confirming that there are no outstanding action plans for these incidents; these

Unconfirmed

	comprise a small number of local incidents, however the majority are national incidents managed by Digital Health & Care Wales (DHCW) and a number of actions are underway. It was accepted that gaps will be identified and targeted, suggesting that current training methods are onerous and could be improved. Stephen Harries suggested that a single session could be run for whole staff groups / departments, combining Information Governance and Cyber Security, as an alternative method of delivery. It was agreed that Board Members could receive this as part of a future Board Development session. Finally, the improvement in user satisfaction relating to use of the Digital Service Desk (now at 98%) was acknowledged and the significant improvement in the service was commended. The Trust Board**:** • **NOTED** the Performance Management Framework detailed analysis for the month of November 2024. • **NOTED** the progress against the nine agreed work packages. • **NOTED** the levels of assurance for each Division/ Directorate, as agreed by Executive Management Board and discussed and noted at Quality, Safety and Performance Committee. • **NOTED** that Executive Management Board concluded that given the levels of assurance and following discussion on a number of the exceptions for this reporting period, there were not any specific matters which were for escalation to the Quality, Safety and Performance Committee nor therefore Trust Board. Executive Management Board agreed that performance exceptions are being appropriately dealt with by the responsible Director.	**Secretariat**
4.4.0	**Financial Report (December 2024)** Matthew Bunce, Executive Director of Finance The report provided an update on the financial position and performance for the period to the end of December 2024. Matthew Bunce advised the following: • **Long Term Agreement (LTA) disputes and uplift to the LTAs** - issues will be subject to further discussion during the next cycle of the IMTP in time for the draft position of the next IMTP. • **New risk -** regarding LTA marginal income from growth in activity may not match the level of investment into services – forecast remains at £700k short of this year's target. • **Integrated Medium Term Plan (IMTP)** – issue of several Health Boards refusing to pass through values allocated to them as set out in allocation letters. Discussions at the previous Commissioners' meeting indicate that the risk is not completely mitigated and further negotiation is required prior to issue of LTAs for signing. • **Key Financial Targets / Key Performance Indicators (KPIs)** – It is anticipated that all 3 KPIs (Revenue, Capital and Public Sector Payment Performance) will be met this financial year. • Recent emergence of a further **risk relating to Same Day Emergency Care funding (SDEC);** Welsh Government has indicated that this funding may potentially be withdrawn from the Trust for the next financial year. Negotiations with Welsh Government are underway to understand the rationale around the decision as it was suggested that this funding should be recurrent year on year.	

Unconfirmed

	Gareth Jones requested further information regarding the new risk and sought information on whether the £700k deficit had resulted from cancer activity growth not being as expected noting that this did not correlate with information within the Audit Wales report on cancer services in Wales. Matthew Bunce advised that while SACT and Outpatient activity is exceeding the set target, the Radiotherapy target had been set relating to Radiotherapy treatment activity (which had not been delivered); a review of forecasting demand and planning and a robust process for the capture of information coming from the wider system is required (for the Trust's own planning) . The Board noted that a significant amount of work had already been undertaken to date to ensure that information is captured correctly. It was recognised that while the three KPIs will be met, the use of £700K of 'growth funding' will be required on the back of anticipated funding that will potentially no longer be received. It was suggested that the rationale for calculation of the figures could be addressed in a Board Development Session, in addition to an update on reflections / lessons learnt which will inform more accurate information for 2025-26. The Trust Board **NOTED** the content of the December 2024 financial report, in particular: • The year to date and forecast revenue out turn position and PSPP performance. • The agreed position on LTA income for 2024-25 from our Commissioners. • The position with Commissioners on the contract rebase agreement. • The latest position on the LTA activity performance for 2024-25.	**MB /Secretariat**
4.5.0	**Public Quality, Safety & Performance Committee Highlight Report (16/01/2025)** Vicky Morris, Independent Member and Chair of Quality, Safety & Performance Committee. *This item was addressed following item 4.7.0 (Health Technology Wales Annual Report).* The report provided the Board with detail of the key issues and risks considered at the January meeting of the Quality, Safety & Performance Committee. Vicky Morris highlighted Policy management and compliance report, which the Committee had received for the first time with the required level of detail. This had provided a more accurate view of compliance across the Trust, which provided assurance regarding compliance with policy management review. The Trust Board **NOTED t**he key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on 16th January 2025.	
4.6.0	**Annual Presentation of Nurse Staffing Levels** Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Scientists The report provided an update on compliance with the Nurse Staffing Levels (Wales) Act 2016 and the position from 1st October 2023 to 30th September 2024. Nicola Williams highlighted the following:	

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	• No reportable harm was reported during the period in relation to the quality indicators in respect of the nurse staffing levels on the First Floor Ward (the only area relevant to the Act). • It was advised that both documents appended to the report would be submitted to Welsh Government and are subject to a six month internal review. • The Trust is currently working to a ratio of Registrants / Health Care Support Workers of 65 / 35 respectively. It was noted that a 60 / 40 ratio is considered best practice, which has been exceeded by the Trust. There were no questions raised and the significant assurance provided by the report was welcomed. The Board **NOTED** the compliance in respect of the Nurse Staffing Levels Wales Act, prior to submission to Welsh Government.	
4.7.0	**Health Technology Wales Annual Report** Peter Groves, Chair HTW, Lisa King, Senior Programme Manager HTW *This item was addressed following item 4.4.0 (Financial Report).* The Chair welcomed Peter Groves and Lisa King to present the Health Technology Wales Annual Report to the Board. Peter Groves introduced the report, outlining the nature of Health Technology Wales as a national programme funded by Welsh Government, which identifies and promotes the uptake of medical technologies within NHS offering benefits to patients and value to the healthcare system. This is achieved by identifying technologies, undertaking evidence based assessments and appraisals, publishing national guidance on the organisation's website, while also subsequently auditing the uptake and adoption of such national guidance. Peter Groves informed the Board of key areas of activity over the reporting period, including: • Identification of topics proposed to the organisation (including a breakdown of sources of topic referrals); • Evidence-based appraisals / assessments (and methods for adoption of medical technologies); • Medical Technology guidance published by Health Technology Wales over the course of the year; • Adoption audit key findings (including themes and barriers to adoption); • Evidence-based MedTech Report to Welsh Government Andrew Westwell requested further information regarding work with the Life Sciences Hub in terms of implementation of recommendations, given their links to industry. Peter Groves advised that implementation and adoption is an important element of the collaborative work with the Life Sciences Hub, facilitated via a memorandum of understanding, sharing of work programmes and regular quarterly meetings to avoid duplication and identify areas that can be worked on together with those who deliver services. Jacinta Abraham welcomed the report, acknowledging that the Trust had been funded by Health Technology Wales to explore and test the Audit Management and Tracking (AMaT) system, which had subsequently become a significant part of the Trust's infrastructure in relation to clinical audits and the Quality & Safety domain.	

Unconfirmed

	Jacinta Abraham also referenced work undertaken with the Trust's Patient Engagement Groups on the use of Artificial Intelligence and questioned how this could be built upon. Peter Groves advised that this crucial work had already contributed to and been referenced within Health Technology Wales' guidance programme. It was acknowledged that Peter Groves' 7 year tenure as Chair of Health Technology Wales would conclude in April of this year and the Chair noted a number of successes under his tenure, in particular: • Routine attendance at the Chair's Peer Group, to communicate the importance of the Health Technology Wales and its function across Wales. • Development of the current collaborative relationship with the Trust and Health Technology Assessment agencies worldwide. • Strengthening and development of patient and public engagement. • That the first ever adoption audit had been undertaken during this time; this has now become routine, providing valuable information. • Recognition of the calibre of HTW appraisals by appraisal centres internationally • The excellent work for rapid appraisals undertaken during the Covid pandemic. Peter Groves was thanked for his significant contribution and the Trust Board **NOTED** the Health Technology Wales Annual Report.	
5.0.0	**PLANNING AND STRATEGIC DEVELOPMENT**	
5.1.0	**Strategic Planning Update** Lauren Fear, Director of Transformation (interim) The report provided the Board with a bi-monthly update on key strategic planning matters for the period. Lauren Fear highlighted the following: • The Integrated Medium Term Planning Framework had been updated to include requirements and national guidance relating to a number of Cabinet Secretary priorities, (included in section 2.1.1). These had been worked through during January for inclusion within the first draft of the IMTP. • Confirmation that the first draft of the full plan will be produced by the end of January 2025, for discussion at Executive Management Board, Strategic Development Committee and subsequently the March meeting of the Trust Board, prior to submission to Welsh Government on 30th March 2025. • Following the development of the South East Wales Regional Cancer Planning Board (comprising Cwm Taf Morgannwg, Cardiff & Vale, Aneurin Bevan and subsequently Velindre in August 2023) the Trust had joined the partnership in 2023. Lauren Fear indicated the inclusion of a summary report from the Regional Cancer Programme Board shared by all Directors of Planning to ensure that a common report is received by all Boards. • The Regional Oversight Board has agreed to amend the status of the Cancer Programme from RED to AMBER to reflect progress made since October 2024. The Chair queried whether completion of the IMTP by the end of March 2025 for submission to Welsh Government was on target. Lauren Fear confirmed that this was the case and that the plan would also address the planning	

Unconfirmed

	guidance issued during December 2024 and a number of Cabinet Secretary priorities. The Trust Board **NOTED** the update for assurance purposes.	
6.0.0	**CONSENT ITEMS**	
6.1.0	**CONSENT FOR APPROVAL**	
6.1.1	**Chair's Urgent Actions Report** Non Gwilym, Director of Corporate Governance (interim) There was one urgent item of business for the Trust Board that was considered via Chair's Urgent Action during this period: • High Voltage Intake Building. The Trust Board **RATIFIED** the Chair's Urgent Action taken between 22nd November 2024 and 23rd January 2025.	
6.1.2	**Commitment of Expenditure Exceeding the CEO Limit** Non Gwilym, Interim Director of Corporate Governance There was one item of expenditure required for Trust Board approval during this period: • Courier Services for Samples at Welsh Bone Marrow Donor Registry (WBMDR) and National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics (H&I) – appendix 1. The Trust Board: • **AUTHORISED** the Chief Executive to **APPROVE** the award of the contracts summarised within this report and supporting appendix. • **AUTHORISED** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements.	
6.1.3	**Budgetary Delegation – Amendment to the Delegated Financial Limits of the Chief Executive Officer and Framework for Officer Financial Limits** Matthew Bunce, Executive Director of Finance The Trust Board: • **APPROVED** increasing the delegated financial limit of the Chief Executive Officer (CEO) from **£100k** to **£500k.** • **NOTED** the proposed delegated Financial Framework and indicative Financial Limits to be provided to officers of the Trust below that of the Chief Executive Financial Limit as set out in the Trust SFIs.	
6.1.4	**Trust Policies for approval** Non Gwilym, Interim Director of Corporate Governance The following 5 amended / new policies were presented to the Board for approval: • Reviewed – Employing Ex-Offenders and People with a Criminal Record Policy	

Unconfirmed

	• Medical and Dental T&C Annual Leave Policy • NHS Wales Job Evaluation Policy and Procedure • NHS Wales Pregnancy Loss Support Policy • NHS Wales Procedure for Recovery of Overpayments The Trust Board **APPROVED** the amended / new policies for adoption within the organisation.	
6.2.0	**CONSENT FOR NOTING**	
6.2.1	**Public Audit Committee Highlight Reports (17/09/2024 & 12/12/2024)** Gareth Jones, Independent Member and Chair of the Audit Committee The Trust Board **NOTED** the content of the reports.	
6.2.2	**Public Strategic Development Committee Highlight Report (22/10/2024)** Stephen Harries, Chair of the Strategic Development Committee The Trust Board **NOTED** the content of the report.	
6.2.3	**Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports (25/09/2024 & 21/11/2024)** Stephen Harries, Acting Chair and Chair of the TCS Scrutiny Sub-Committee The Trust Board **NOTED** the content of the reports.	
6.2.4	**Local Partnership Forum Highlight Report (12/12/2024)** Sarah Morley, Executive Director of Organisational Development & Workforce The Trust Board **NOTED** the content of the report.	
6.2.5	**Remuneration Committee Highlight Report (20/11/2024)** Professor Donna Mead OBE, Chair of Remuneration Committee The Trust Board **NOTED** the content of the report.	
6.2.6	**Trust Seal Report** Non Gwilym, Interim Director of Corporate Governance The Trust Board **NOTED** the content of the Trust Board Seal Register for the period **26th September 2024 – 27th November 2024**.	
6.2.7	**Health & Wellbeing Champion Annual Report** Stephen Harries, Vice Chair The Trust Board **NOTED** the content of the report.	
6.2.8	**Academic Partnership Report** Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The Trust Board **NOTED** all the academic partnership working that has taken place during 2024.	
7.0.0	**Any Other Business**	

	Prof. Donna Mead OBE, Chair One item of any other business was raised by Nicola Williams, relating to the current Cardiff University consultation and future provision of pre-registration training for nurses. It was formally noted that measures would be implemented to support current students and that discussions among Executive Directors of Nursing across Wales would feed directly into the consultation; discussions are currently focusing on options to ensure that training requirements are met across Wales in order to sustain future workforce.	
8.0.0	**DATE OF NEXT MEETING** The next public meeting of the Trust Board will take place on Thursday 27th March 2025.	
9.0.0	**CLOSE**	
10.0.0	**It was noted that the following items would be addressed at the Private / Part B Session of the Trust Board:** • Minutes of previous private Trust Board meeting • Action log • Velindre Cancer Service Structure • Electronic Prescribing and Medicines Administration • Private Committee Highlight Reports	

Unconfirmed

MEETING DATE	AGENDA ITEM	Action number	ACTION	LEAD	DEADLINE DATE	UPDATE (including date)	STATUS
23.05.2024			**REVISIONS TO SCHEDULE 3 OF TRUST STANDING ORDERS**				
	7.1.4	**3**	Terms of Reference for relevant Committees to be amended to include reference to requirements to demonstrate quality-led decision-making through receipt of Quality Assessments (at Committees where strategic decisions are undertaken).	Interim Director of Corporate Governance	~~**26/09/2024**~~ **27/03/2025**	**3 March 2025** All Committee Terms of Reference under review. New Terms of Reference to be confirmed by Trust Board May 2025. **16 January 2025** Updated Terms of Reference template for all Trust Board Committees to have proposed new wording which ensures that all matters, including Quality Impact Assessments, that need to be undertaken by the Trust Board in decision making, are referenced. (ie the Impact Assessment section of the cover paper). This is included in the Corporate Governance Manual for Audit Committee in December. Action to be reconsidered following Audit Committee meeting and consideration of manual. All ToR to be revised accordingly and considered as part of annual cycle.	**OPEN**
28.11.2024			**VUNHST RISK REGISTER**				
	4.1.0	**19**	Confirm timescale for when 'target rating' may be achieved. To be discussed with Executive Team.	Interim Director of Corporate Governance	~~**30/01/2025**~~ **27/03/2025**	**3 March 2025** Target ratings in register from May 2025. Target dates are included on Datix, as part of the intial assessment and review process. **16 January 2025** Target date for target rating to be reviewed at next EMB discussion of risk on 10 February.	**OPEN**
28.11.2024			**TRUST ASSURANCE FRAMEWORK**				
	4.2.0	**23**	Confirm timescale for an update on the risk score trend (to be agreed at Executive Management Board).	Interim Director of Corporate Governance	~~**30/01/2025**~~ **27/03/2025**	**3 March 2025** New narrative refers directly to risk score trend to allow for improved scrutiny. **16 January 2025** Target date for target rating to be considered by all Strategic Risk Owners in advance of Strategic Development Committee consideration of TAF 18 February 2025.	**PROPOSE TO CLOSE**
28.11.2024			**COMMITMENT OF EXPENDITURE EXCEEDING CEO LIMIT**				
	6.1.2	**30**	Inconsistencies in dates within the paper require correction, prior to circulation.	Chief Operating Officer	~~**30/01/2025**~~ **27/03/2025**	Updated Documentation to be circulated to IMs independently.	**OPEN**
30.01.2025			**VUNHST RISK REGISTER**				
	4.1.0	**31**	Amend Risk 2249 so that risk level of 16 appears in the first column. Risks 3270 and 3332 has most recent update showing as November - these are to be captured in the new reporting process which will be rolled out to both divisions. Risk 3543 - include rationale for reduction of risks within the cover paper and not appendix to avoid having to refer to multiple documents. Risk 3542 - As this (closed) risk relates to an open risk, create single merged risk to capture information from both. Risk 3468 regarding advertising on Twitter / X - to ascertain the overall Wales position regarding use of Twitter / X as a means for conducting business to inform next steps for the Trust.	Interim Director of Corporate Governance	**27/03/2025**	2249 - action complete 3270 - reviewed in February 2025 3332 - reviewed 20 February 2025 3543, 3542 - risks have been reviewed and rationalised with RIsk 3541. With reference to 3468, paper on X in draft for EMB consideration.	**PROPOSE TO CLOSE**
30.01.2025			**VUNHST RISK REGISTER**				
	4.1.0	**32**	Risk 2187 and 2249 - Develop report specific to Workforce risks for discussion at Board.	Executive Director of Organisational Development & Workforce	**22/05/2025**	**Update March 2025**: On track for May 2025 Board consideration.	**OPEN**
30.01.2025			**VUNHST RISK REGISTER**				
	4.1.0	**33**	Risk 3348 - Paper regarding development of leadership role to be presented to future Strategic Development Committee.	Executive Medical Director / Chief Operating Officer	**27/03/2025**	**Update 21/03/2025** 1) A revised service delivery model has been developed in conjunction with leads across the region. 2) Risk 3348 has reduced to level 12. 3) This work is being picked up via the fragile services' response, therefore the requirement for a paper is to be reconsidered.	**OPEN**
30.01.2025	**4.2.0**		**TRUST ASSURANCE FRAMEWORK**				

		34	TAF07 - Amend 2nd and 3rd lines of defence to potentially reference benchmarking / quality standards. Seek to utilise the 7 levels of assurance in assurance rating. To be considered when mapping out assurance for the coming year. Cover paper amendment: Amendment of date from April 2026 to 2025 in relation to TAF04 action 03.12). Cover paper amendment: Amendment of date from February 24 to February 25 at top of page 6 relating to paper due at SDC. Cover paper amendment: TAF06 action 06.06 - amend from 'activity ongoing, no firm date for completion' to include further information regarding ongoing benchmarking and quarterly reporting.	Executive Medical Director / Executive Director of Nursing Interim Director of Corporate Governance As above As above Interim Director of Corporate Governance / Interim Chief Operating Officer	**27/03/2025**	Confirmation that 7 levels of assurance is to be used in the TAF for remainder of the 2024-25 reporting period and for 2025-26. ***THIS ACTION CAN BE CLOSED.*** 7 levels of Assurance adopted for TAF. This will be the case for the 2025-26 TAF. ***THIS ACTION CAN BE CLOSED.*** Remaining actions to be closed as they have been actioned. This action to be deleted once amendment made.	**PROPOSE TO CLOSE**
30.01.2025	**4.3.0**		**PERFORMANCE MANAGEMENT FRAMEWORK**				
		35	Possible training to be provided at a future Board Development Session to cover Cyber Security and Information Governance.	Secretariat	**27/03/2025**	**Update January 2025** - To be included on April Board Development agenda.	**PROPOSE TO CLOSE**
30.01.2025	**4.4.0**		**FINANCIAL REPORT - DECEMBER 2024**				
		36	Calculation of Marginal Income figures to be addressed at a Board Development session.	Executive Director of Finance	**10/04/2025**		**OPEN**

TRUST BOARD	
CHAIR'S UPDATE REPORT	
DATE OF MEETING	27th March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Prof. Donna Mead OBE, VUNHST Chair
APPROVED BY	Non Gwilym, Interim Director of Governance and Chief of Staff
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chair's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	To **NOTE** the content of the Chair's update report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	
7 LEVELS OF ASSURANCE – N/A	

APPENDICES – N/A

1. SITUATION

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

2. BACKGROUND

2.1 Matters addressed in this report cover the following areas:

- Board Development Sessions (13th February 2025)
- Private Trust Board meeting (30th January 2025)
- Wear Red for Wales and Velindre (31st January 2025)
- Ministerial Visit (4th February 2025)
- Medical Engagement Conference (5th February 2025)
- Welsh Blood Service Donor Awards – Cwmbran area (18th / 19th February 2025)
- Climate Emergency Leadership Day (21st February 2025)

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Board Development Sessions

One Board Development Session took place during the period (13th February 2025 2024), to discuss the following:

- Reflections – David Donegan, Chief Executive Officer
- Lessons Learnt (Contract Management and the wider nVCC Project)
- Corporate Manslaughter Education
- Organisational Culture
- Proposed Changes to the NHS Wales Chairs' Appraisal Process

3.2 Private Trust Board meetings:

30th January 2025 (regular) - Discussions at this private meeting of the Trust Board addressed the following items:

- Velindre Cancer Service Structure
- Electronic Prescribing and Medicines Administration (ePMA) Full Business Case
- Private Committee Highlight Reports

3.3 Wear Red for Wales and Velindre





On Friday 31st January, the Velindre Charity hosted its annual Wear Red for Wales and Velindre Campaign; a day dedicated to raising vital funds to enhance the experience of Velindre staff, patients and their families.

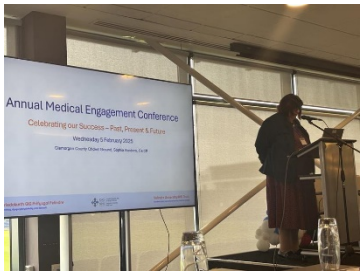
The funds raised from the campaign allow the Trust to invest in projects that directly impact the work at Velindre, making a positive difference for the patients, families and colleagues we serve.

3.4 Ministerial Visit – World Cancer Day



We were delighted to welcome Cabinet Secretary for Health, Jeremy Miles MS, into our Clinical Trials department for World Cancer Day (4th February). He also met Lesley Jenkins, the first patient in Wales to receive an investigational vaccine designed to fight her own specific form of cancer, as part of a groundbreaking new research study supported by Health and Care Research Wales.

3.5 Medical Engagement Conference



The Trust hosted this year's Medical Engagement Conference (5th February) at Sophia Gardens, Cardiff. The event brought together healthcare professionals, educators and senior healthcare leaders to showcase the outstanding work and innovative practices across the organisation.

This year's theme, 'Celebrating Our Success – Past, Present and Future', provided an opportunity to reflect on the outstanding standards the Trust has achieved, while also looking ahead to the continued transformation of our service in Wales and beyond.

3.6 Welsh Blood Service Donor Awards – Cwmbran area



The donor engagement team hosted its February (18th and 19th) event in Cwmbran. The team presented a special award to 79 year old Vaughan Smith, who has donated blood an incredible 132 times over 63 years, which made him one of Wales' longest-serving donors and his donations alone have saved up to 396 people across Wales.

Across the two nights, the team recognised more than 110 donors who have collectively saved an incredible 20,000 lives through whole blood, platelets or stem cell donations.

3.7 Climate Emergency Leadership Day

The Chair and members of the Executive Team attended the Climate Emergency Leadership Day (21st February), held at Sophia Gardens in Cardiff. The aims of the day were to raise awareness across leadership cohorts of the climate emergency, showcase a range of sustainability projects currently being undertaken, achieve a collective input to common themes and barriers identified when delivery sustainability activity and provide a challenge / action / aim for attendees to achieve.

3.8 On 19th March, the Chair attended a **meeting of Chairs of All Welsh Public Bodies** at the Temple pf Peace and Health in Cardiff. One of the key agenda items was the Diversity on Public Boards report. A presentation was received from Professor Emanual Ogbonna, joint chair of the External Accountability Group and what actions are being taken, the barriers and what further support can be provided. This will be followed up at a forthcoming board development agenda.

3.9 The Chair represented the Trust at a **leaving event for Peter Groves, outgoing Chair of Health Technology Wales.** HTW is hosted by Velindre University NHS Trust. Under Professor Grove's leadership, HTW has developed into an organisation respected for technology appraisals throughout Wales, the UK and internationally.

3.10 The process for appointing a **Vice Chair for the Trust** is ongoing. A decision from the Cabinet Secretary for Health and Social Care is awaited.

3.11 The March Board meeting of Velindre University NHS Trust is the last one for **Stephen Harries**. It is difficult to put into words the outstanding contribution which

Stephen has made during the last 8 years. His contribution to the work of the board included staff health and well-being, patient experience, information governance, and transforming cancer services and much more. He has been an outstanding support to me as Chair. On behalf of the Board, I give Stephen our very best wishes for the future.

3.12 The Chair recently chaired the appointment panels for **two new Consultant posts.** Both were appointed to, the calibre of the candidates appointed was excellent.

3.13 The Chair recently attended a **fundraising lunch organised by the Maxwell family** for the Craig Maxwell fund. There was an opportunity to talk to Craig and his family and to congratulate Craig in person for being awarded an OBE in the last New Years honours.

4 IMPACT ASSESSMENT

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

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD	
CHIEF EXECUTIVE'S UPDATE REPORT	
DATE OF MEETING	27 March 2025
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	David Donegan, VUNHST Chief Executive
PRESENTED BY	David Donegan, VUNHST Chief Executive
APPROVED BY	David Donegan, VUNHST Chief Executive
EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chief Executive's activity since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the content of the Chief Executive's update report.
GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	
7 LEVELS OF ASSURANCE – N/A	

APPENDICES – N/A

1. SITUATION

This paper provides the Trust Board with an overview of Chief Executive's activity since the January Trust Board meeting.

2. UPDATE

2.1 Cabinet Secretary visit to Velindre Cancer Service

On 4 February we were delighted to welcome Cabinet Secretary Jeremy Miles MS into our Clinical Trials department for World Cancer Day.

This was the Cabinet Secretary's first visit to Velindre Cancer Centre where he met with Lesley Jenkins - the first Welsh patient to receive an investigational vaccine against colorectal cancer. It was a great honour to welcome everyone to Velindre Cancer Centre and hear about the ground breaking research trials hosted by the service. I am grateful to Dr Rob Jones in particular for his support on the day, and indeed all contributors who emphasised the unique positioning of our Trust not only throughout Wales, but also in the UK, as a single Trust that manages blood, transplantation and cancer services.

2.2 Attendance at key NHS Wales events

Along with other colleagues, I have represented the Trust at a number of events over the reporting period including:

- the NHS Wales Value and Sustainability Board on 19 Feb
- the Climate Emergency Leadership Day 21st February.
- 4th March – Chief Execs Management Team in person event at the Village Hotel – NHS services delivery planning.

2.3 Appointments

I am delighted to inform you that we have secured several key appointments to the Trust over the reporting period.

Following a comprehensive recruitment process we appointed **Mark Trumper** to the role of Senior Responsible Officer (SRO) for the new Velindre Cancer Centre (nVCC) project. As the SRO, Mark will work with the nVCC Project Team and the wider Executive Team to deliver the new Velindre Cancer Centre which will treat first patient in summer of 2027. Mark has extensive experience as a senior leader, director and estates professional within the NHS and in the private sector, having delivered capital led, transformational change programmes across multi-campus, complex and diverse operational estates. Mark's previous NHS experience includes roles as Executive Director of Estates at NHS London North West University Hospitals NHS Trust and Executive Director of Estates at Oxford University Hospitals, where he led major transformation and infrastructure programmes, including the use of Public Private Partnership models. Mark joined the Trust earlier in March.

Anne Carey was appointed as the Trust's permanent Chief Operating Officer in February. Anne has been our Interim Chief Operating Officer since July 2024 and during that time has worked tirelessly with Velindre Cancer Service and Welsh Blood Service to support the delivery of those services. Following a highly competitive recruitment process which drew a robust field for this role Anne was selected for our permanent position.

In March, we appointed into three key leadership roles within Velindre Cancer Service (VCS), forming our Divisional Triumvirate. These roles will provide leadership capacity and support, recognising the demands of the new hospital and clinical service pressures, while we continue to evolve to meet the needs of our patients and colleagues.

Kate Hannam has been appointed as the Divisional Director and will lead the Divisional Triumvirate.

Kate brings to significant executive and senior operational experience to VCS, having led and developed teams to achieve excellence in healthcare delivery and outcomes at both a local and system level.

With over 20 years working in the NHS, Kate has held a number of senior positions within the NHS, most recently Deputy Chief Operating Officer - UEC (Urgent and Emergency Care) and Outpatient Transformation at East Kent University Hospital NHS Trust.

Dr Carys Morgan was appointed as the Divisional Clinical Director.

Carys has 15 years' experience as a Consultant Clinical Oncologist, specialising in the treatment of Oesophagogastric and Neuroendocrine tumours. She has been Clinical Director for Oncology at VCS and national lead for Wales Upper GI Cancer Site Group, developing national optimal pathways for oesophageal and gastric cancer. She is part of the South Wales Neuroendocrine team recently designated as an ENETs centre of excellence and is currently commencing a PRRT (peptide receptor radioisotope therapy) service for Welsh NET patients.

Emma James was appointed as Nursing, Allied Health Professionals and Healthcare Scientists Director, completing our Divisional Triumvirate team. Emma is an experienced Nurse Director whose background includes both nursing and operational leadership including emergency and acute medicine and critical care. Emma has extensive experience in staff development, organisational change, patient flow and the development of patient pathways. She also has board level experience through her work with City Hospice.

2.4 Annual Medical Engagement Event

One of the highlights in February was attending the Annual Medical Engagement event on 4 February 2025. This event brought together healthcare professionals, educators, and senior healthcare leaders to showcase the outstanding work and innovative practices within the Trust. This year's theme was 'Celebrating Our Success – Past, Present & Future'. It provided a unique opportunity for me to meet with and hear directly from a range of our medical staff across the Trust and to reflect on the outstanding achievements and standards we are adhering to as we continue to focus on improving and transforming our services. Speaking personally, it was a wonderful opportunity to meet with so many of our clinical colleagues and hear about their ambitions for the future of the Trust.

2.5 Celebrating staff and their achievements

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

Celebrating our Blood Donors	We presented a special award to 79-year-old Vaughan Smith who has donated blood an incredible 132 times over 62 years. One of Wales' longest-serving blood donors, Vaughan donated for the first time shortly after his 18th birthday in 1963. Christopher Thomas, who hit the 50-donation milestone *and* has donated stem cells to a patient in need of a transplant • Second-year medical student, Danny Lloyds, who also donated stem cells and promised to never forget the generosity of blood donors when he prescribes blood to patients in the future • Husband and wife, Lawrence and Angela Savage, who both received awards for hitting their 75 milestones • Nine other donors who have reached the milestone of 100 blood donations It means Vaughan's donations alone have saved up to 396 people across Wales.
Celebrating Healthcare Science Week	We celebrated specialists in transfusion science, haematology, and donor services at the Welsh Blood Service who ensure that every patient receives safe, high-quality blood and stem cell products when they need them most. Within the Velindre Cancer Service, we celebrated the healthcare scientists who work behind the scenes and at the

	bedside—developing cutting-edge treatments, advancing diagnostics, and conducting life-changing research into cancer therapies. From pathology to genomics, their expertise helps provide faster, more accurate diagnoses and personalised treatment plans.
Celebrating International Women's Day	To celebrate International Women's Day, we welcome multi-award-winning consultant, trainer, writer, Sara Robinson who delivered a talk titled: '*Late diagnosis and neurodivergence in the workplace: My journey to acceptance '*
Celebrating our 5 minute improvement of the month winners	The Welsh Blood Service January 5 Minute Improvement of the Month Award was won by the Solid Organ Transplant team members for the improvement 'Returning Carboard Sample Boxes to Hospitals for them to Reuse'.
Celebrating Sign-Language week	We welcomed Sarah Roberts from the Centre of Sign Sight Sound, to talk to us about working as an Interpreter as a hearing person.
WBS Preoperative anaemia screening dashboard launched	As part of its work to implement a national pathway for gold-standard preoperative testing and treatment based on NICE Quality Standard 138, the Blood Health National Oversight Group (BHNOG) Anaemia Team. The main way of identifying anaemia is through testing blood haemoglobin level. The most common treatable cause of anaemia is iron deficiency, which is also identified using a blood test. Working with the Digital Health and Care Wales (DHCW) Information Delivery team, the new dashboard will display: ▪ The number of patients undergoing major surgical procedures ▪ The percentage of those patients who have their Haemoglobin tested within 90 days prior to the procedure ▪ Patient outcomes stratified by blood test results prior to surgery ▪ The percentage of anaemic patients who have had a test of iron levels (Ferritin or Transferrin Saturation) within the 90 days prior to their procedure. The aim of this dashboard is to highlight variation, allow local teams to see their own data and help BHNOG identify areas of best practice throughout Wales.
Celebrating Cancer Clinical Nurse Specialists	This National Cancer CNS Day, we spoke to members of the team about their journey to becoming a CNS, and the valuable experience they've earned along the way.

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	**Choose an item** N/A
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD	
VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT DETAILED ANALYSIS FOR JANUARY 2024/25.	
DATE OF MEETING	27 March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Peter Gorin, Head of Strategic Planning and Performance
PRESENTED BY	Lauren Fear, Director of Transformation - interim, Anne Carey, Chief Operating Officer – interim, Rachel Hennessy, Acting Director VCS, Alan Prosser, Director WBS, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	**PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW** The report provides the detailed analysis of all the Performance Management Framework Key Performance Indicators (KPIs) and supports the PMF Executive High-level slides in Section 1 which focus on the key issues to be raised and discussed for the month of January 2024.
RECOMMENDATION / ACTIONS	**The Trust Board is asked to:** • Note the Performance Management Framework detailed analysis for the month of January 2025. • Note the progress against the nine agreed work packages. • Note the levels of assurance for each Division/ Directorate, as agreed by Executive Management Board and discussed and noted

	at Quality, Safety and Performance Committee.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SMT / Performance Review	(12/02/2025)
VCS SLT / Performance Review	(19/02/2025)
Executive Management Board	(25/02/2025)
Quality Safety and Performance Committee	(13/03/2025)

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Summary and outcome of previous governance discussions

The report has been considered and endorsed at the VCS and WBS Performance Review meetings, Executive Management Board and QSP Committee and is presented to the Trust Board for assurance.

The Executive Management Board received an overview of the PMF developmental work packages along with the escalations associated with Duty of Candour and Manual Handling, the following was agreed / noted.

- The Director of Nursing, AHPs & Healthcare Scientist provided assurance to EMB that the six reported Duty of Candour incidents were subject to investigation in accord with Trust policies.
- EMB Noted the progress being reported to insource manual handling training to improve statutory and mandatory training compliance. This would include work to confirm whether staff needed refresher, or full training and active discussions are ongoing with operational teams to identify protected time for training which may include weekends. EMB requested sight of a plan with key dates (acceptable to operations) to address compliance.
- A discussion took place regarding the lack of Trending / SPS reporting for Radiotherapy at a summary level similar to SACT. The Head of Strategic Planning and Performance to consider how achievable this is and to link in with the Chief Operating Officer to find a solution. The RT SPC chart was shared subsequently which demonstrated an improving performance trend over the last 24 months.

The Quality Safety and Performance Committee noted:

PMF Internal Audit

- An internal audit has been carried out on the PMF development work and the current new format PMF reporting process concluding ‘reasonable assurance’ with recommendations made to sharpen the definition of some of the development outcomes

Manual Handling

- The quarterly meeting of the Health and Safety Committee agreed that weekly updates on progress will be provided by Divisional Leads to monitor improvement in patient manual handling training.

Velindre Cancer Service

- The successful move to 'go paperless' was noted as a key enabler to maximize RT utilization and productivity to match patient demand
- The decision to extend the useful life of two Linacs was also noted to maintain capacity prior to the move to the new hospital
- Non-Emergency SACT performance has achieved the 98% target in February for the first time since October 2023

Workforce and OD

- The main focus remains on improving the PADR take up across the Trust

Digital

- The general improvement in service desk response times and satisfaction was noted.
- Cyber compliance is a key focus as well as Statutory and Mandatory cyber training

Estates

- Progress is being made on the PPM backlog, focusing on high priority areas to be completed by the end of March 2025
- Health and Safety have two RIDOR reportable events which are being address and the learning points identified

The QSP Committee considered the report and noted that the performance exceptions and items escalated were being dealt with by the relevant Directors.

7 LEVELS OF ASSURANCE	
Velindre Cancer Service	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Welsh Blood Service	**Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes**
Workforce & Wellbeing	**Level 4 – Increased extent of impact from actions**
Digital Services	**Level 4 – Increased extent of impact from actions**
Estates, Infrastructure and Sustainability	**Level 3 – Actions for symptomatic, contributory and root causes, impact from actions and emerging outcomes**
Health and Safety	**Level 4 – Increased extent of impact from actions**
Financial Services	**Level 4 – Increased extent of impact from actions**

APPENDICES	
	Not applicable

ACRONYMS AND INITIALISM	
VUNHST	**Velindre University NHS Trust**
QSP	**Quality Safety and Performance Committee**

EMB	**Executive Management Board**
SLT	**Senior Leadership Team**
PMF	**Performance Management Framework**
QSF	**Quality Safety Framework**
KPI	**Key Performance Indicators**
SPC	**Statistical Process Control Charts**
SMART	**Relating to goal setting – "Specific, Measureable, Achievable, Relevant, Time-based"**

1. SITUATION AND BACKGROUND
VELINDRE NHST PERFORMANCE REPORT FOR JANUARY 2025

PMF Work Packages – Progress since last reporting period

The Velindre University NHS Trust Executive Management Board have approved nine packages of work in relation to the Trust Performance Management Framework. Progress as at 25th February 2025 is reported below. The NWSSP Internal Audit Plan for 2025 will include a review of the PMF development.

Work Package	Work Package Summary	Target Completion Date	Progress Update	Lead(s)
1 Current Performance Measures and the Level of Statutory Compliance	To analyse the current range of Trust Performance Metrics and to evaluate the current level of Statutory Compliance	December 2024 (To be repeated 6 - monthly)	**Completed** – Compliance summary table now included in each PMF (see report section 3) **Next Compliance table June 2025**	Director of Velindre Cancer Service Director of Welsh Blood Service Trust-wide PMF leads
2 Duty of Quality & Always On reporting targets	The Health and Social Care (Quality and Engagement) Wales Act, which came into force on 1 April 2023, places a number of additional reporting requirements. The mechanisms to report on these areas are being developed. In particular, the Quality Act requirement for 'always on'	30th June 2025	**On Target** - **Re-baselined (as at September 2024)** - The Trust is required to report against Duty of Quality & Always On reporting targets. There is now agreement on the implementation plan for the Quality metric development, in sprints of three weeks over 20	Executive Director of Nursing, Allied Health Professionals and Health Science

	reporting on key performance areas.		weeks. This will be completed in time for reporting from Quarter 2 (2025 / 2026).	Chief Digital Officer
3 Single Source of the Truth for Data, Mapped to Pathways	Since September 2024, there has been development of the structure of the Regional Cancer Programme Board, which includes the consideration of the regional approach to the development of a Regional Minimum Data Set and Patient Transfer List. In addition, the Trust is pursuing its own requirement for a Patient Transfer list locally.	30th June 2025 (tbc.)	**On Target -** The Trust is working with Commissioning Health Boards and via the Regional Cancer Board to ensure that the regional is effectively prioritizing this development; working effectively with Public Health Wales, Wales Cancer Network and Digital Health and Care Wales on the responsibilities to deliver effective cancer data and performance outcome metrics. Led by IQSG.	Chief Operating Officer
4 Inclusion of Targets	To ensure that all KPIs have a set target against which to manage performance.	31st January 2025	**On Target** - New KPI targets have been developed where possible for. For those KPIs where a target has not been identified work continues in this area	Head of Strategic Planning and Performance (with support from service and Trust-wide PMF leads)
5 Exception/ Threshold Reporting	To agree an approach in relation to exception / threshold reporting.	29th November 2024	**Completed** - An approach has been agreed to include exception reporting data only for the Trust Executive Management Board, the Trust Quality, Safety and	Director of Transformation – Interim

			Performance Committee and the Trust Board.	
6 Future PMF Development Plans	VCS, WBS and Trust-wide PMF leads to review the current Trust PMF. This must include any further additional Quality metrics.	31st March 2025	**On Target** - A number of new KPI measures have been added to PMF Scorecards, including RT and SACT 30 day mortality, Antimicrobial Usage, Hand Hygiene and Duty of Candour. New measures being developed for: R&D KPIs Phycology service KPIs	Director of Velindre Cancer Service Director of Welsh Blood Service Trust-wide PMF leads
7 PMF Automation	To 'automate' the production of the PMF performance report in order to reduce the current level of manual interactions in the current process.	28th February 2025	**On target** - Work is also progressing well in relation to the automation' of the production of the PMF. The current focus of the BI team relates to completing the Digital data warehouse build for VCS, WBS and Corporate systems plus developing Digital training video/package.	Head of Strategic Planning and Performance Trust Business Information PMF lead

8 Pyramid Reporting	To agree with the Executive Management Board a preferred way for reporting within the IMTP.	21st December 2024	**Completed** – It has been agreed that, from January 2025, the PMF will be based upon 'exception only' reporting and that the EMB will make this assessment based upon the agreed levels of assurance.	Director of Transformation - Interim
9 Benchmarking	To agree the scope and approach to being able to benchmark our performance data against other comparable organizations.	31st March 2025	**On target** – A Trust Lead has been identified to lead this work programme and it has been agreed that this will be a standard agenda item at the Trust Performance Management Framework Project Group.	Head of Strategic Planning and Performance

1.1 Radiotherapy

Radiotherapy Waiting Times

January 2025

Scheduled	Number referrals	214
	% within 21 days (target 100%)	189 (88%)
	Longest wait 34 days	
Urgent SC	Number of referrals	39
	% within 7 days (target 100%)	33 (85%)
	Longest wait 24 days	

Updates on Last Month:

- Pre-treatment CT capacity remained constant at 17 hours per day
- Planned Linac Capacity is 76.5 hours per day
- Linac uptime Varian 98.3% and Elekta is 98.5% . Machine breakdown on LA5 Halycon was lowest preforming with 97.00% actual uptime. All breakdowns reported and escalated as per agreed policy.
- Schedule performance reduced from 90% to 88%, Urgent SC improved from 73% to 85% and Emergency improved from 89% to 100%.
- Longest wait for scheduled was 34 days due to a complex plan requirement compared to 36 days in November
- Demand in January increased with referrals for Radiotherapy in month at 358. Average monthly referrals in Q1-Q3 were 355.

Key Issues / Risks

- Alignment of consultant job plans with radiotherapy pathway timings results in non-capacity related breaches.
- Ability to forecast and manage this will increase once Aria InSightive post March 2025. This is a delay is due to the DHCW 'Go paperless' programme

Ongoing Assurance Underway:

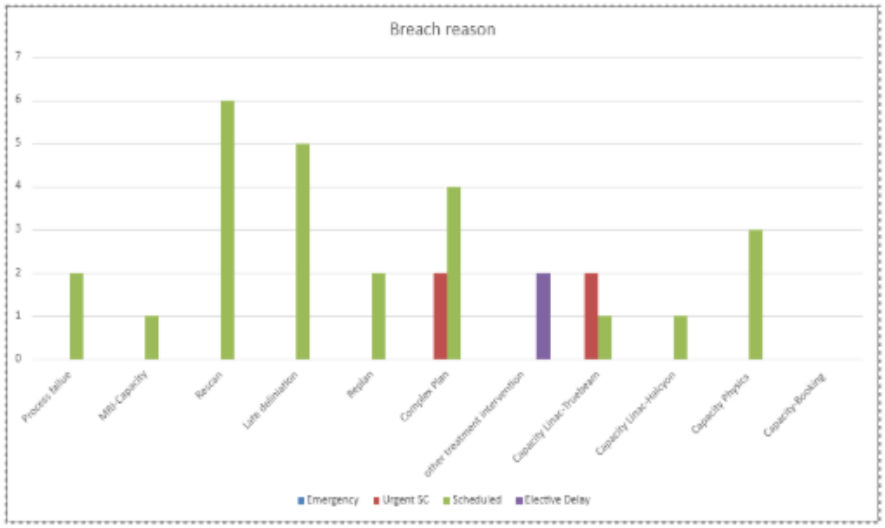
- Where demand exceeds capacity, all referrals are submitted through escalation for clinical prioritisation.
- All failures to meet waiting times targets are investigated at pathway level to identify delay reasons and have a clinical review. Themes are logged and mitigations developed to offset as far as possible before fleet replacement
- Extension of LA7 post May 2025 is in approval process, this will maintain patient treatment capacity
- Investigation into extension of LA7 and LA8 until May 2026 to further mitigate capacity loss.

Forecast / Next Month:

- Performance will continue to recover and stabilise in February due to capacity gained form LA1 extension.
- Actual performance improvements may be evident in the medium/long term and linked to improvement in pathway management as well linac capacity.
- February capacity is planned to be maintained at 76.5 hours.
- March capacity will increase further in line with approval of recruiting for locum radiographers.

Radiotherapy - Breach data

January 2025



2-Process failure
1- Capacity MRI
6- Rescan
2 - Replan
5- Late delineation

6- Complex plan required
2- Other Treatment Intervention
3- Capacity Linac- Truebeam
1- Capacity Linac -Halcyon
3- Capacity -Physics

Improvement Plan (Breach Themes)

Capacity

Scrutiny Business case and SBAR for locum staff to ensure Linac Capacity is maintained through paperless implementation due by Feb 2025 to conclude April 2025 - Approved.

Business case for locum staff to ensure Linac Capacity is maintained through Radiotherapy Satellite at Nevill Hall Hospital implementation due by April 2025 to conclude July 2025 - Approved on 11.2.25 for 4 agency staff to support the service.

SBAR for extension of LA7 end of life from 1/5/2025 - Awaiting decision.

Review of linac uptime to be undertaken with Radiotherapy and Radiotherapy physics ensure downtime is recorded in Aria aligns with Varian Equip reporting to be concluded by 1 Feb 2025

Pathway

Implementation of Aria Radiotherapy request as part of the IRS paperless solution from March 2025 – reduce the risk of process failures in requesting radiotherapy

Implementation of Carepath for Radiotherapy IR(ME)R practitioners – improved visibility of the individual patient pathway due to complete March 2025

Activity Reporting

Review of data capture on Aria with data and insights, finance and Radiotherapy physics computing, to better reflect RT activity informing:

- Income
- Capacity utilisation
- Development in readiness to InSightive (Oncology Specific Analytics) implementation
- Development of activity reporting for Brachytherapy – following paperless go live
- Development of activity reporting – following paperless go live

Radiotherapy – Utilization

January 2025

	December	January	February
Planned Linac Clinical capacity	1386.5 hrs	1661 hrs	*1530 hrs*
Scheduled (booked) Linac activity	1217.6 hrs	1529 hrs	TBC
Delivered Linac activity	**1160.1hrs**	**1236.75hrs**	**TBC**
Cancelled Linac activity	57.5 hrs	92.25hrs	TBC

- Due to the number of working days in January, the total resource available was 1661 linac hours
- Scheduled 92% utilised 75%
- Cancelled 92.25 hours (5.5%) due to patient cancellations and late delineations
- Reactive Linac capacity 18.3 hours delivered out of hours.
- Overall, January utilisation was 75% against 84% in December due several Linac breakdowns, this is being contractually investigated
- Only marginal productivity gains possible ahead of Insightive becoming operational

1.2 SACT

SACT Non-Emergency Waiting Times

January 2025

Month	Validated Performance
September 2024	88%
October 2024	91%
November 2024	95%
December 2024	86%
January 2025	83%

Updates on Last Month:

- The Cancer PTL (single source of the truth) has commenced via an 18-week programme delivery for April 25
- Pharmacy capacity increased by 45 additional slots live as of 13 Jan, with a positive impact forecast for February's performance
- Work in train to review the Model of Care for SACT pre-assessment transitioning from Consultant delivered to Consultant led (phase 1) . Progress 1 X ACP recruited. Others out to advert.
- Workshop held for extra capacity options to further improve performance
- Planned pharmacy expansion compete .

Key Issues / Risks:

- Demand continues to be closely monitored with all SACT services under pressure.
- Seasonal spike in January (not as high as expected)
- Work underway with HBs to gain further intelligence to help inform forecast demands
- There are mitigations in place for the lack of visibility of patients with Cancer PTL, phase 1 due April 25
- Bespoke and targeted recruitment process continues .

Action / Mitigation Underway:

- As part of the Phase 1 SACT Pre-assessment and VAP service business case approved, work to plan implementation initiated
- Pathway coordinators undergoing training plan to complete February validation independently
- Unused capacity report live to maximise scheduling of chemotherapy delivery across the week
- Soft launch of SharePoint data on 25th February
- Perago workshop has informed a business case to improve data quality and leadership in bookings team.

Forecast / Next Month:

- Update on-going initiatives via the SACT delivery group
- Exploring options for further hours required per week.
- February performance forecast at above 90% as a result of planned capacity increase.

Breach data

January 2025

Number of days waiting		November 24 Referrals	November 24 Percentage of referrals treated within time frame		December 24 Referrals	December 24 Percentage of referrals treated within time frame
0-7 days		158	43.9%		186	51.7%%
8-14 days		45	12.5%		79	21.9%
15-21 days		107	29.7%		113	31.4%
22 - 28 days		49	13.6%		48	13.3%
29 - 35 days		1	0.3%		26	7.2%
36 - 42 days					1	0.3%
43-49 days					2	0.6%
Total		360			455	

3 longest waits over 36 days – patient choice/clinical advice
2 = consultant preferred start date in Chemocare – no suspension information documented.
1 = administration error (incorrect pre SACT assessment date) patient unable to attend. Clinical advice - no urgency on treatment
All three would have been prevented by the Cancer PTL functionality

Capacity Actions

- All breaches are clinical driven or due to capacity challenges
- Increasing Data graduality helping develop mitigations and remedial actions required.
- Unused capacity is being identified with reports available to identify avoidable and unavoidable driving improvements across the weekly capacity with consultant engagement
- Themes include OON completion and processing, clinic-based issues, shredding and booking errors.
- Improvement actions include
  - coordinator QA in place
  - attendance at SMSC to highlight OON process failures with medical team.
- Meeting took place at consultant meeting 8th January to address this and work to improve, scheduled update March SMSC
- On-going review of SACT performance and capacity via the SACT Steering and Delivery groups.
- 12-hour shift patterns now in place to assist with chair capacity – providing flexibility and room for growth
- Series of workshops planned to develop 6/7 day working business case, with patient involvement

1.3 **Welsh Blood Service**

WBS Incidents

January 2025

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Welsh Blood Service

Incidents reported to Regulator / Licencing Authority

One adverse event was reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in January.

- Incorrect assessment of a donor's travel related risk at a previous donation (24/08/24) . There was no recipient risk as the previous donation was discarded (poor filtration). A Malaria screening result for the most recent donation (24/01/25) has been reported as negative.

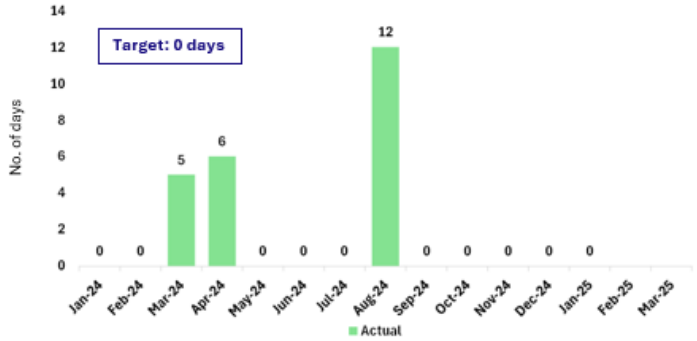
A Root Cause Analysis (RCA) investigation is being undertaken. The report will be submitted to the MHRA before 24/02/2025.

The volume of reportable incidents to date is comparable with the same period last year and is consistent with other UK Blood Services.

Red Cell Stock Level (below 3 days): O, A & B+ Groups

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Welsh Blood Service

January 2025



Updates on last month:

- In January, all clinical demand was met for O, A & B+ groups without triggering an alert or escalation measures for the fifth consecutive month, which compares favourably across the UK landscape.
- As anticipated, red cell stock levels increased from the previous month. In January, the number of red cells manufactured was 107% of the number of red cells issued, which has supported the stock build.

Key Issues / Risks:

- Differences in hospital demand and blood collection across various blood groups can lead to an imbalance between supply and demand.

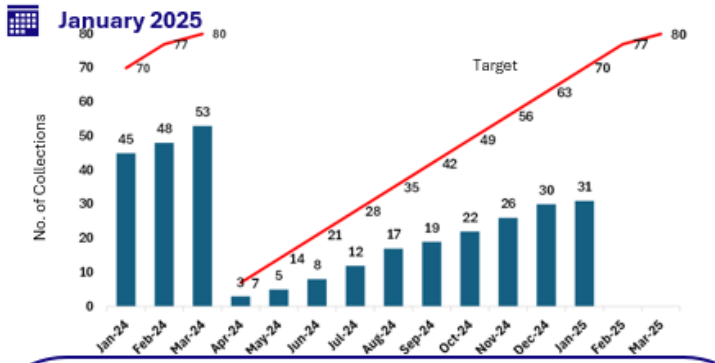
Action / Mitigation Underway:

- Daily Resilience Group meetings to ensure immediate operational responses to mitigate issues.
- The monthly Capacity / Demand Planning Group has been reviewed. Its terms of reference have been updated, the chair has been handed over to the Head of Planning & Performance Services, and its name has been changed to the Blood Supply Chain Planning Group. Task & Finish Groups will be established as required, starting with a group to distinguish between regular fluctuations and unusual changes in the blood supply chain for more informed decision-making.

Forecast / Next Month:

- The forecast for next month is anticipated to meet the target, and planning for the forthcoming bank holidays is underway.

Stem Cell Collections



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Welsh Blood Service

Key Issues / Risks:

- Currently experiencing cancellation/postponement rates of up to 41%. This is driven by patient fitness issues and lack of donor availability.
- Achieving this target would require a panel of over **123,000** donors, however current donor panel, whilst growing, is ~ **73,500.**
- Although swab recruitment has increased volunteers, ~ 33% of these donors have poor DNA quality and sub-optimal genetic typing results delaying entry into the system and reducing their visibility on the database.

Updates on Last Month:

- Demand for Stem Cell collections was met, but did not achieve the target of 7 Peripheral Blood Stem Cell (PBSC) collections per month. This shortfall was due to an insufficient number of requests and / or transplant centre cancellations.
- For donors recruited between January – December 2024 who shared their ethnicity, those from Black, Asian, mixed, or minority ethnic heritage accounted for 20%, compared to the current population ethnicity data in Wales, which stands at 5.8%.
- The total cell provision for the service was 6:
  - 1 PBSC collections from Welsh donor (*included in KPI*)
  - 1 Peripheral Blood Lymphocyte from Welsh Donor *(not included in KPI)*
  - 4 cell imports from other registries for the University Hospital of Wales (*not included in KPI*)

Action / Mitigation Underway:

- Maintain enhanced recruitment levels via buccal swab, as there is a correlation between the number of donors on the volunteer panel and stem cell collection requests.
- Improve genetic test results by increasing awareness of proper swab techniques with Collection Teams (training dates being confirmed).
- The annual target of 80 collections per annum (set in 2016) requires review to ensure next year's plan and projections are appropriate.

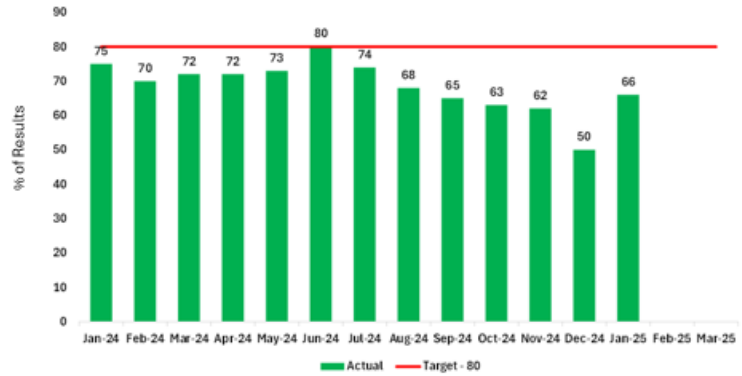
Forecast / Next Month:

- Building on our growing understanding of the relationship between the size of the donor volunteer panel and the number of stem cell collections, the strong performance in recruiting stem cell donors via buccal swabs is expected to enhance overall performance in the longer term. However, the target needs to be reviewed whilst being mindful of advances in other therapies.

Reference Serology Turnaround Times (2 working days)

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Welsh Blood Service

January 2025



Updates on Last Month:

- Performance for non-urgent referrals increased in January from (50 - 66%), primarily due to additional test authorisation capacity, however, did not met the current target. This target is under review (refer to 'Key Issues / Risks').
- **It should be noted that 100% of all time critical testing was reported within the required timeframe of 2 days.**

Key Issues / Risks:

- RCI User Guide standard requires 90% of non-urgent results to be provided within 5 working days – which was achieved. The deficiency in our KPI has resulted in not meeting target and was noted in the latest MHRA inspection.
- England and Northern Ireland blood services are aligned with RCI User Guide. Awaiting info from Scotland.

Action / Mitigation Underway:

- Review of metric underway as part of the wider KPI evaluation. If the target is correctly aligned with the RCI User Guide, it would have been met this month.
- Over 90 recommendations from the independent RCI review have been prioritised. An action plan focusing on critical areas first is being implemented through WBS Futures, with systematic improvements expected by March 2026.

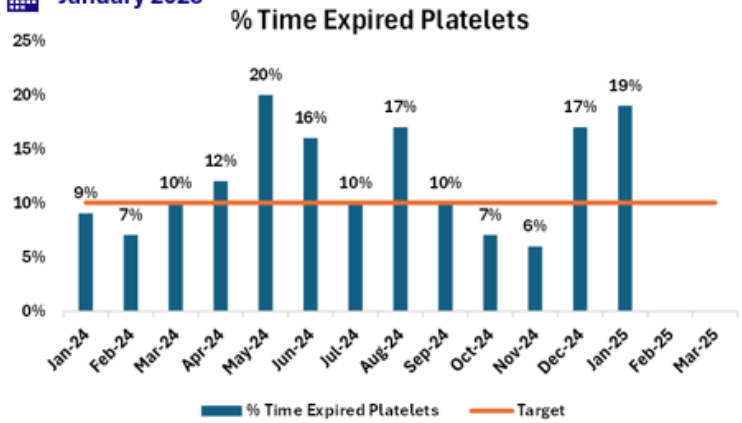
Forecast / Next Month:

- Correctly aligning the target with the RCI User Guide is expected to result in meeting the target next month.
- Medium to longer term improvements (6-12 months) are anticipated from implementing the independent RCI review recommendations.

Time Expired Platelets

Gwasanaeth Gwaed Cymru
Welsh Blood Service

January 2025



Updates on Last Month:

- In January, platelet expiration reached 19%, exceeding the 10% target due to planned overproduction for the Christmas holiday period and reduced hospital demand at the beginning of the month. This led to expected excess expiry in January, with performance anticipated to return to target in February.

Key Issues / Risks:

- Planned overproduction to address demand uncertainties and limited production opportunities of bank holiday periods, may lead to excess platelet expiry, given their relatively short shelf life of 5-7 days.

Action / Mitigation Underway:

- Monitoring the age of platelet stock as part of the daily Resilience Group meetings.
- Developing a platelet strategy to optimise platelet production and minimise wastage (completed by December 2025).
- Developing a forecasting tool to inform decisions around pooled platelet manufacture. The evaluation was completed at the end of January. We are currently analysing the feedback.

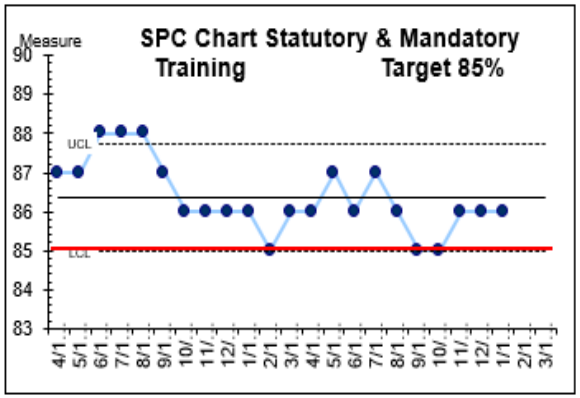
Forecast / Next Month:

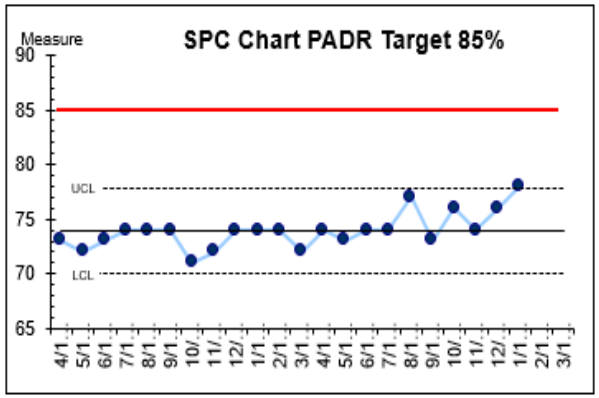
- Platelet expiry is expected to reduce significantly in February and be close to the target value.

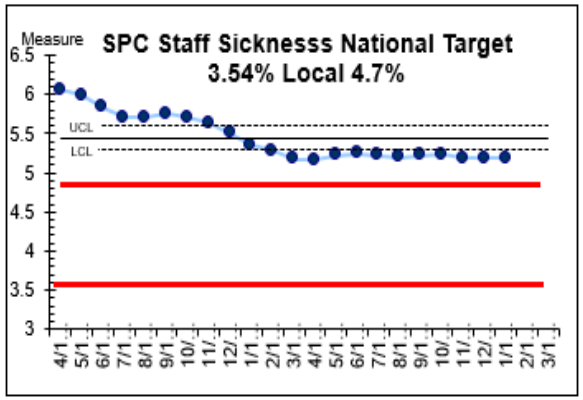
1.4 Workforce and Wellbeing

Workforce, Wellbeing & Organisational Development

January 2025







Updates on Last Month:

- **PADR** – New templates and supporting documents in pilot stages to provide a robust framework for implementation of the new People Development Policy
- **Sickness** – Trust action plans following detail absence analysis are ongoing and progress towards target is being seen.

Forecast / Next Month:

- **PADR** – as systems for completion of PADR's improves we forecast an improving trend towards the KPI target if 85%
- **Sickness** – forecast expected to continue the improve as divisional action plans are drawn up aligned to the detailed data analysis.

Action / Mitigation Underway:

- Full review of policy and processes combined with data analysis to draft comprehensive and holistic action plans for improving KPIs.
- Fundamentals of Management Training Package launched with a plan to roll out more comprehensively across the Trust

Key Issues / Risks:

- Capacity of management time to undertake effective people management activities alongside clinical workload
- Capability and confidence of managers to effectively undertake people management activities

Ymddiriedolaeth GIG Prifysgol Felindre
Gofal ardderchog, dysgu ysbrydoledig, pobl lachach

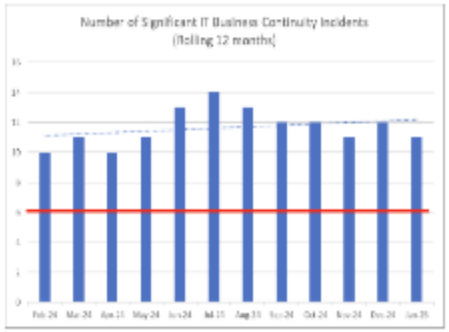
GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre | Velindre University NHS Trust

Velindre University NHS Trust
Excellent care, inspirational learning, healthier people

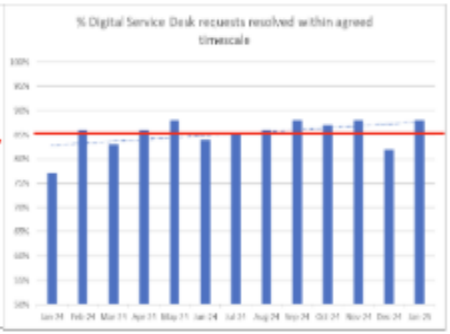
1.5 Digital Services

Digital Services

January 2025









Updates on Last Month:

- Performance improvements in Digital Service Desk performance observed following introduction of HaloITSM platform – performance measures for user satisfaction and resolution times all achieved in January 2025.
- Marginal reduction in rolling 12-month number of significant IT incidents in January 2025.Achieved 85% target incident resolution rate through improved performance and efficiency again for a third month.
- Installation of new managed print service across all VUNHST sites completed in January 2025.

Forecast / Next Month:

- Work ongoing to increase automation of tasks across Digital Service Desk, to ensure current performance gains can be sustained.
- Additional capital funding has been approved for the Technical refresh of digital client devices and network/server infrastructure. Procurement / delivery to be completed by 31/03/2025.

Action / Mitigation Underway:

- **Significant Incidents** – Ongoing work with DHCW to improve service management arrangements of national IT services (e.g. WCP).

Key Issues / Risks:

- Compliance with IG and Cyber security statutory and mandatory training below target. Velindre Cancer Centre are the only outlier below target of 85%. Targeted comms / engagement (e.g. additional face-to-face training) underway to drive up performance.

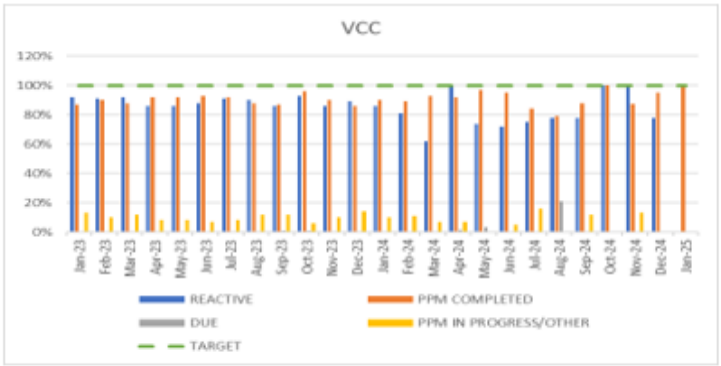
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Gofal ardderchog, dysgu ysbrydoledig, pobl lachach

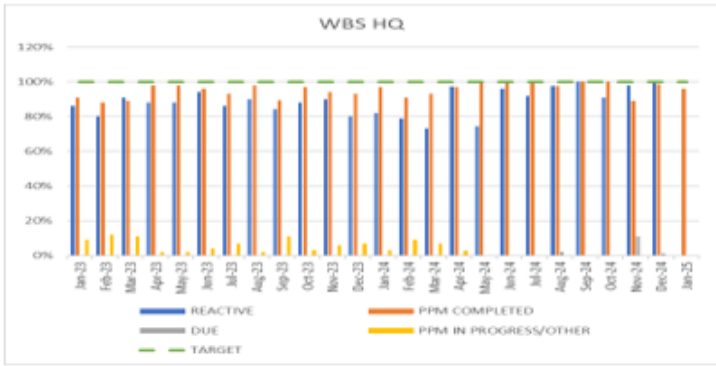
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1.6 Estates Infrastructure and Sustainability

Estates and Infrastructure

January 2025





Updates on Last Month:
- VCS PPM 99% Reactive - No Data This Period
- WBS HQ PPM 96% Reactive No Data This Period
- Dafen PPM & Reactive 100%
- Wrexham PPM 78% Reactive 99%
- Bangor PPM 100% Reactive 99%
- 19 Park Road PPM 70% Reactive No Data this Period
- Nantgarw HQ PPM 98% Reactive 99%

Action / Mitigation Underway:
- Manually cross-referencing PPM tasks to ensure system continuity of work PPM tasks to be distributed.

Forecast / Next Month:
- 445PPMs planned for VCC
- 150 PPMs planned for WBS sites.
- Prioritise Outstanding PPM's for Wrexham & 19 Park Road.

Key Issues / Risks:
- Reporting function on Symbiotic currently causing issue. Road map to resolve fix estimated by 31st March 2025.
- Unable to meet PPM benchmark compliance at Wrexham & 19 Park Road, Estates prioritising Tasks through February 2025.
- Cafm System Reporting function experiencing issues, meeting scheduled with developers to resolve 26/02/2025 to resolve.

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Gofal ardderchog, dysgu ysbrydoledig, pobl lachach

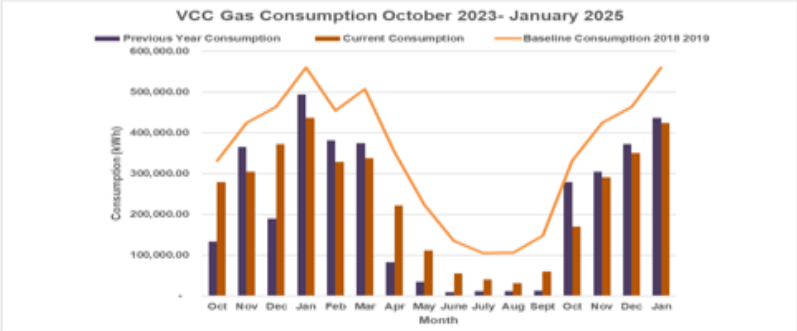
GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

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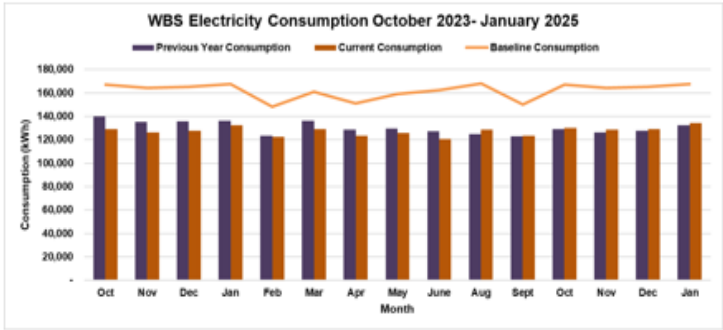
Estates Sustainability

January 2025

Gas - VCS



Electricity - WBS



Updates on Last Month:

- Reduction of gas consumption across VCS (significant reduction against baseline figures)
- Slight increase in electricity consumption across the Trust, still lower than baseline consumption.
- Operational energy audits underway, identifying areas of continued increase of consumption

Forecast / Next Month:

- Elevation in gas / electricity cost- all energy purchased through All Wales contract
- Ongoing Building Management system Monitoring to improve levels of usage within VUNHST Buildings.

Action / Mitigation Underway:

- Internal Energy Management Audits of departments ongoing
  - Talbot Green atrium– identified significant heat loss and comms campaigns underway to address
  - LINAC audit complete, resulting in collaboration with Swansea Bay to review scheduling and current usage.
- Monitoring of consumption ongoing through Estates Management Group with BMS controls monitored to identify hotspots/recurring increases to reduce consumption
- Attendance at WEOG to monitor potential price increases

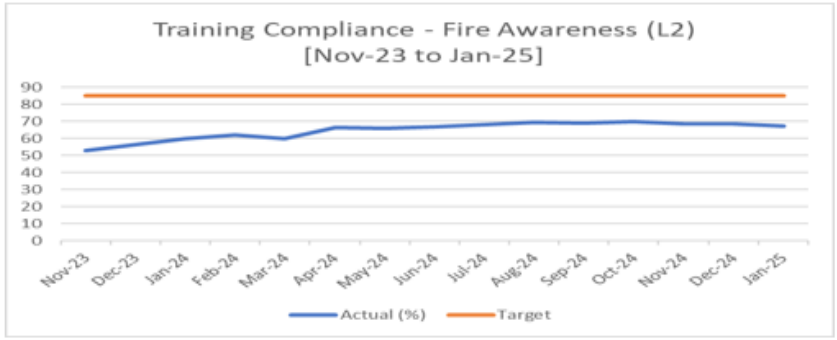
Key Issues / Risks:

- Elevated gas usage for the Trust due to cooler temperatures increase in heating usage across VUNHST buildings.
- Energy prices are still elevated and is monitored through the Welsh Energy Operational Group (WEOG) where VUNHST staff (finance and estates) attend.
- Vacant post, currently out for recruitment.

Fire Safety

January 2025





Updates on Last Month:

- 3 protocols drafted to support Trust fire safety policy
- Compliance for L1 fire safety training improved but still below WG benchmark
- Compliance for L2 fire safety training has dropped.

Forecast / Next Month:

- Request for exemption to SWF&RS policy to be submitted (**Feb-25**)
- Submission of drafted fire safety protocols to VCS and WBS SLTs and other interested groups for ENDORSEMENT (**Feb/Mar-25**)
- Service to run evacuation exercises based on agreed schedules (**Feb/Mar-25**)
- Continuation of integrated working by Trust Fire Safety lead [EPRR, RPOG, H&S]

~~Action / Mitigation Underway:~~

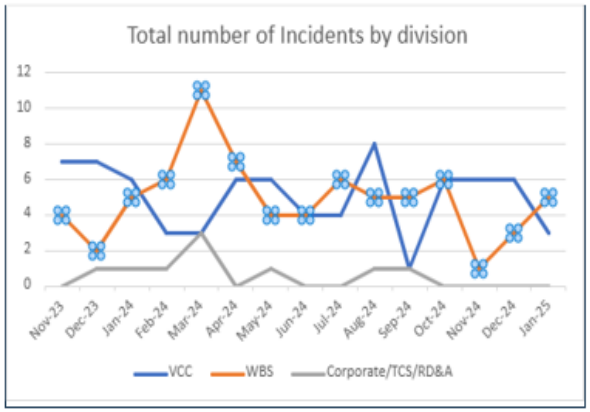
- VCS and WBS SLTs received Exemption BC for SWF&RS policy change for endorsement **(Feb-25)**
- VCS and WBS SLTs taking ownership of fire safety training compliance and need for support to undertake emergency drills and exercises **(Feb-25)**
- All services aware of importance of evacuation drills and exercises and developing schedules (**Feb-25**) to support monitoring and compliance.

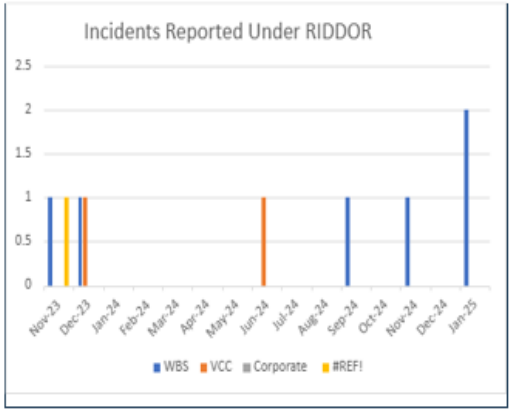
Key Issues / Risks:

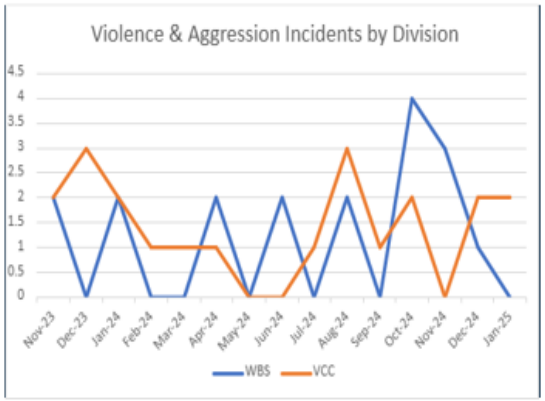
- SWF&RS to implement new policy on response to automatic fire alarms (Apr-2025)
- Continued low compliance for fire safety training
- Delays in finalisation of fire strategy for nVCC
- Need for evacuation drills and exercises in all Services

Health & Safety

January 2025







Updates on Last Month: Total of 8 incidents

- WBS – 5 x incidents
- VCS – 3 x Incidents
- Corporate – 0 x incidents
- 2 – RIDDOR Reports both at WBS (LATE x 1)
- 0 – Violence and Aggression Incidents

Forecast / Next Month:

- Continue to engage with staff surrounding the safety culture survey
- Send out reminders surrounding the process of reporting incidents as we received a late RIDDOR report
- Band 5 interviews complete and person appointed. Start date 7th April

Action / Mitigation Underway:

- Organisational change consultation documentation being completed with workforce.
- Policy to Procedures change progressing and working through the governance process to be signed off by the end of March

Key Issues / Risks:

- Patient manual Handling compliance continues to decline, await protected times from VCS – Meeting to take place 20th Feb with the Business support Managers

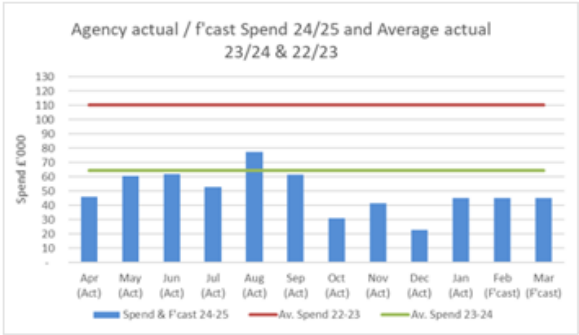
1.7 Finance

Financial Services

January 2025

Trust Revenue Position (core)	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual (Cumm) £k	30	5	7	8	8	15	18	21	23	29	32		
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	0

Trust Capital Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual Cum)	31.002	0.416m	2.113m	4.925m	6.322m	7.419m	8.153m	14.749m	23.018m	£24.451m	£25.792m		
Target £17.784m CEL		0.416m	2.113m	4.925m	6.322m	7.419m	8.153m	14.749m	23.018m	£24.451m	£25.792m		





Updates on Last Month:

- The revenue position for December was broadly in line with the IMTP planning assumptions and is forecast to breakeven at year end albeit with some risk associated.
- At this stage the Trust is expected to achieve its CEL (Capital Expenditure limit) subject to receiving funding from WG to support the nVCC enabling and project costs.

Forecast / Next Month:

- The revenue position for January is broadly in line with the IMTP planning assumptions and is forecast to breakeven at year end with all risks expected to be managed within the overall financial position for 2024-25.
- The Trust is expected to achieve it CEL (Capital Expenditure limit) following funding being provided from WG to support the nVCC enabling and project costs.

Action / Mitigation Underway:

- VCS LTA Activity is under urgent review within the Division to assess if the original forecast income will recover to forecast demand and ensure that all activity is being captured and costed correctly.

Key Issues / Risks:

- VCS LTA income activity will not match the level of investment into services at VCS.

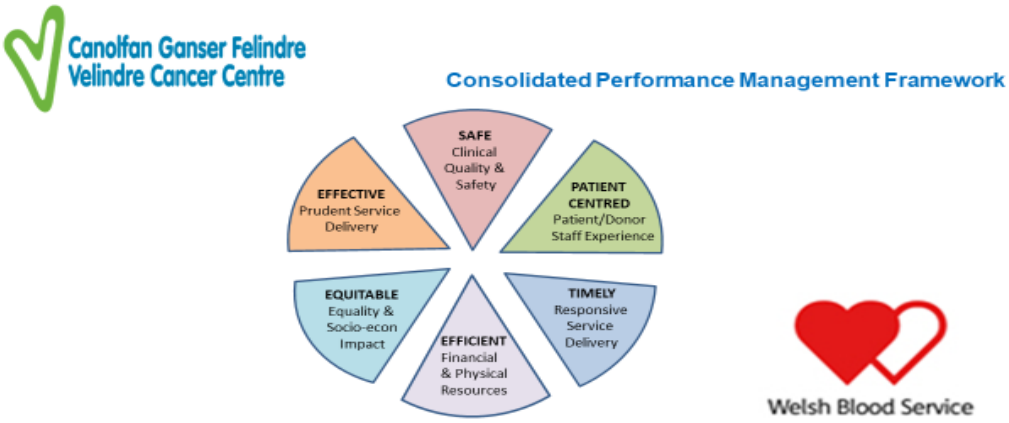
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Gofal ardderchog, dysgu ysbrydoledig, pobl lachach

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2. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION VELINDRE NHST PERFORMANCE SCORECARDS FOR JANUARY 2025.

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



2.2 Navigating our PMF Performance Report

The following PMF Scorecards report performance against both mandatory, local stretch and best practice targets, reporting on an exception basis, focusing upon the key issues to be brought to the Trust Board's attention

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.

2.3 Cancer Services Scorecard as at January (month 10) 2024/25.

QSF Domain	Cancer Services Safety Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	Number of Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	1	✗	➔	Minor variance
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	➔	
	% Patients with a Sepsis NEWS score >or= 3 receiving all 6 treatment elements within 1 hour	National	Monthly	100%	100%	100%	✓	➔	
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0	✓	➔	
	Number of Healthcare acquired Infections (HAIs) MRSA bacteraemia **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	<1 24/25	1 24/25	✗	➔	Minor variance
	Number of Healthcare acquired Infections (HAIs) MSSA bacteraemia **(WHC 2024 (38) target**	National	Monthly	23/24 Base	<1 24/25	0 24/25	✓	➔	
	Number of Healthcare acquired Infections (HAIs) P. aeruginosa bact. **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	0 24/25	0 24/25	✓	➔	
	Number Healthcare acquired Infections (HAIs) Klebsiella spp bact. **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	4 24/25	1 24/25	✓	➔	
	Number of Healthcare acquired Infections (HAIs) C Difficile. **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	<3 24/25	3 24/25	✗	➔	Minor variance
	Number of Healthcare acquired Infections (HAIs) E Coli bacteraemia **(WHC 2024 (38) target)**	National	Monthly	23/24 Base	3 24/25	1 24/25	✓	➔	
	Number of Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	23/24 Base	<13 24/25	3 24/25	✓	➔	
	Total Antimicrobial (AMR) Usage **(WHC 2024 (38) target) reduction by 2029/30**	National	Monthly	2019 Base	5% reduction	TBA	✓	➔	
	Proportion of total AMR usage WHO 'Access' category **(WHC 2024 (38) target) by 2029/30**	National	Monthly	2019 Base	reduction to 70%	TBA	✓	✓	
	% Compliance with World Health Organisation 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	98%	✓	✓	

	Number of Health and Safety Incidents recorded	**Local**	**Monthly**	**9**	**9**	**3**	✓	✓	
	Number of National VCS Reportable Incidents	**National**	**Monthly**	**0**	**0**	**2**	✗	✓	Slide pg.23
	Number of Duty of Candour Incidents recorded	**National**	**Monthly**	**0**	**0**	**6**	✗	➔	IQSG report
	Number of 'Never Events' recorded	**National**	**Monthly**	**0**	**0**	**0**	✓	➔	
	% compliance for staff who have completed the Core Skills and Training Framework Level 1.	**National**	**Monthly**	**85%**	**85%**	**83%**	✗	➔	Slides pg.18
	Number of Staff RIDDOR Incidents, Injuries and Work Related Accidents	**Local**	**Monthly**	**0**	**0**	**0**	✓	➔	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗		**Cumulative data trend (15 months) = Improving 🡅 stable ➔ fluctuating 🡅🡇 deteriorating 🡇**							

QSF Domain	**Cancer Services Effectiveness Scorecard**			**Performance as at Month 10 (January)**			**Compliance against Target or Standard**		**Slide Ref. for Exceptions**
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
Effectiveness	Radiotherapy (RT) 30 Day Mortality Benchmark	**Curative**	**Monthly**	**TBA**	**TBA**	**TBA**	✓	➔	
		Palliative	**Monthly**	**TBA**	**TBA**	**TBA**	✓	➔	
	SACT 30 Day Mortality Benchmark	**Curative**	**Monthly**	**TBA**	**TBA**	**0.06%**	✓	➔	
		Palliative	**Monthly**	**TBA**	**TBA**	**1.37%**	✓	➔	
	Inpatient Mortality	**Inpatient**	**Monthly**	**TBA**	**TBA**	**3**	✓	➔	
	Number of Pathway of Care Delays	**National**	**Monthly**	**1**	**0**	**5**	✗	➔	Minor variance
	% Personal Appraisal Development Reviews (PADR) Compliance	**National**	**Monthly**	**72%**	**85%**	**79%**	✗	🡇	Slides pg.18
	% Rolling average Staff sickness levels	**National**	**Monthly**	**6.43%**	**3.54% 4.70%**	**5.04%**	✗	🡅	Slides pg.18
Symbols Key: In Month = Compliant ✓ Non-compliant ✗		**Cumulative data trend (15 months) = Improving 🡅 stable ➔ fluctuating 🡅🡇 deteriorating 🡇**							

QSF Domain	Cancer Services Experience Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95	85%	95% 97%	✓	➔	
	% of 'formal' concerns responded to within 30 working days	Local	Monthly	100	85%	0%	✗	➔	Minor variance
	Number of Incidents of violence and aggression to staff	Local	Monthly	7	0	0	✓	🡻	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	Cancer Services Timeliness Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	88%	✗	🡻	Slides pg. 8 - 10
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	85%	✗	➔	Slides pg. 8-10
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	100%	✓	🡹	
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days	National	Monthly	27% 32%	80% 100%	94% 94%	✓	🡹	
	% Patients Beginning Non-Emergency SACT within 21 days June **Position**	National	Monthly	98%	98%	83%	✗	🡹🡻	Slides pg. 11-12
	% Patients Beginning Emergency SACT within 5 days June Position	National	Monthly	100%	98%	100%	✓	🡹	
	% Patients receiving equitable and timely access to Therapy Services	Local	Monthly	100%	100%	97%	✗	🡹	Minor variance
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable ➔ fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	Cancer Services Efficient Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions.
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Electricity performance in kilowatt hours (kWh)against target consumption budget profile	National	Monthly	N/A	283k	307k	✗	↑↓	Slide pg.21
	Gas performance in kilowatt hours (kWh) against target consumption budget profile	National	Monthly	N/A	361k	347k	✓	↑↓	
	Water performance usage in cubic metres against target consumption	Local	Monthly	N/A	2000m3	1750m3	✓	↑	
	Financial Balance – achievement of VCC forecast (£k) in line with revenue expenditure profile	National	Monthly	£0k	£0k	£13k	✓	↑	
	VCC expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£156k	£156k	£354k	✗	→	Slides pg.24
	Cost Improvement Programme – VCC achievement of savings (£k) in line with profile	National	Monthly	£939k	£743k	£804k	✓	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

2.4 Blood and Transplant Scorecard as at January (month 10) 2024/25.

QSF Domain	Blood and Transplant Safety Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	Number of Health and Safety Incidents recorded	Local	Monthly	5	n/a	5	n/a	🡻	Slide pg.23
	Quality Incidents closed within 30 days	Local	Monthly	96%	90%	94%	✓	🡻	
	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	1	✗	🡺	Slide pg.13
	Number of Duty of Candour Incidents recorded	National	Monthly	0	0	0	n/a	n/a	
	Number of 'Never Events' recorded	National	Monthly	0	0	0	n/a	n/a	
	Numbers of critical and major non-conformances through external audits or inspections	Best practice	Monthly	0	0	0	✓	🡹	
	% staff compliance who have completed the Core Skills and Training Framework Level 1 competences	National	Monthly	95%	85%	93%	✓	🡹	
	Number of Staff RIDDOR Incidents, injuries, and work-related accidents.	Local	Monthly	0	0	2	✗	🡻	Slide pg.23

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

QSF Domain	Blood and Transplant Effectiveness Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	New Whole Blood Donors	Local	Quarterly	1660	2750	1,795	n/a	n/a	
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	107%	✓	🡅	
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	132%	✓	🡅	
	Red Blood Cell Stock Level (below 3 days)	Local	Monthly	0	0	0	✓	🡆	Slides pg.14
	% Time Expired Platelets (adult)	Local	Monthly	20%	10%	19%	✗	🡇	Slides pg.17
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	1%	0.03%	✓	🡇	
	New Apheresis Donors	Local	Quarterly	21	14	22	n/a	n/a	
	Number of Stem Cell Collections per month	Local	Monthly	6	7	1	✗	🡇	Slides pg.15
	New WBMDR Bone Marrow Donors	National	Monthly	3341	333	364	✓	🡅	
	Enhance the impact of RD&I & celebrate success - number of conference presentations	Local	Monthly	n/a	5/year (rolling target)	9	✓	🡇	
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	National	Monthly	86%	85%	84%	✗	🡆	Slide pg.18
	% Rolling average Staff sickness levels	National	Monthly	6.8%	3.54% 4.70%	6.81%	✗	🡅	Slide pg.18

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇

QSF Domain	Blood and Transplant Experience Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Donor/ Staff Experience	% Unsuccessful Venepuncture	Best practice	Monthly	1.7%	2.0%	1.7%	✓	🡻	
	% Part Blood Bags collected	Best practice	Monthly	2.7%	3.0%	2.1%	✓	🡹	
	% Donor Satisfaction	Local	Monthly	95%	95%	97%	✓	🡹	
	Number of Concerns	Local	Monthly	9	0	5	✗	🡺	Slide pg.13
	% Responses to informal concerns within required 2-day timescale	Local	Monthly	100%	100%	100%	✓	🡺	
	% Responses to formal concerns within 30 working days	Local	Monthly	100%	100%	n/a	✓	🡺	
	Number of incidents of violence and aggression to staff	Local	Monthly	1	n/a	0	✓	🡹	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable 🡺 fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	Blood and Transplant Timeliness Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	79%	n/a	n/a	
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	92%	✓	🡹	
	% Reference Serology Turnaround Times (2 working days)	Best practice	Monthly	70%	80%	66%	✗	🡹	Slides pg.16
	% Turnaround Time (Deceased Donors Typing / Cross matching)	Best practice	Quarterly	84%	80%	89%	n/a	n/a	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable 🡺 fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	Blood and Transplant Efficient Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Whole Blood Collection Productivity	Best practice	Monthly	1.12	1.25	1.15	✗	↑	Minor variance
	Manufacturing Productivity	Best practice	Monthly	418	392	395	✓	↑	
	% Controllable Manufacturing Losses	Best practice	Monthly	0.06%	0.5%	0.12	✓	↓	
	Electricity performance kilowatt hours (kWh) against target consumption budget profile	National	Annually	N/A	128k	134k	✗	→	Slide pg.21
	Gas performance in kilowatt hours (kWh) against target consumption budget profile	National	Annually	N/A	131k	135k	✗	↑↓	Slide pg.21
	Water performance usage in cubic metres against target consumption	Local	Monthly	N/A	285m3 Sep	250m3	✓	↑	
	Financial Balance – achievement of WBS forecast (£k) in line with revenue expenditure profile	National	Monthly	£0k	£0k	£(656)k	✗	↓	Slides pg.24
	WBS expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	£0k	£0k	£22k	✗	→	Slides pg. 24
	Cost Improvement Programme – WBS achievement of savings (£k) in line with profile	National	Monthly	£569K	£566k	£407k	✗	↓	Slides pg.24
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

2.5 Trust-wide Services Scorecards as at January (month 10) 2024/25.
Estates Services.

QSF Domain	Estates Safety Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 1900 kgCO2	-16% 18/19 kgCO2	1600 kgCO 2	✓	➔	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Estates Effectiveness Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	Compliance with Sustainable Development Assessment Tool (SDAT)	Local	Annually	TBA	TBA	TBA	N/A	N/A	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Estates Timeliness Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timelines s	% PPM undertaken completed against plan	Local	Quarterly	90%	95%	87% Sept	✗	↑	Slide pg.20
	% Reactive maintenance achieved within agreed days/hours	Local	Quarterly	80%	95%	85% Sept	✗	↑	Slide pg.20
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Estates Efficient Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Trust HQ Electricity performance in kilowatt hours (kWh) against target consumption budget	National	Quarterly	N/A	2482	2697	✗	🡅	Slide pg.21
	Trust HQ Gas performance in kilowatt hours (kWh) against target consumption budget	National	Quarterly	N/A	6627	6807	✗	🡅	Slide pg.21
	Trust Waste Recycling performance by weight (Kg)	Local	Monthly	4500Kg	4500Kg	4800Kg	✓	🡅	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

Health and Safety Services

QSF Domain	Health and Safety Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	RIDDOR reportable incidents of workforce	Local	Monthly	0	0	2	✗	🡆	Slide pg.23
	% Fire Action Plan actions implemented	Local	Quarterly	78%	100%	96%	✗	🡅	Slide pg22
	Number of Health and safety incidents recorded	Local	Monthly	14	14	8	✗	🡅🡇	Slide pg23
	% Fire Drills completed accordance with schedule	Local	Quarterly	paused	100%	6 Jun	✗	🡆	Slide pg22
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Health and Safety Effectiveness Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	% staff overall compliance with Level 1 (Essential) Level 2 (fire Warden) & Level 3 Fire safety training	Local	Monthly	89%	85%	81%	✗	➔	Slide pg22
	% Training compliance – Manual Handling (level 1 and 2), Health & Safety, Violence and Aggression (module A and B) and Display Screen Equipment	Local	Monthly	80%	85%	82%	✗	➔	Slide pg22
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Health and Safety Experience Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	Number of Incidents of violence and aggression to staff	Local	Monthly	7	0	0	✓	↓	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

Workforce and Organisational Development

QSF Domain	Workforce and OD Safety Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% staff compliance who have completed the Core Skills and Training Framework Level 1 competences	National	Monthly	87%	85%	86%	✓	🡅	Slides pg.13
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Workforce and OD Effectiveness Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions.
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	78%	✗	🡅🡇	Slides pg.18
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.18%	✗	🡅	Slides pg.18
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Workforce and OD Experience Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	March 23	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	% staff who would recommend the Trust as a place to work	National	Annually	65%	85%	65%	✗	🡆	Annual position
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Workforce and OD Equitable Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Mean Gender Pay Gap – Annual	Local	Annually	13.45%	5%	13.85% (Mar 24)	N/A	N/A	
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	6%	6.64%	✓	➔	
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	6.58%	✗	↑	Minor variance
	% of Workforce who have declared Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	94.67%	✗	↑	Minor variance
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

Digital Services

QSF Domain	Digital Safety Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance against NCSC "10 Steps to Cyber Security" best practice standards	Local	Bi-annual	88%	90%	87%	✗	↓	Slides pg.19
	% compliance with cyber security statutory & mandatory training	Local	Monthly	TBA	85%	83% Dec	✗	↑	Slides pg.19
	% of Trust expenditure in digital	Local	Annually	TBA	4%	2.6%	✗	↑	Slides pg.19
	Number of significant IT business continuity incidents	Local	Monthly (rolling 12 months	12	6	11	✗	↓	Slides pg.19
	Cyber Security - % of employees clicking on internal phishing campaigns	Local	Quarterly	TBA	<10%	1.5% Nov	TBD	N/A	
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Digital Experience Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline Oct 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	% User satisfaction with Digital Service Desk	Local	Quarterly	87%	95%	98%	✓	↑	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Digital Timeliness Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions.
	KPI Measure	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	% Digital Service Desk requests resolved within agreed (SLA) timescales	Local	Monthly	81%	85%	88%	✓	↑	
	% Digital Service Desk incidents resolved within agreed (SLA) timescales	Local	Monthly	80%	85%	90%	✓	→	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Digital Efficient Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% uptime of critical digital systems (% availability by service, excl. planned maintenance windows)	Local	Monthly	TBA	99%	TBA	N/A	N/A	
	% of outpatients consultations performed virtually	Local	Monthly	32.9%*	TBA	24%	TBD	↓	
	% of donors booking online	Local	Monthly	82.2%*	TBA	n/a	TBD	↓	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

Finance Services

QSF Domain	Finance Timeliness Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	KPI Measure	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	➔	
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Finance Efficient Scorecard – Trust-wide position			Performance as at Month 10 (January)			Compliance against Target or Standard		Slide Ref. for Exceptions
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 24	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.032 m	✓	➔	
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.179 m	£0.503 m	✗	➔	Slides pg.24
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	£17.784m	£25.792m	£25.792 m	✓	➔	
	Cost Improvement Programme £2.6m achievement of savings (£k) in line with profile	National	Monthly	N/A	£2.466 m	£2.368 m	✗	➔	Slides pg.24
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

3. Analysis of Current Range of PMF Performance Measures (KPIs) and Level of Statutory Compliance (average/usual level will be reviewed every six months0

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

Notes

1 Quality Act 2023

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

3 WBS and Trust-wide PADR and Sickness targets

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

1. 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 -Organisational and Clinical Governance 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	**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). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY IMPACT ASSESSMENT *The duty of quality requires quality-driven decision-making for all strategic decisions. The duty of quality is operationalised through the Heath and Care Quality Standards. Therefore, when making decisions about healthcare services, NHS organisations are required to consider the impact of that decision on the Health and Care Quality Standards.*	Not required - not a strategic decision The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required *[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].* **Click or tap here to enter text**
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals:	

• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item**

	Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

2. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
	[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	

TRUST BOARD	
FINANCE REPORT FOR THE PERIOD ENDED 31 JANUARY 2025 (M10)	
DATE OF MEETING	27 March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Claire Bowden – Interim Head of Financial Planning & Reporting Steve Coliandris – Acting Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of January 2025. The three main issues are highlighted below: **1. Long Term Agreement (LTA) Financial values & Contract Rebase** <u>LTA Financial Values</u> All 2024-25 LTA financial values have been agreed and signed. The financial settlement resulted in a: i. £318k reduction in recurrent NICE drug income (£145k Aneurin Bevan University Health Board (UHB), £115k Cwm Taf Morgannwg UHB & £58k reverting to old baseline) compared to plan.

ii. £483k reduction in Hywel Dda UHB income non-recurrently compared to plan.

The £483k reduction in income from Hywel Dda will become a recurrent reduction in 2025/26 based on the 12 months' notice of intention to withdraw the funding. A further recurrent reduction by Hywel Dda of c£360k baseline activity income was also included in the notification, the argument being that Hywel Dda patient flows have been redirected from Velindre to Swansea Cancer services.

The Trust has reviewed the Hywel Dda activity over the past 5 years and the Director of Finance (Dof) has formally written to the Hywel Dda Dof in response to the Health Boards intention to change the Trust funding base from the historic shares to actual costs, with an argument in place to mitigate the proposed income loss. Unless an agreement can be reached imminently, the Trust will not be in a position to sign the LTAs for 2025-26 which is expected to lead to arbitration.

<u>LTA Contract Rebase</u>

The Chair of the Collective Commissioners Group wrote to all Commissioner DoF on 25th September seeking responses by 18th October to the rebasing proposals:

- Retain the original principles of the 2019/20 rebasing exercise.
- Revise the original rebasing exercise to update the baseline using 2023/24 actual activity, expenditure, and income.
- Retain the original agreement to a resource neutral impact by matching changes in rebased expenditure with a matched change in revenue resource allocation.
- The implementation of the rebased LTA Activity & Expenditure for 2025/26 LTAs.
- The adoption of paying for NICE & High Cost Drugs based upon actual utilisation from 1st April 2025.

	The majority of Health Boards have now responded and are broadly in favour of the rebasing exercise to be included as part of the 2025-26 LTAs, however on the condition that all Health Boards are in agreement. Hywel Dda currently continue to dispute the implementation of the rebased LTA Activity, so discussions are currently ongoing. **2. Integrated Medium Term Plan (IMTP) – Financial Plan / Forecast** • The Trust submitted a balanced three year IMTP, covering the period 2024-25 to 2026-27 to Welsh Government on the 30 March 2024. • Following agreement on the LTA the Trust financial plan was revised and the shortfall in LTA income has been recovered through a combination of increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures thus ensuring that the Trust continues to have a balanced financial plan. • A new financial risk emerged recently whereby LTA marginal income from cancer activity growth may not match the level of investment into services. Latest position is a forecast underachievement of c£0.500m against the target which is not yet reflected in the position. This is still currently under urgent review to assess if the forecast income will recover during the remainder of the year based on forecast demand and ensure that all activity is being captured and costed correctly. However, given that we are going into the final months of the financial year it is now very unlikely to recover before the end of March. **3. Key Financial targets / KPIs** • The Trust is currently reporting a small underspend on revenue and is forecasting to achieve an outturn position of Breakeven. • The Trust is currently overachieving and expected at this stage to meet the Public Sector

	Payment Performance (PSPP) target of paying 95% of non-NHS invoices within 30 days for 2024-25. The Trust is expecting to achieve the Capital Expenditure Limit (CEL) which is following the Trust securing the funding for the nVCC Enabling and project costs for 2024-25. • The uncommitted non-recurrent reserve and emergency reserve had been on hold to ensure the Trust could support the financial risk in relation to the nVCC implementation staff & advisor costs and EW advisor costs until WG funding is secured. However, following recent FBC approval there are non-recurrent revenue funds available and should be considered by EMB for investment before the end of March 2025.
RECOMMENDATION / ACTIONS	**TRUST BOARD** is asked **NOTE** the contents of the January 2025 financial report and in particular: • The year to date and forecast revenue and Capital out turn position, and PSPP performance. • The agreed position on LTA income for 2024-25 from our Commissioners. • The position with commissioners on the contract rebase agreement. • The latest position on the LTA Activity performance for 2024-25.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	25/02/2025
Quality, Safety and Performance Committee	27/03/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

APPENDICES	
Appendix 1	Trust Finance Report – January 2025
Appendix 2	nVCC Finance Report – January 2025

1. SITUATION / BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of January 2025.

1.2 The financial information included within this report relates to the Core Trust (including HTW). The financial position reported does not include NHS Wales Shared Services Partnership (NWSSP) as it is directly accountable to WG for its financial performance. The balance sheet (SoFP) and cash flow provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

2. ASSESSMENT / SUMMARY MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.032	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.341	25.792	35.240
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.0%	98.0%	97.0%

2.2 Revenue Budget

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

The overall position against the profiled revenue budget to the end of January 2025 is an underspend of **£0.032m** and a forecast outturn position of **Breakeven.**

LTA Income

A new financial risk emerged recently whereby LTA income activity will not match the level of investment into services at VCS. There is currently a forecast underachievement of c£0.500m against the target and investment of £1.300m which has been made in the service. October did see some recovery with the monthly target being achieved, however activity dropped again in November, and significant over activity performance will be required during the remaining months of the year in order for the annual target to be achieved. The data insights team are currently undertaking a piece of work to ensure that all Radiotherapy activity is being recorded correctly, with the finance team requiring to undertake an exercise to look at the costing and currency rates. At this stage it is still being flagged as a risk and not in the year to date financial position whilst it is under investigation. However, as we going to the final months of the financial year it is very unlikely to recover before the end of March and therefore the expectation is that the Trust reserves will need to support the position during 2024-25.

Pay Award

The AFC and M&D pay award processed in November cost the Trust £4.811m based on actual staff in post. This will leave a gap in funding against full establishment of c£0.337m, and a shortfall against increments of £0.280m which will not be funded by WG which divisions will be required to manage via an increased vacancy factor / additional savings.

The cost of the AFC band 8 and above incremental spinal points processed in January was £0.306m and the pay award relating to VSM was £0.091m

The 2023/24 medical pay award which was processed in September totals £1.121m (£0.755m recurrent).

WG have now confirmed that the Trust will be funded based on the actual costs as provided above.

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

LTA Contract Position

Following discussions between Chief Executives, and to avoid arbitration, a compromise position was agreed on the LTA financial values in line with 30th June deadline which has led to a financial impact to the Trust for 2024-25 as follows:

- £318k Reduction in recurrent baseline uplift income compared to plan.
- £483k Reduction in non-recurrent income compared to plan.

The £483k reduction in income from Hywel Dda will become a recurrent reduction in 2025/26 based on the 12 months' notice of intention to withdraw the funding. A further recurrent reduction by Hywel Dda of c£360k baseline activity income was also included in the notification, the argument being that Hywel Dda patient flows have been redirected from Velindre to Swansea Cancer services.

The Trust has reviewed the Hywel Dda activity over the past 5 years and the Director of Finance (Dof) has formally written to the Hywel Dda Dof in response to the Health Boards intention to change the Trust funding base from the historic shares to actual costs, with an argument in place to mitigate the proposed income loss. Unless an agreement can be reached imminently, the Trust will not be in a position to sign the LTAs for 2025-26 which is now expected to lead to arbitration.

The shortfall in LTA inflationary uplift income has been recovered this financial year through a combination of increased savings target, pausing previously agreed investment decisions and mitigating cost pressures.

<u>LTA Contract Rebase</u>

The Chair of the Collective Commissioners Group wrote to all Commissioner DoF on 25th September seeking responses by 18th October to the rebasing proposals:

- Retain the original principles of the 2019/20 rebasing exercise.
- Revise the original rebasing exercise to update the baseline using 2023/24 actual activity, expenditure, and income.

- Retain the original agreement to a resource neutral impact by matching changes in rebased expenditure with a matched change in revenue resource allocation.
- The implementation of the rebased LTA Activity & Expenditure for 2025/26 LTAs.
- The adoption of paying for NICE & High Cost Drugs based upon actual utilisation from 1st April 2025.

The majority of Health Boards have now responded and are broadly in favour of the rebasing exercise to be included as part of the 2025-26 LTAs, however on the condition that all Health Boards are in agreement. Hywel Dda currently continue to dispute the implementation of the rebased LTA Activity, so discussions are currently ongoing.

The Trust is reporting a year end forecast revenue breakeven position, however this assumes that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2024-25.

2.3 Savings

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

Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875m was required to help compensate for the loss of income from the LTA agreements.

The overall Trust savings performance as of January 2025 is an underachievement against plan of **£(0.098)m**. However, at this stage is expected to deliver to target by the end of the financial year.

2.4 PSPP Performance

During January 2025 the Trust (core) achieved a compliance level of **98.02%** (December 98.9%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.01%** at the end of month 10, and a Trust position (including hosted) of **97.01%** compared to the target of 95%.

2.5 Covid Expenditure

The Trust will not require drawing down any covid funding support during 2024-25.

2.6 Reserves

The uncommitted non-recurrent reserve and emergency reserve had been on hold to ensure the Trust could support the financial risk in relation to n VCC implementation staff & advisor costs and EW advisor costs until WG funding is secured. However, following recent FBC approval there are non-recurrent funds available and should be considered by EMB for investment before the end of March 2025.

Action: EMB to consider use of non-recurrent reserves for investment by the 31st March 2025.

The recurrent underlying reserves position is being considered in conjunction with the IMTP planning exercise for 2025-26 and is dependent on several key factors including the VCS marginal income risk, LTA contract rebase risk, achievement of 2024-25 recurrent savings, underlying and new emerging cost pressures, Divisional CIP targets and Trust investment decisions / choices.

2.7 Financial Risks

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2024-25. As of the end of January the majority have now either been reduced in risk or mitigated completely for 2024-25. The only remaining risks relate to the underperformance on the VCS LTA Activity which can be supported by the Emergency reserve.

2.8 Capital

All Wales Programme

The Trust has now received funding towards the nVCC project and enabling costs and received assurance from WG Capital colleagues that funding would be provided to support the nVCC Enabling works QRA and Whitchurch Hospital and land matters for 2024-25.

The Trust has been provided a funding award letter towards the OBC/ FBC stage for the WBS TGI infrastructure scheme, however progression is currently paused whilst the Trust works with the contractor to understand the proposed step up in costs for delivery of the scheme. WG are both aware and understanding of the situation.

Other Major Schemes in development that are detailed in the finance report will be considered during 2024-25 or beyond in conjunction with WG.

Discretionary Programme

The discretionary programme is now fully committed and expected to deliver to the CEL allocation.

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

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: 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*	08 - Trust Financial Investment Risk
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**

	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT

The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:

YES - Select Relevant Goals below

If yes select the relevant goals:

- A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒
- A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐
- A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☐
- A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☐
- A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐
- A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☐
- Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐

FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of **£0.032m** underspend to January 2025, which is currently in line with the IMTP plan.

EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is 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	Yes - please complete sections below
WHAT IS THE RISK?	Individual financial risks are discussed in section 2.7 of the report and the overall financial sustainability and value risk assessment is reflected in the Trust Assurance Framework (TAF)
WHAT IS THE CURRENT RISK SCORE	Ibid
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?	Individual risks to be managed with the financial envelope for 2024-25. Overall financial and sustainability risks reported and manged through the TAF.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Gwasanaeth Canser Felindre
Velindre Cancer Service

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED JANUARY 2024/25

TRUST BOARD
27/03/2025

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, highlight the financial risks, and forecast for the financial year, and outline the actions required to deliver the IMTP Financial Plan for 2024-25.

2. Background / Context

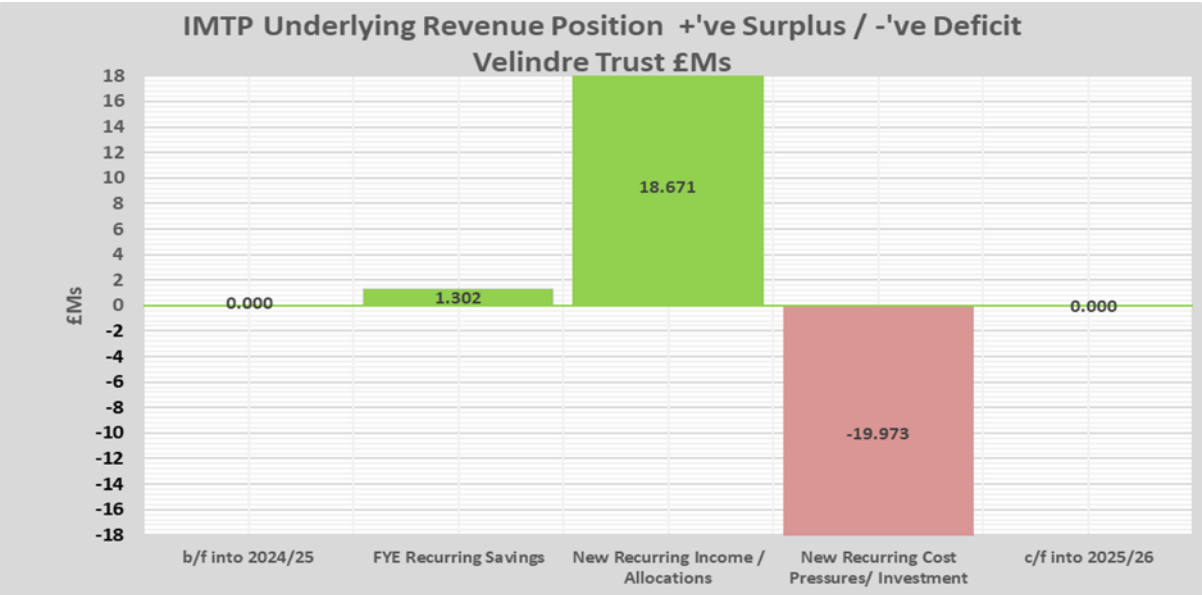
The draft Trust IMTP Financial Plan for the period 2024-2027 was set within the following context:

- The Trust submitted a balanced three year IMTP, covering the period 2024-25 to 2026-27 to Welsh Government on the 30 March 2024.

- For 2024-25 the Plan included;
  - A balanced position brought forward from 2023-24,
  - FYE **of new cost pressures / Investment** of **-£19.973m,**
  - offset by **new recurring Income** of **£18.671m,**
  - and Recurring FYE **savings schemes** of **£1.302m,**
  - Allowing **a balanced position** to be carried into 2025-26.

- **A significant risk is currently associated with the income that the Trust is expected to receive from its commissioners in relation to the 3.67% discretionary uplift, which could impact on the plan and the ability to achieve a balanced financial position.**

- **To achieve a balanced financial position, the savings target set for 2024-25 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or managed through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2024/25	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.000	1302	18.671	-19.973	0

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.032	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.341	25.792	35.240
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.0%	98.0%	97.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	0.033	(0.098)	0.000

Revenue

The core Trust has reported £0.002m underspend position for January 2025, which gives a cumulative year to date position of **£0.032m** underspent and an outturn forecast of **Breakeven.**

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

- £318k Reduction in recurrent discretionary income compared to plan.
- £483k Reduction in non-recurrent income compared to plan. The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP.

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

Capital

The approved Capital Expenditure Limit (CEL) as of January 2025 is **£34.761m**. This represents all Wales Capital funding of **£32.850m**, and Discretionary funding of **£1.911m.** The Trust reported total Capital spend to January 2025 is £25.792m and is forecast to remain within the CEL, subject to the Trust receiving the expected funding for the nVCC enabling works QRA and Whitchurch Hospital site fees.

The Trust's current CEL is broken down as follows:

	Opening CEL	Movement	Current CEL
	£m	£m	£m
Discretionary Capital	**1.911**		1.911
All Wales Capital:			
IRS	5.164	0.000	5.164
IRS RSC	11.265	-1.200	10.065
Digital WHAIS	0.000	0.443	0.443
Digital RISP	0.160	0.000	0.160
BECS	0.750	-0.416	0.334
Backlog Maintenance	0.350	-0.200	0.150
WG Year End Capital Slippage Funding	0.000	0.220	0.220
Whitchurch Land Transfer	0.000	7.800	7.800
nVCC Enabling Costs	0.000	3.500	3.500
nVCC Project Fees	0.000	4.140	4.140
Digital Tech Refresh	0.000	0.874	0.874
Total All Wales Capital	**17.689**	**15.161**	**32.850**
Total CEL	**19.600**	**15.161**	**34.761**

PSPP

During January 2025 the Trust (core) achieved a compliance level of **98.02%** (December 98.9%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.01%** at the end of month 10, and a Trust position (including hosted) of **97.01%** compared to the target of 95%.

Efficiency / Savings

In conjunction with the overall financial plan an in depth review of the Trust's savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875m was required to help compensate for the loss of income from the LTA agreements.

The overall Trust savings performance as of January 2025 is an underachievement against plan of **£(0.098)m**. However, at this stage is expected to deliver to target by the end of the financial year albeit with some risk associated due to progression of a couple of schemes.

Revenue Position

Cumulative			
£0.032m Underspent			
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	(188.769)	(190.325)	1.556
Pay	80.833	80.050	0.783
Non Pay	107.936	110.243	(2.307)
Total	0.000	(0.032)	0.032

Forecast		
Breakeven		
Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
(229.783)	(231.339)	1.556
97.240	96.458	0.783
132.543	134.882	(2.339)
0.000	(0.000)	0.000

The overall position against the profiled revenue budget to the end of January 2025 is an underspend of **£0.032m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

The Trust is reporting a year end forecast revenue breakeven position; however, this assumes that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2024-25.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

As per the IMTP Financial Plan the Trust brought a balanced position into 2024-25 and is expected to maintain this position over the course of the 3-year planning period albeit there is some risk to this specifically related to the Trust securing funding towards SDEC.

To retain a balanced position, the Trust will be required to manage all current and new financial risks, deliver the agreed savings target, and mitigate or remove any cost pressures that may emerge over the final months of the year.

Income

The Trust continues to benefit from receiving high levels of bank interest because of interest rate rises, however a significant amount £1.012m (previously £0.662m) has been set against the Trust revised savings target for 2024-25, which is in addition to the baseline budget of £0.165m.

WBS overachievement on Plasma sales had been significantly impacted by supplier payment issues, which following referral to CCI debt management the outstanding debt has now been fully recovered. Due to the suspension of deliveries to the supplier Randox, WBS are currently holding 24 pallets of plasma in storage and are currently looking for a new supplier to purchase the plasma with the Division having issued a reverse tender with expectation now following the tender evaluation results that WBS will be able to recover the full selling price.

A new financial risk emerged recently whereby LTA income activity will not match the level of investment into services at VCS. There is currently a forecast underachievement of c£0.500m against the target and investment of £1.300m which has been made in the service. Recent months have seen some recovery however, a significant over activity performance will be required during

the remaining months of the year in order for the annual target to be achieved. The data insights team are currently undertaking a piece of work to ensure that all Radiotherapy activity is being recorded correctly with the finance team requiring to undertake an exercise to look at the costing and currency rates. At this stage it is still being flagged as a risk and not in the year to date financial position whilst it is under investigation. However, as we go into the final couple of months of the financial year it is very unlikely to recover before the end of March and therefore the expectation is that the Trust reserves will need to support the position during 2024-25.

VCS Long Term Agreement (LTA) Contract Performance

The Trust has undertaken discussions with LHB Commissioners in accordance with a few important principles: -

- national guidance from WG regarding the principle of pass through (which for 2024/2025 was 3.67%).
- working in partnership to support all organisations to thrive and deliver safe services of a high quality.

The key differences in LHB Commissioner positions relate to the pass through of the Recurrent Discretionary uplift of 3.67%.

A clause was included within all signed 2023/24 LTAs to proceed with the contract rebase exercise and it was expected that this could be implemented from 2024/25 onwards in line with signed agreements. However, LHB Commissioners have not reached consensus on this matter with areas for resolution as follows:

- The baseline year for activity (currently set at 2019/20)
- The allocation adjustment to be applied to maintain cost neutrality at a system level.
- Transfer of Non Specialist services and High Cost Drugs from JCC to LHBs

Consequently, the Trust has had to prepare LTAs on an historic basis, which is not reflective of the population's utilisation of Velindre's services for LHB Commissioners. Further, the lack of agreement regarding the transfer of service has created a contractual risk to the Trust. To manage and mitigate this, the Trust has needed to negotiate a second contract with JCC (value £24m) whilst the matter is resolved.

To avoid arbitration, discussions between Chief Executives led to a compromise on the LTA financial settlement.

All 2024-25 LTA financial values have been agreed, but the Trust is still awaiting return of LTA documents from two Health Boards.

The financial settlement resulted in a:

i. £318k reduction in recurrent NICE drug income (£145k Aneurin Bevan University Health Board (UHB), £115k Cwm Taf Morgannwg UHB & £58k reverting to old baseline) compared to plan.

ii. £483k reduction in Hywel Dda UHB income non-recurrently compared to plan.

The £483k reduction in income from Hywel Dda will become a recurrent reduction in 2025/26 based on the 12 months' notice of intention to withdraw the funding. A further recurrent reduction by

Hywel Dda of c£360k baseline activity income was also included in the notification, the argument being that Hywel Dda patient flows have been redirected from Velindre to Swansea Cancer services. The Trust is currently reviewing the Hywel Dda activity over the past 5 years and the elements of the LTA funding that are not activity related in order to argue a reduction in this income loss. This will need to be considered as part of the 2025-26 financial plan included with the IMTP.

LTA Contract Rebase

The Chair of the Collective Commissioners Group wrote to all Commissioner DoF on 25th September seeking responses by 18th October to the rebasing proposals:

- Retain the original principles of the 2019/20 rebasing exercise.
- Revise the original rebasing exercise to update the baseline using 2023/24 actual activity, expenditure and income.
- Retain the original agreement to a resource neutral impact by matching changes in rebased expenditure with a matched change in revenue resource allocation.
- The implementation of the rebased LTA Activity & Expenditure for 2025/26 LTAs.
- The adoption of paying for NICE & High Cost Drugs based upon actual utilisation from 1st April 2025.

The Commissioner plan is set out below:

• Agree Proposed Baseline LTA for each HB & NHSWJCC	31/10/2024
• Agree Proposed Baseline NICE/HCD Expenditure for Each HB & NHSWJCC	
• Agree Resource Allocation Adjustment for notification to WG for Initial 2025/26 Allocation Letter.	30/11/2024
• Agree LTA Schedules for 2025/26 Velindre NHS Trust LTA	31/01/2025

The majority of Health Boards have now responded and are broadly in favour of the rebasing exercise to be included as part of the 2025-26 LTAs, however on the condition that all Health Boards are in agreement. Hywel Dda currently continue to dispute the implementation of the rebased LTA Activity, so discussions are currently ongoing.

Pay Highlights / Key Issues

The Trust has received confirmation from WG via the pay matrix that the full 2023-24 consolidated pay award will be funded, and that the income anticipated by the Trust for awards paid in 2024-25 will be provided on a non-recurrent basis while they resolve any remaining issues across NHS Wales. The recurrent value of the Trust allocation will be confirmed in due course.

The AFC and M&D pay award processed in November cost the Trust £4.827m based on actual staff in post. This will leave a gap in funding against full establishment of c£0.337m, and a shortfall against increments of £0.280m which will not be funded by WG which divisions will be required to manage this shortfall via an increased vacancy factor / additional savings.

The cost of the AFC band 8 and above incremental spinal points processed in January was £0.306m and the pay award relating to VSM was £0.091m

The 2023/24 medical pay award which was processed in September totals £1.121m (£0.755m recurrent).

WG have now confirmed that the Trust will be funded based on the actual costs as provided above.

Several 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. During August VCS was provided funding that was agreed as part of the IMTP to support several of the unfunded posts. The remaining unfunded posts are currently under review alongside the LTA activity to try and align the cancer activity demand forecasts and associated income to help mitigate the financial risk exposure.

On top of the savings plans and the shortfall in pay award VCS (£0.450m), WBS (£0.450m) and Corporate (£0.150m) hold a recurrent vacancy factor target, which will need to be achieved to balance the financial plan for 2024-25.

Non Pay Key Issues

Per the allocation letter the Trust has received £0.563m of recurrent funding from WG to support the increase in energy prices during 2024-25. The latest forecast schedule from NWSSP suggests that the full year energy costs will be c£1.745m, this will leave a shortfall of £0.142m against the budget of £1.603m (£1.040m underlying budget plus £0.563m funding provided by WG) which is held by the Trust. Latest forecast for 2025/26 assumes that costs will reduce to c£1.516m which will be in line with the financial envelope held by the Trust.

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

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust revised savings target for each division has been updated as VCS £0.939m, WBS £0.569m (previously £0.650), RD&I £0.230m and Corporate £1.138m (previously £0.787m) for 2024-25.

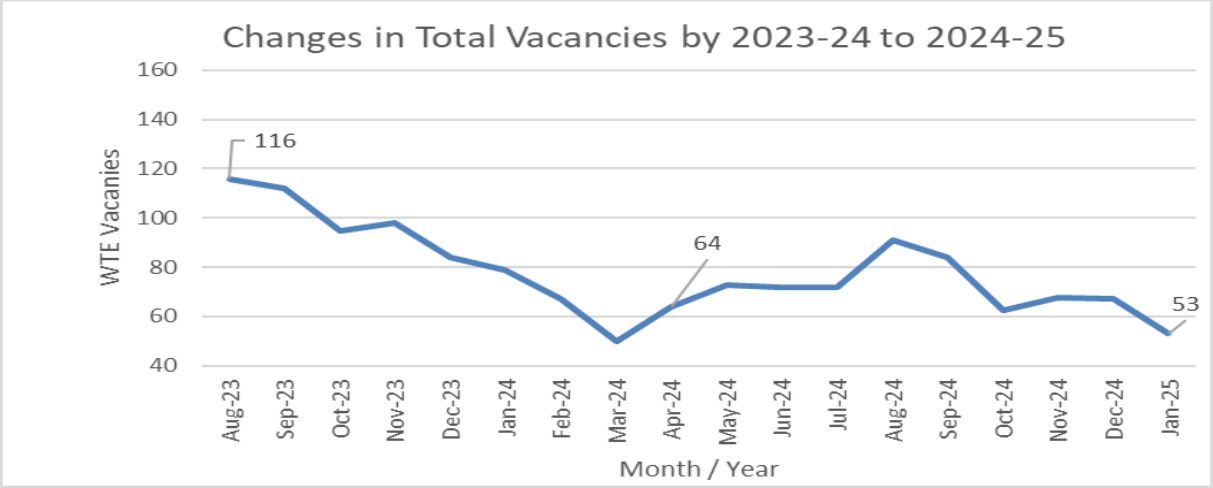
4.2 Pay Spend Trends (Run Rate)

As of January 2025, the current staff in post is 1,648 WTE (December 1,638). The number of vacancies is 52 WTE, which represents a vacancy rate of 3.05% (3.9% December) against the budget of 1,700 WTE. The vacancy gap is largely being met using agency staff, overtime, or the use of bank, and is also supporting each of the division's vacancy factor savings target.

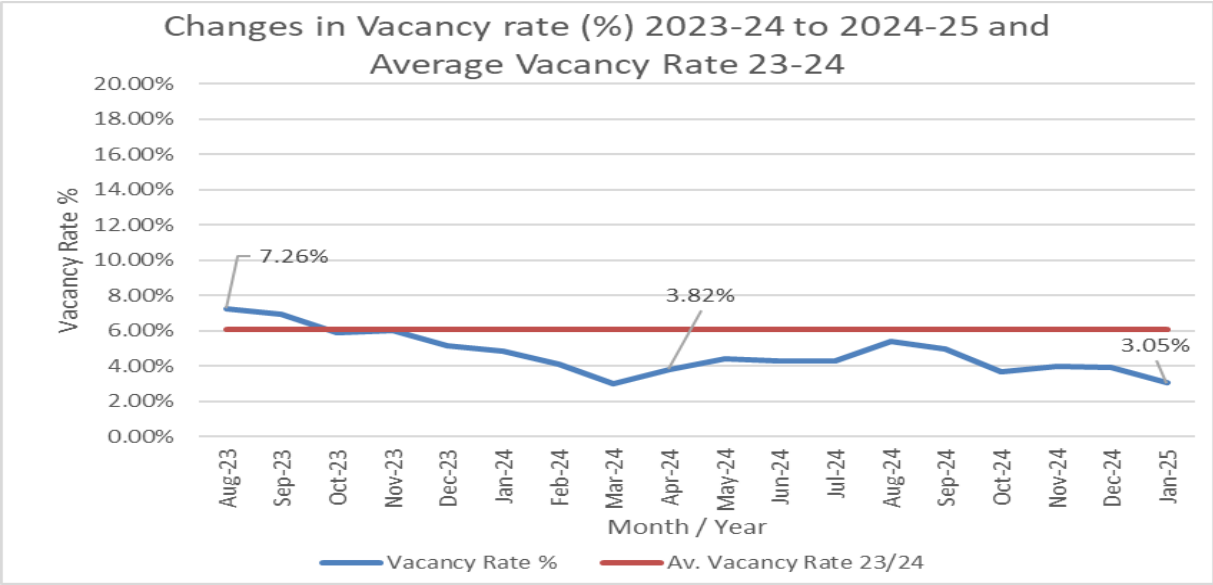
The level vacancies fell over the course of 2023-24 across several services areas but largely due to the recruitment of 17 WTE Nurses via the international recruitment scheme as demonstrated in the historic trend line on the chart below. As of August'24 vacancies had stated to rise again which is principally due to VCS receiving funding and setting budgets during the period for unfunded posts approved via the IMTP, and also for vacancies materialising from approved projects.

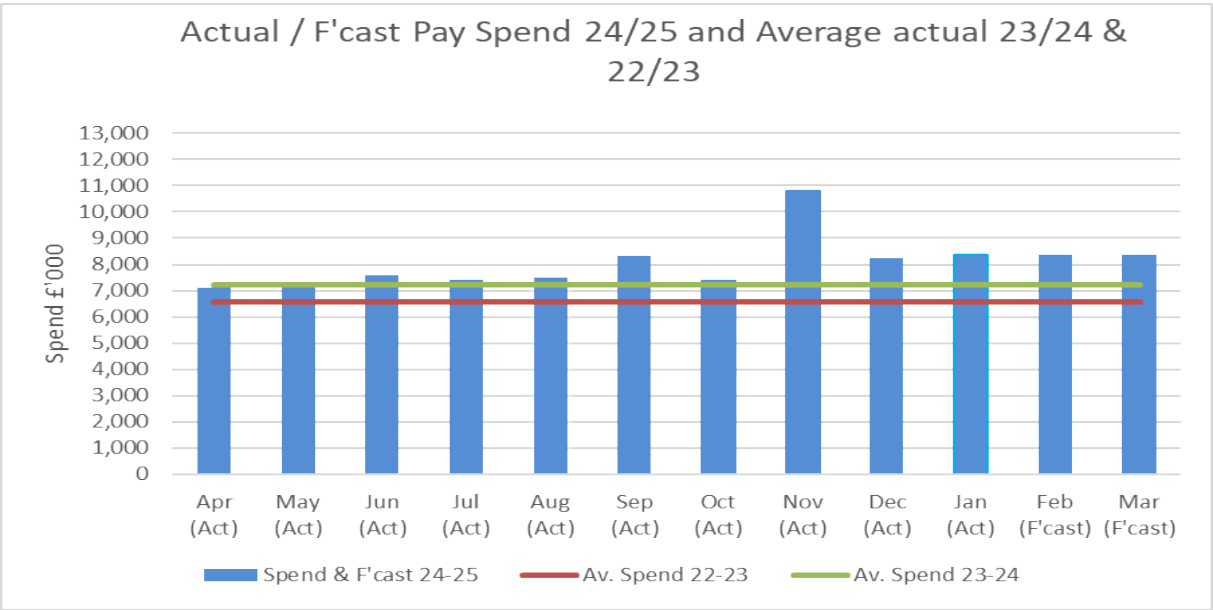
During October VCS recruited into five posts under Additional clinical services (1 in SACT day case, 2 in Pharmacy and 1 in Radiation services). Several posts were also recruited under Professional Scientific & Technical.

Several staff were recruited into VCS during December which included posts within SACT Nursing, Pharmacy, Radiotherapy, Therapiies and Medical Records A&C.



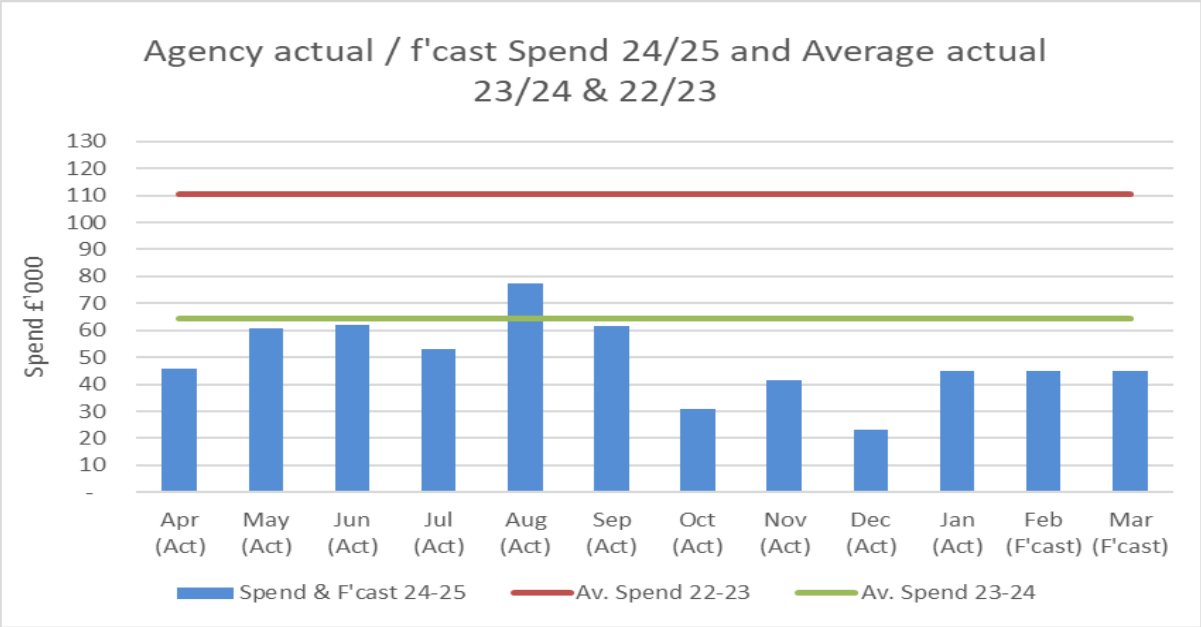
The total Trust vacancies as of January 2025 is 53 WTE (December 67 WTE): VCS (21 WTE), WBS (8 WTE), Corporate (12 WTE), R&D (10 WTE), TCS (1 WTE) and HTW (1 WTE).





The September pay includes the Junior Doctors pay award and back pay relating to 2023-24. The 2024-25 AFC and M&D pay award was processed during in November, and the additional increments for band 8+ staff and VSM pay award was processed in January, which explains the step up in cost during the periods and going forward.

The spend on agency for January 2025 was **£0.045m** (December £0.023m) which gives a cumulative year to date position of **£0.501m** and a current forecast outturn spend of circa **£0.591m** (£0.775m 2023/24).



The use of agency within Medical, Physics and Estates has now ceased, and the last member of agency within Radiotherapy is expected to leave shortly. The Trust is currently relying on short term agency support within Therapies to cover sickness and maternity leave and there has been a requirement to get a short term use of agency in Pharmacy to support vacancies. The reliance on Admin and Clerical agency is reducing from last year but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

In line with the Value & Sustainability agenda and Finance & Investment Enhanced monitoring arrangements the Trust is aiming to move away from the dependence on agency, and where possible the Trust will aim to utilise bank staff to reduce reliance on agency and the premium costs associated.

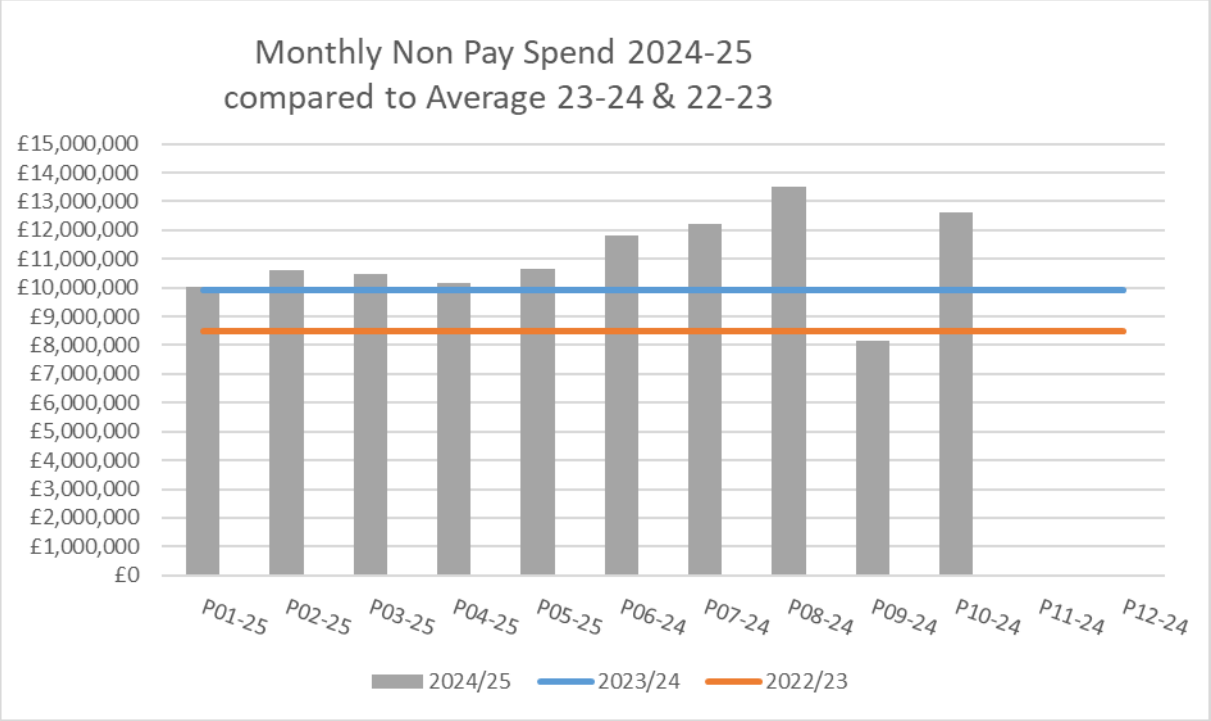
4.3 Non Pay

Average non-pay spend for 2023/24 was £9.8m per month which is a £1.4m increase from the previous whole year average. Largest movement was in drug spend which has increased by £10m in total or £0.9m average per month when compared with the previous year's spend for the same period. Other notable increases year on year include WBS Wholesaling £3.3m or £0.3m average per month and depreciation charges of £1.2m or £0.100m per month.

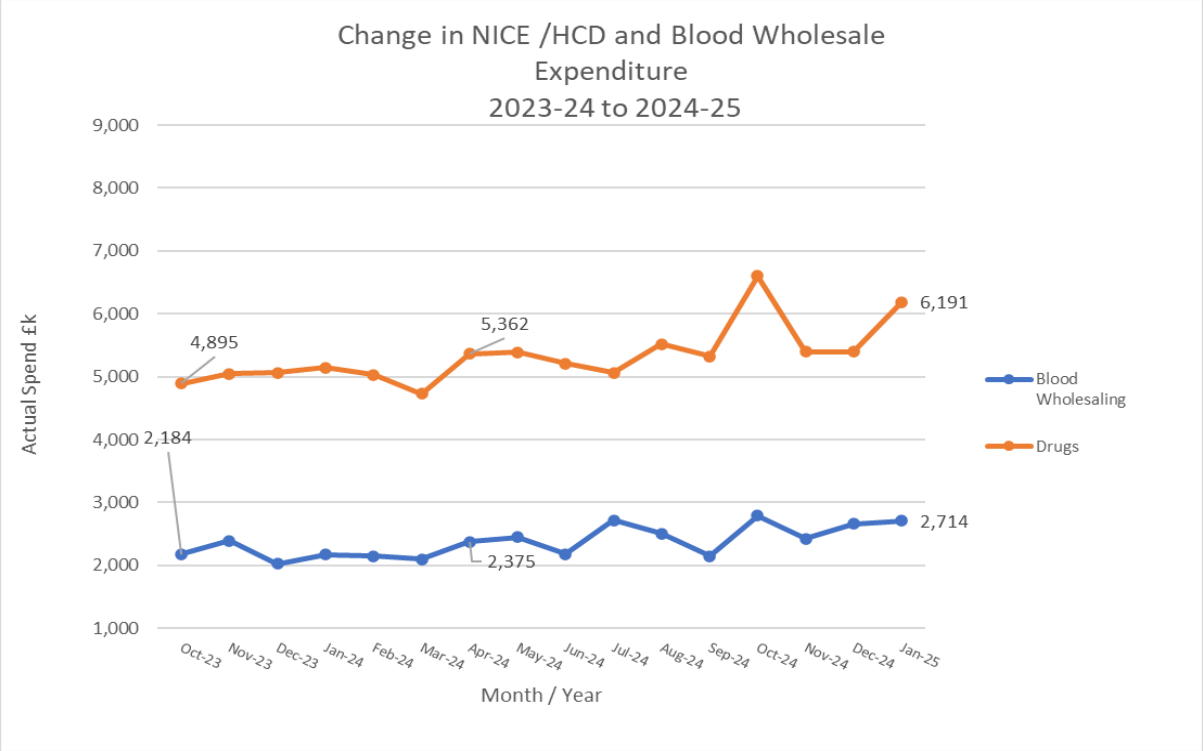
Non- Pay average spend so far for 2024/25 is currently £11m which is currently £1.2m higher than the average at the same point last year. NICE and HCD drugs (£0.7m), blood wholesale costs (£0.5m) and Clinical Service & Supplies (£0.1m) have increased which are offset by income, whilst

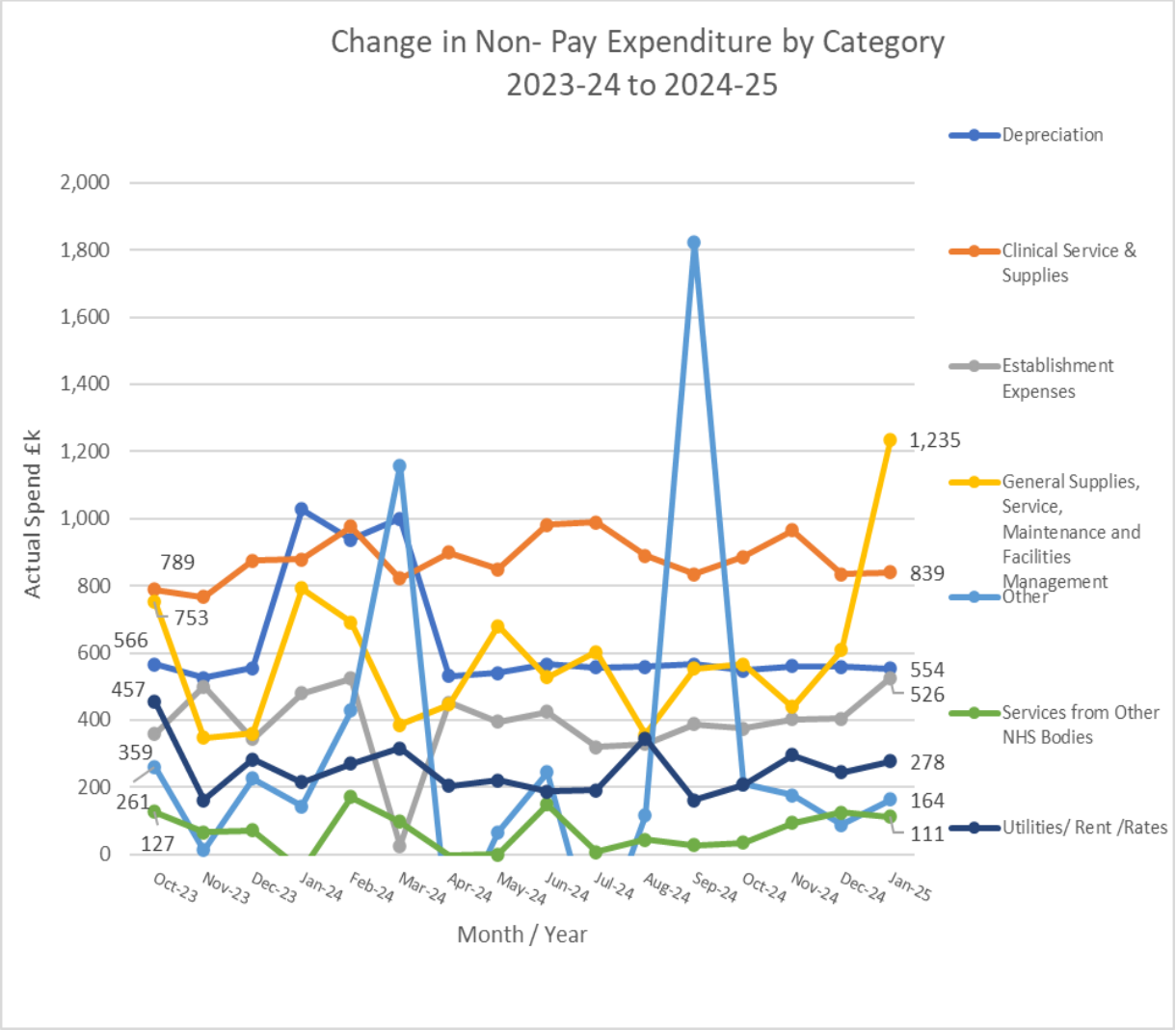
depreciation has currently reduced by £0.1m. All other costs have remined fairly static when compared with the year on year average.

Lab consumables and blood collection costs (bags and harnesses) under Clinical Services have seen an increase in costs year on year in line with increased activity.



The graphs provided below show the change in non-pay spend split by expenditure category over the period from April 2023 to January 2025.





Establishment Expenses includes expenditure such as travel, lease cars, education, printing, postage, stationary, mobile phone charges, and other miscellaneous expenditure.

*Other spend in period M12 23-24 includes a provision for legal fees which has been partly released in 24-25. Spend in month 6 also relates to the provision for legal fees that was incorrectly accounted for as income at the end of 23-24.

*The graph excludes one off spends which incurred in period M12 23-24 which adversely affects the run rate such as the £7.35m AZ income received and transferred as expenditure to the Charity, along with the pass back contribution to WG which supported the overall NHS position.

The increase in General Supplies, Maintenance and facilities management during December is largely due to a catch up on the revenue charges associated with the replacement of Radiotherapy Treatment machines, and several other small variances across the Trust.

4.4 Covid-19

The Trust will not require any covid funding support during 2024-25. However, if at any point in the future the Trust is required to support the LHBs with the vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

4. Savings

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

In conjunction with the overall financial plan an in depth review of the Trust's savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.876m was required to help compensate for the loss of income from the LTA agreements.

Of the revised £2.875m total savings target £1.247m (previously at IMTP planning stage £1.302m) is recurrent and £1.629m (IMTP £1.304m) is non-recurrent, with £1.155m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.720m (IMTP £1.427m) being via income generation.

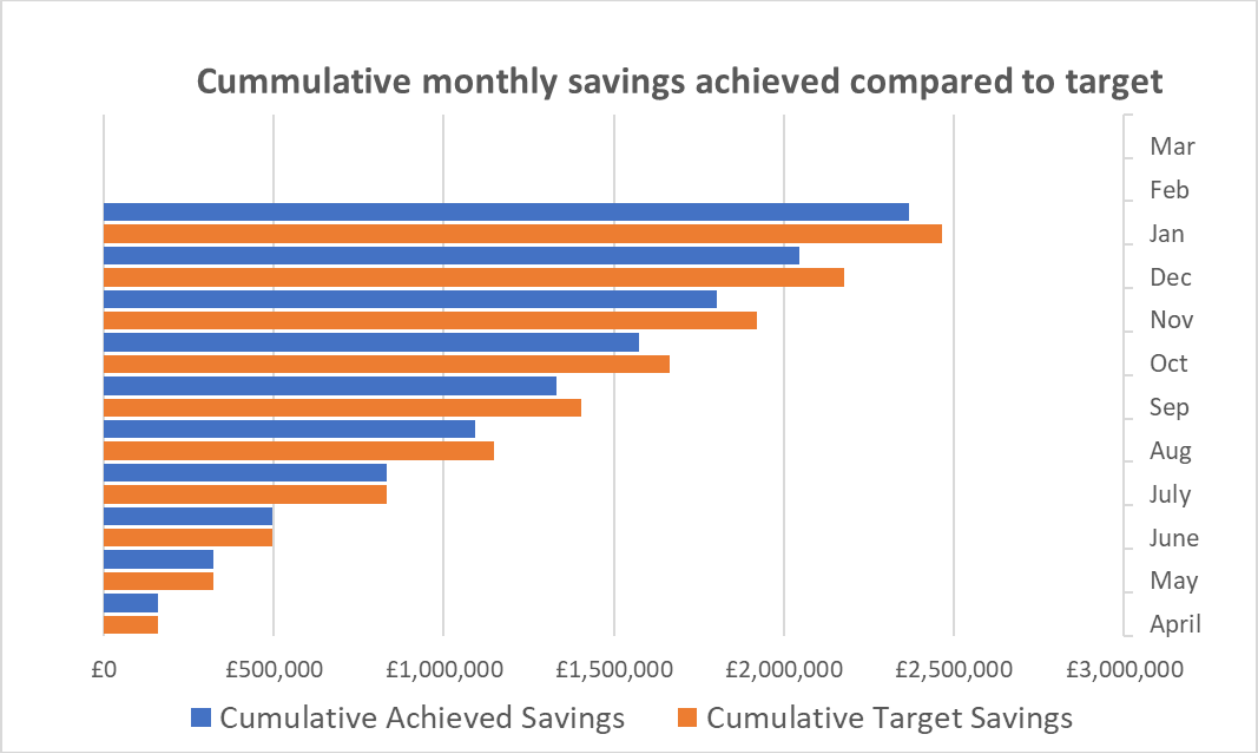
The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

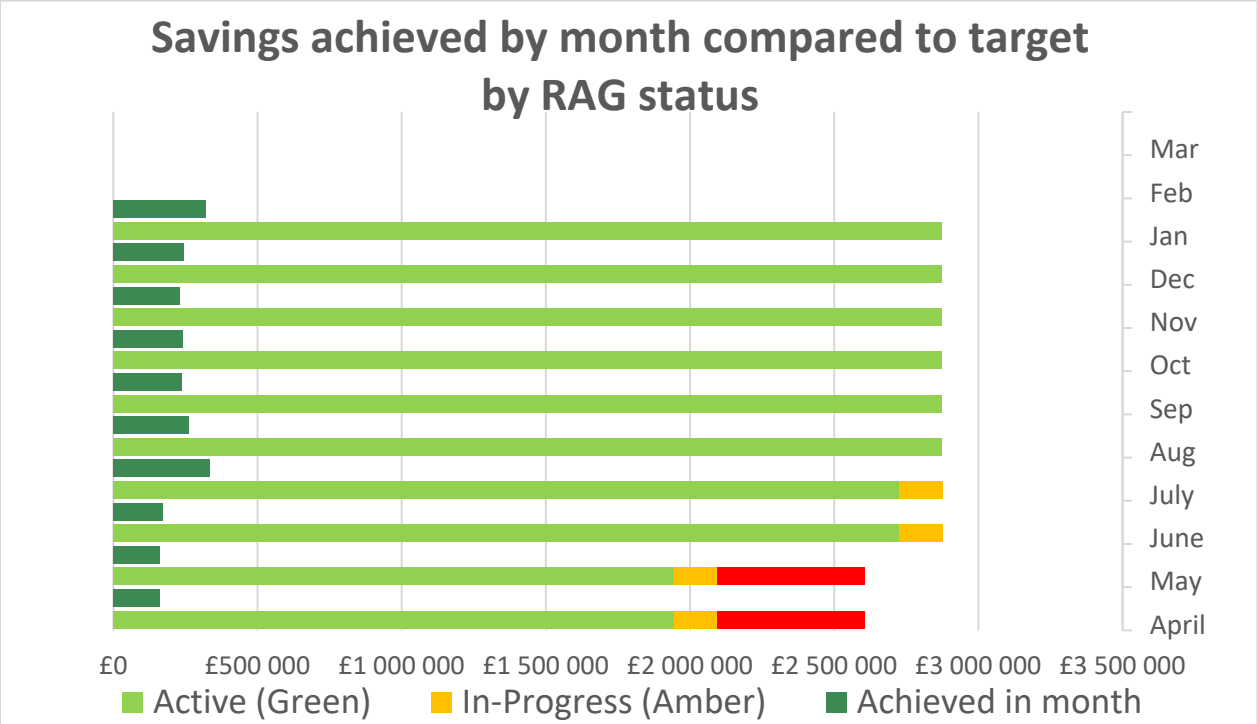
The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, the majority of the replacement schemes that were found are non-recurrent in nature. It is therefore extremely important that work continues in the Division to implement recurrent savings plans to ensure that a balanced position can be carried into 2025-26.

Performance

The overall Trust savings performance as of January 25 is a underachievement against plan of **£(0.098)m**, however at this stage are expected to deliver to target by the end of the financial year. Whilst some savings schemes are overachieving against the target, there are some schemes within WBS and VCS such as the demand planning, procurement efficiencies and private patients which are underperforming against the original plan. The WBS Stock control is now not expected to achieve any savings during 2024-25 with the target expected to be met via overachievement in other schemes such as bank interest.

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


Cummulative monthly savings achieved compared to target
Mar
Feb
Jan
Dec
Nov
Oct
Sep
Aug
July
June
May
April
£0
£500,000
£1,000,000
£1,500,000
£2,000,000
£2,500,000
£3,000,000
Cumulative Achieved Savings
Cumulative Target Savings


Savings achieved by month compared to target by RAG status
Mar
Feb
Jan
Dec
Nov
Oct
Sep
Aug
July
June
May
April
£0
£500 000
£1 000 000
£1 500 000
£2 000 000
£2 500 000
£3 000 000
£3 500 000
Active (Green)
In-Progress (Amber)
Achieved in month

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**939**	**743**	**804**	**61**	**939**	**0**
			108%		**100%**	
WBS TOTAL SAVINGS	**569**	**566**	**407**	**(159)**	**569**	**0**
			72%		**100%**	
CORPORATE TOTAL SAVINGS	**1,137**	**966**	**966**	**0**	**1,137**	**0**
			100%		**100%**	
RD&I TOTAL SAVINGS	230	**192**	**192**	**0**	**230**	**0**
					100%	
TRUST TOTAL SAVINGS	**2,875**	**2,466**	**2,368**	**(98)**	**2,875**	**0**
			96%		**100%**	

Scheme Type	Division	Recurrent / Non-Recurrent	RAG Rating	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes									
Radiation Services - Agency Reduction	VCS	NR	Green	50	42	50	8	50	(0)
Establishment Control	VCS	R & N/R	Green	234	178	194	16	234	0
Service Workforce Redesign	VCS	R & N/R	Red						
Procurement - Supply Chain	VCS	R	Green	50	39	39	0	50	0
Establishment Control	WBS	R	Green	54	83	67	(16)	67	13
Stock Control - Scan for Safety Enabled	WBS	NR	Green	150	125	0	(125)	0	(150)
WBS Demand Planning	WBS	R	Red						
WBS Demand Planning	WBS	NR	Green	75	83	67	(16)	95	20
WBS Productivity Efficiencies	WBS	NR	Red						
Procurement - Supply Chain	WBS	R	Green	50	39	18	(21)	30	(20)
Service Workforce Redesign	WBS	R	Red						
Departmental CIP	Corporate	R	Green	50	42	42	0	50	0
Establishment Control	Corporate	R & N/R	Green	75	63	63	0	75	0
R&D Establishment Control	RD&I	R & N/R	Green	80	67	67	0	80	0
New / Replacement Schemes					0		0	0	0
Productivity Efficiencies	VCS	R & NR	Green	35	27	27	0	35	0
SACT Provision	VCS	R	Green	150	120	135	15	150	0
Creditor Review	WBS	NR	Green	100	100	100	0	100	0
Budget Efficiences	WBS	NR	Green	40	31	35	4	40	0
Total Saving Schemes				**1,193**	1,039	902	(137)	1,055	(138)
Income Generation									
Private Patients - Recovery of Debt	VCS	NR	Green	150	125	150	25	150	0
Private Patients - Contract Renewal	VCS	R	Amber	150	117	114	(3)	150	0
Productivity Efficiencies	VCS	R	Red						
Sales of Plasma	WBS	R	Green	100	104	120	16	141	41
WBS Productivity Efficiencies	WBS	R	Red						
Bank Interest	Corporate	R & N/R	Green	662	552	582	30	662	0
R&D Commercial Income	RD&I	R	Green	150	125	125	0	150	0
New / Replacement Schemes					0		0	0	0
Private Patients	VCS	NR	Green	70	54	54	0	70	0
Maximising Income	VCS	R	Green	50	40	40	0	50	0
Bank Interest	Corporate	R	Green	350	280	280	0	447	97
Total Income Generation				**1,682**	1,397	1,465	69	1,820	41
TRUST TOTAL SAVINGS				**2,875**	**2,436**	**2,368**	**(68)**	**2,875**	**(97)**
						97%		**100%**	

5. Reserves

The financial strategy for 2024-25 enabled the establishment of a recurrent and non-recurrent reserve to support the Trust investment, transformation, and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.500m.

The use of investment reserves has been on hold while the Trust reached an agreement with our commissioners around the 3.67% baseline LTA uplift. However, following a review of the overall Trust financial position undertaken in June £0.808m of funding was made available to support investment decisions / choices which were agreed at EMB on the 25th June 2024.

The uncommitted non-recurrent reserve and emergency reserve had been on hold to ensure the Trust could support the financial risk in relation to n VCC implementation staff & advisor costs and EW advisor costs until WG funding is secured. However, following recent FBC approval there are non-recurrent funds available and should be considered by EMB for investment before the end of March 2025.

Action: EMB to consider use of non-recurrent reserves for investment by the 31st March 2025.

The recurrent underlying reserves position is being considered in conjunction with the IMTP planning exercise for 2025-26 and is dependent on several key factors including the VCS marginal income risk, LTA contract rebase risk, achievement of 2024-25 recurrent savings, underlying and new emerging cost pressures, Divisional CIP targets and Trust investment decisions / choices.

6. End of Year Forecast / Risk & Opportunity Assessment

There were several financial risks that could have impacted on the successful delivery of a balanced position for 2024-25, but the majority have either been re-assessed at a reduced risk level or mitigated completely. The Trust is continuing to take actions to ensure that the remaining risks are appropriately managed and mitigated against. All areas of financial plan delivery are risk assessed and where necessary identified risks are included within the Trust wide Risk Register.

The remaining key financial risks & opportunities which have been highlighted to Welsh Government are provided below.

Risks

LTA Contract Activity Income – (Medium)

A financial risk remains whereby LTA marginal income from cancer activity growth may not match the level of investment into services. Latest position is that performance has improved with the forecast outturn underachievement reducing and now expected to be c£0.500m against the target which is not yet reflected in the position. This is still currently under urgent review to assess if the forecast income will recover during the remaining couple of months of the year based on forecast demand and ensure that all activity is being captured and costed correctly. If the income doesn't

recover the Trust may need to utilise some / all of the emergency reserve to support the position on a non-recurrent basis during 2024-25.

Opportunities

Emergency Reserve – (Medium)

It is important that the Trust keeps a reserve for emergency cost pressures which may arise over the course of the year, however, if this reserve is not required during 2024-25 the Trust may be in a position to release this funding on a non-recurrent basis. The emergency reserve is currently being held to support the risk on the cancer service LTA activity marginal income, although as above the position on the LTA activity has improved in January 2025.

The Trust is expecting to manage all risks and opportunities to deliver a forecast breakeven position for 2024-25.

7. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL £000s	YTD Spend £000s	Committed Orders Outstanding £000s	Budget Remaining @ M10 £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme						
IRS - Integrated Radiotherapy Solution	5,164	2,534	0	2,630	5,164	0
IRS RSC - Radiotherapy Satellite Centre	10,065	7,860	0	2,205	10,065	0
nVCC Enabling Costs	3,500	3,183		317	3,500	0
nVCC Enabling Works, Asda QRA	0	0		0	368	(368)
nVCC Project Fees	4,140	2,950		1,190	4,140	0
nVCC Whitchurch Hospital Site		33		(33)	111	(111)
WBS TGI		0		0	0	0
Digital - WHAIS	443	369		74	443	0
Digital - RISP	160	41		119	160	0
BECS	334	94		240	334	0
WBS Electrical Resilience - Backlog Maintenance	150	28		122	150	0
WG Year End Capital Slippage Funding	220	0		220	220	0
Whitchurch Land Transfer	7,800	7,800		0	7,800	0
Digital Tech Refresh	874	0		874	874	0
Total All Wales Capital Programme	32,850	24,892	0	7,958	33,329	(479)
Discretionary Capital	1,911	900	0	1,011	1,911	0
Total	34,761	25,792	0	8,969	35,240	(479)

The approved 2024-25 Capital Expenditure Limit (CEL) as of January 2025 is £34.761m (December £33.694m). This includes All Wales Capital funding of £32.850m, and discretionary funding of £1.911m.

In line with fixing the CEL on the 30th of October the Trust confirmed the position on the Capital programme which resulted in £1.816m being given back to WG during 2024/25 with a request that £1.616m is re-provided back in 2025/26.

i. £1.2m in relation to the IRS SRU (to be re-provided during 2025/26) due to a delay in the build completion resulting in the Trust not having access to the building until 15th April (previously 13th February).
ii. £0.416m in relation to the Blood Establishment Computer System (BECS) programme (to be re-provided during 2025/26), and
iii. £0.200m given back in relation to backlog building maintenance on a permanent basis.

The Trust CEL has been updated to reflect these changes in 2024/25 and whilst the Trust has assumed that that the £1.616m will be re-provided next year, we have requested formal confirmation from WG Capital colleagues to confirm this position.

The Trust has now secured the funding from WG to support the nVCC Enabling and Project works, with expectation that the Trust will also receive Capital funding for the nVCC Asda QRA works and Whitchurch site fees required this financial year which was confirmed at the WG Capital meeting on the 21st January.

The Trust has now completed the transfer of the Whitchurch Land with C&V at a purchase cost of £7.800m which was funded by WG.

The discretionary allocation of £1.911m represents an increase of 12% on the £1.683m provided during 2023-24 and is now fully committed for 2024-25.

The table below the list of prioritised Capital schemes that was discussed and agreed at the Capital Planning Group on the 16th December.

Capital Schemes by Division	Scheme Cost (£k)
Current Discretionary Balance	**583**
VCS	
Mobile digital x-ray replacement	-100
Bispectoral Index Monitoring Equipment	-5
Replacement Electric Tug	-40
ECG & Ancillary Equipment	-10
Refurbishment of Toilets	-12
Conversion of Room for Medical Storage	-40
Environment Improvements Outpatients	-75
WBS	
WBS Survey Conditions	-34
WBS Critical list	
Total Protein Analyser	-36
Freezer Replacement (1 x -20 / 3 x -40)	-34
Room Temperature Incubator	-6
Liquid Nitrogen Freezers x 2	-22
WBS Priority list	
Fast Filter Wheel for Ix83 Olympus Microscope	-13
Stage Top Incubator	-21
Corporate	
Corporate HQ Refurbishment	-35
Remaining Balance before contingency	**100**
Contingency	**-25**
Remaining Balance	**75**

The Trust is currently still in conversation with WG colleagues around securing funding from All Wales capital during 2024-25 to support the WBS Talbot Green Infrastructure (TGI) OBC Developments. The Trust has so far incurred expenditure of £0.363m from its discretionary funding during 2024-25 which was required to complete the OBC stage of the WBS TGI scheme. WG colleagues have been made aware that to produce a completed OBC/ FBC stage there is a total funding requirement of £2.142m. The Trust received a funding letter from WG on the 18th October acknowledging this requirement, however the Trust is not in a position to sign the letter due a substantial increase in cost for the works proposed by the contractor. WG colleagues are aware of the situation with the Trust engaging with the contractor to come to an agreed resolution.

WG yearend Slippage

An e-mail was received from WG Capital colleagues on the 13th September asking the Trust to identify a prioritised list of backlog maintenance, infrastructure risks & equipment funding requests for consideration which need to be deliverable in-year. WG intention was to re-allocate the slippage on schemes already returned to the Welsh Government in early October (subject to Cabinet Secretary for Health and Social Care clearance) and for a further tranche should extra slippage / underspends be reported through the end of October 2024 exercise.

The Trust responded to this request on the 30th September with a prioritised list totalling c£1.300m which was submitted to and approved by EMB. WG informed the Trust on the 24.10.2024 that £0.220m has been awarded to support several schemes within the overall prioritisation list as listed below.

Capital Scheme	Capital Cost 2024/25 (£k)
Centrifuge	44
Centrifuge	44
WBS - Luminex Analyser (2)	58
Platelet Incubator - PC3200I	16
Platelet Incubator - PC3200I	16
PlateletTrac	20
Electronic Delivery Scanning System	12
UNOS Comparison Utility	10
Total	**220**

On the 10th December the Trust received a further funding award letter from WG totalling £0.874m to support all of the digital schemes that were included in the WG yearend prioritisation list.

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

Performance to date

The actual expenditure to January 2025 on the All-Wales Capital Programme schemes was £24.892m, this is broken down between spend on the nVCC schemes of £6.133m, the IRS £2.534m, RSC £7.860m, RISP £0.041m, BECS £0.094m, WHAIS £0.369m, WBS Electrical Resilience £0.028m, Whitchurch Hospital Site £0.033m, and the Whitchurch Land Transfer £7.800m.

The current spend on the Discretionary Capital programme as of January is £0.900m.

Year-end Forecast Spend

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

Major Schemes in Development

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

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

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

The latest position of schemes that are being considered for inclusion in the IMTP for 2025-26 and beyond is provided in the table below:

All Wales Approved and Unapproved Capital Schemes	2025-26 £m	2026-27 £m	2027/28 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes					
TCS nVCC	22.835	39.954	6.056	0.000	68.845
Integrated Radiotherapy Solution (IRS)	1.020	16.820	0.943	0.000	18.783
Radiotherapy Satellite Unit	1.200	0.000	0.000	0.000	1.200
RISP (DPIF)	0.471	0.000	0.000	0.000	0.471
Total Approved Capital Schemes	**25.526**	**56.774**	**6.999**	**0.000**	**89.299**
All Wales Unapproved Schemes					
Whitchurch Hospital Site	1.134	0.945	1.741	0.000	3.820
WBS TGI Infrastructure	2.457	5.762	17.292	41.600	67.111
WBS BECS Blood Management System	TBC	TBC	TBC	TBC	0.000
WBS Plasma for Fractionation	0.910	0.002	0.001	0.000	0.913
WBS Fleet Replacement	0.364	1.124	1.465	0.000	2.953
WBS Asset Replacement	0.532	0.215	0.000	TBC	0.747
Digital WHAIS	0.092	0.000	0.000	0.000	0.092
LIMS 2.0	TBC	TBC	TBC	TBC	0.000
EPMA (DPIF)	0.086	0.025	0.000	0.000	0.111
Digital CRM Multi Case Functions (WBMDR, AOS etc	0.500	0.000	0.000	0.000	0.500
Digital IT Infrastructure	0.500	0.500	0.500	0.500	2.000
Other Digital Service Developments	TBC	TBC	TBC	TBC	0.000
Other Service Developments (New)	TBC	TBC	TBC	TBC	TBC
Total Unapproved Capital Schemes	**6.575**	**8.573**	**20.999**	**42.100**	**78.247**
Total All Wales Capital Plans	**32.101**	**65.347**	**27.998**	**42.100**	**167.546**

8. BALANCE SHEET (Including Hosted Organisations)

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

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

	Opening Balance Beginning of Apr 24	Closing Balance End of Jan-25	Movement from 1st April Jan-25	Forecast Closing Balance End of Mar 25
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	226.135	245.888	19.753	245.888
Intangible assets	10.893	10.894	0.001	10.894
Trade and other receivables	1,316.876	1,316.722	(0.154)	1,316.722
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,553.904	1,573.504	19.600	1,573.504
Current Assets				
Inventories	31.227	31.532	0.305	31.532
Trade and other receivables	530.547	527.986	(2.561)	551.428
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	20.956	41.576	20.620	18.134
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	582.730	601.094	18.364	601.094
TOTAL ASSETS	2,136.634	2,174.598	37.964	2,174.598
Current Liabilities				
Trade and other payables	(229.886)	(268.374)	(38.488)	(268.374)
Borrowings	(1.020)	(0.910)	0.110	(0.910)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(338.517)	(588.487)	(249.970)	(588.487)
Current Liabilities sub total	(569.423)	(857.771)	(288.348)	(857.771)
NET ASSETS LESS CURRENT LIABILITIES	1,567.211	1,316.827	(250.384)	1,316.827
Non-Current Liabilities				
Trade and other payables	(3.330)	(3.330)	0.000	(3.330)
Borrowings	(31.785)	(33.100)	(1.315)	(33.100)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,320.849)	(1,069.027)	251.822	(1,069.027)
Non-Current Liabilities sub total	(1,355.964)	(1,105.457)	250.51	(1,105.457)
TOTAL ASSETS EMPLOYED	211.247	211.370	0.123	211.370
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	35.956	35.956	0.00	35.956
PDC	155.832	155.924	0.092	155.924
Retained earnings	19.459	19.490	0.031	19.490
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	211.247	211.370	0.123	211.370

9. CASH FLOW (Includes Hosted Organisations)

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

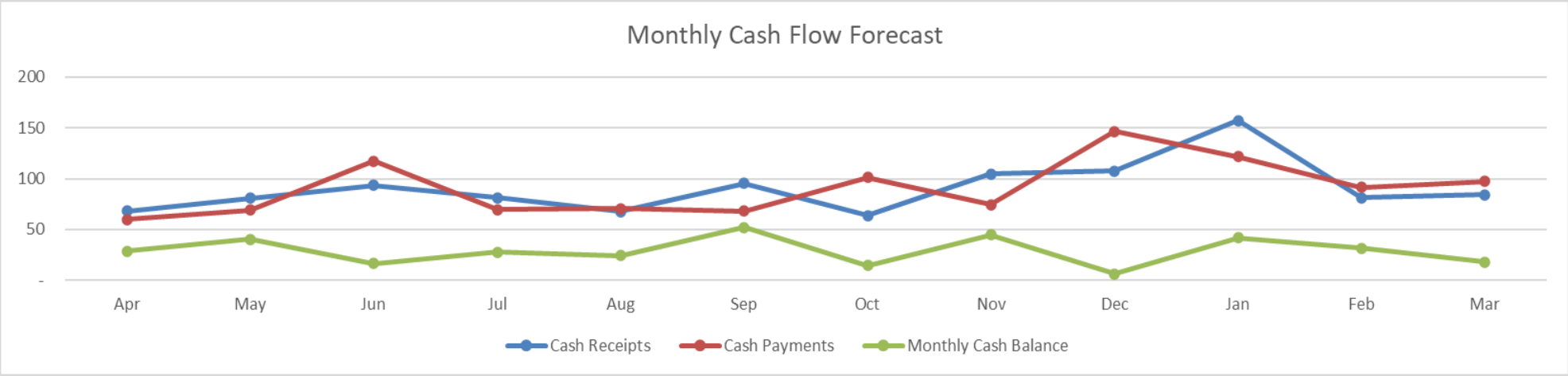
As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

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

The Trust has so far received 75% of funding (based on the HEIW Pay Model) towards the A4C and M&D pay award which was processed during November. The final cash payment will be provided once an invoice is used to Welsh Government for the balance of the final pay award settlement that has recently been confirmed by WG.

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

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	Income from other Welsh NHS	50.519	42.117	43.016	40.489	54.755	66.517	49.810	61.858	50.112	66.717	55.117	54.854	635.881
2	WG Revenue Funding	10.504	31.147	45.405	20.761	10.370	24.691	9.261	26.885	52.615	84.112	21.725	22.023	359.499
3	Short Term Loans													0.000
4	PDC								7.800				2.165	9.965
5	Interest Receivable	0.179	0.143	0.186	0.158	0.155	0.167	0.197	0.156	0.161	0.171	0.150	0.150	1.973
6	Sale of Assets													0.000
7	Other	6.657	7.151	4.914	19.701	2.092	4.223	4.503	8.142	4.830	6.253	4.068	5.000	77.535
8	**TOTAL RECEIPTS**	**67.860**	**80.558**	**93.521**	**81.109**	**67.372**	**95.598**	**63.771**	**104.841**	**107.718**	**157.253**	**81.060**	**84.192**	**1,084.853**
	PAYMENTS													
9	Salaries and Wages	25.845	35.256	35.185	35.848	37.838	48.036	51.634	47.845	51.069	41.726	41.611	41.505	493.398
10	Non pay items	31.288	30.780	81.237	33.050	32.438	19.146	48.747	12.495	94.037	78.729	40.325	48.787	551.059
11	Short Term Loan Repayment													0.000
12	PDC Repayment		0.000										0.000	0.000
14	Capital Payment	2.880	3.178	0.977	0.833	0.470	0.845	0.650	14.205	1.409	1.305	9.297	7.168	43.218
15	Other items													0.000
16	**TOTAL PAYMENTS**	**60.013**	**69.214**	**117.399**	**69.731**	**70.746**	**68.027**	**101.031**	**74.545**	**146.515**	**121.760**	**91.233**	**97.460**	**1,087.674**
17	Net cash inflow/outflow	7.846	11.344	(23.878)	11.378	(3.374)	27.571	(37.260)	30.296	(38.797)	35.493	(10.173)	(13.268)	
18	Balance b/f	20.956	28.802	40.146	16.268	27.646	24.272	51.844	14.584	44.880	6.083	41.576	31.403	
19	Balance c/f	28.802	40.146	16.268	27.646	24.272	51.844	14.584	44.880	6.083	41.576	31.403	18.134	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(40.468)	(40.455)	0.013	(48.054)	(48.041)	0.013
RD&I	0.263	0.231	(0.031)	0.284	0.253	(0.031)
WBS	(18.766)	(19.422)	(0.656)	(22.675)	(23.331)	(0.656)
Sub-Total Divisions	**(58.972)**	**(59.646)**	**(0.674)**	**(70.445)**	**(71.120)**	**(0.674)**
Corporate Services Directorates	(11.740)	(11.165)	0.576	(14.147)	(13.472)	0.674
Delegated Budget Position	**(70.712)**	**(70.811)**	**(0.099)**	**(84.592)**	**(84.591)**	**0.000**
TCS	(0.627)	(0.497)	0.130	(0.720)	(0.720)	0.000
Health Technology Wales	(0.145)	(0.145)	0.000	(0.174)	(0.174)	0.000
Trust Income / Reserves	71.483	71.483	0.000	85.485	85.485	0.000
Trust Position	0.000	0.032	0.032	0.000	0.000	0.000

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**72.782**	**74.122**	**1.340**	**87.217**	**88.557**	**1.340**
Expenditure						
Staff	47.629	47.520	0.109	57.166	57.057	0.109
Non Staff	65.620	67.057	(1.437)	78.104	79.541	(1.437)
Sub Total	**113.249**	**114.577**	**(1.327)**	**135.270**	**136.598**	**(1.327)**
Total	**(40.468)**	**(40.455)**	**0.013**	**(48.054)**	**(48.041)**	**0.013**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of January 2025 was **£0.013m underspent**. Noting that the VCS marginal activity underperformance is not yet reflected in the position which will force the division into an **overspend** outturn forecast position.

Income at Month 10 represents a surplus of **£1.340m**. A significant overachievement on private patient drug income which is offsetting the ytd savings target. Other overachievements include the

VAT savings from delivering drug home case, catering income, and an increase in the radiation protection SLA with C&V.

There is a risk that the LTA income activity does not match the level of investment into services. There is currently an underachievement of c£0.500m against the target and the £1.3m investment which has been made in the service. This is still under urgent review within the Division to assess if the original forecast income will recover during the remainder of the year based on forecast demand and ensure that all activity is being costed and recorded correctly. This is being flagged as a risk whilst under investigation so is not currently reflected in the divisional position, however given that we are in the final few months of the financial year it is now very unlikely to recover before the end of March.

VCS have reported a year to date underspend of **£0.109m** against staff. Snr Medical costs continue to be the largest pressure for VCS, however, have significantly reduced following funding being provided during August from the Trust Discretionary uplift in funding, agreed as a part the IMTP. Vacancies remain across several service areas in particular Radiation services due to vacancies related to the satellite centre along with general recruitment challenges. Positively, there have been some recent appointments including posts within SACT Nursing, Pharmacy, Radiotherapy, Therapiies and Medical Records A&C. The vacancies have been helping to support the posts appointed at risk, and the divisional savings target and vacancy factor.

Non-Staff Expenditure at Month 10 was **£(1.437)m** overspent which is largely due to an increase in facilities management expenses (Postage, security, rates and ad hoc works on site), catch up of general drugs activity and cost increase expenditure, recruitment fees for Junior doctors, legal fees provision, pathology and haematology SLA, the divisional management savings target and the additional cost improvement programme (CIP) required to support the potential shortfall in pay award funding, with the Trust having confirmed that funding will be received based on actual staff in post rather than full establishment.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**29.772**	**29.555**	**(0.218)**	**34.592**	**34.375**	**(0.218)**
Expenditure						
Staff	15.514	15.882	(0.368)	18.624	18.992	(0.368)
Non Staff	33.024	33.094	(0.070)	38.644	38.714	(0.070)
Sub Total	**48.538**	**48.977**	**(0.438)**	**57.268**	**57.706**	**(0.438)**
Total	**(18.766)**	**(19.422)**	**(0.656)**	**(22.675)**	**(23.331)**	**(0.656)**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of January 2025 was an overspend of **£(0.656)m** with an **overspend** outturn forecast position now expected for 2024-25.

An underachievement of **£(0.218)m** on income due to underperformance on bone marrow (currently achieving c50% of target year to date), partly offset by increased activity on Renal marginal activity.

Whilst Plasma Sales activity has been increasing deliveries to Randox (main supplier) were suspended due to the supplier not making payment. A bad debt provision of £0.366m was created at the end of last financial year which has now been settled. The current year debt of £0.289m has also now been fully settled. Due to the suspension of deliveries to Randox WBS are currently holding 24 pallets of plasma in storage and are currently looking for a new supplier to purchase the plasma with the Division having issued a reverse tender. Following the latest position on the tender evaluation it is now expected that WBS will be able to recover the full selling price. There has been a lack of growth in the bone marrow registry, which was largely impacted during the pandemic, which is yet to show signs of recovery despite the significant swab testing taking place at the beginning of the year. Whilst it was originally expected that the payback from the additional swabs would start to be realised later in this financial year this is now more likely to crystalise next financial year, however, remains a risk. WBS continue to run campaigns to try and grow the panel in locations such as schools and universities and raise awareness through advertising on platforms such as social media, however there is recognition that the target is too high and needs to be reviewed and considered as part of the IMTP process

Staff overspend of **£(0.368)m** is due to an increased CIP (savings target), along with advance recruitment and appointments made at risk without identified funding source. Work continues to be underway within WBS SLT to either secure additional funding to support these posts or continue to look into options of migrating staff into vacancies to help mitigate the current risk exposure. The finance team are currently creating an unfunded post analysis to determine the current year and recurrent cost pressure to be considered as part of the Trust IMTP for 2025-26.

Non-Staff reported an overspend of **£0.070m** as at month 10. There are overspends in areas such as room hire costs which are no longer funded by NHSWJCC, temporary additional security costs at the rear of the building, additional spend within molecular genetics for test kits, the cost of blood imports that took place during August and the Divisional non pay CIP. The cost pressures are being offset by underspends in Apheresis harnesses volume and price savings, price savings from bulk purchase of test kits, reduced spend on fuel due to the delay in lease vehicles being introduced, and reduced costs from lower activity on bone Marrow which is a direct correlation with income under performance.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**3.727**	**4.063**	**0.336**	**4.670**	**5.006**	**0.336**
Expenditure						
Staff	12.612	11.651	0.961	15.314	14.353	0.961
Non Staff	2.855	3.577	(0.721)	3.503	4.125	(0.622)
Sub Total	**15.467**	**15.228**	**0.240**	**18.817**	**18.478**	**0.339**
Total	**(11.740)**	**(11.165)**	**0.576**	**14.147**	**13.472**	**0.675**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of January 2025 was an underspend of **£0.576m**. The Corporate division is currently expecting to achieve an outturn **underspend** position for 2024-25.

The Trust continues to benefit from receiving high levels of bank interest because of interest rate rises, however a significant amount £1.012m (previously £0.662m) has been set against the Trust revised savings target for 2024-25, which is in addition to the baseline budget of £0.165m.

Several vacancies within the division are resulting in a large underspend year to date and will offset the use of agency and the divisional savings target.

Non-pay overspend is again expected and largely relates to divisional CIP target and the increased running costs associated with the hospital estate. Funding was set aside as part of the Trust IMTP to partly support the Estates costs on a non-recurrent basis during 2024-25 which was transacted during September.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**3.861**	**3.886**	**0.025**	**4.947**	**4.972**	**0.025**
Expenditure						
Staff	3.040	3.061	(0.022)	3.939	3.961	(0.022)
Non Staff	0.559	0.593	(0.034)	0.724	0.758	(0.034)
Sub Total	**3.598**	**3.654**	**(0.056)**	**4.663**	**4.719**	**(0.056)**
Total	**0.263**	**0.231**	(0.031)	**0.284**	**0.253**	**(0.031)**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of January 2025 was an overspend of **(£0.031m)** with a forecast outturn **overspend** expected for 2024-25.

Pay overspend is a result of late charges from Cardiff University for staff relating to 2023-24 and cannot be recharged to the Charity in 2024-25.

Clinical Trials and Charitable funds income will fluctuate and is expected be drawn down in line with expenditure.

nVCC – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.028**	**0.068**	**- 0.039**	**0.068**	**0.107**	**- 0.039**
Expenditure						
Staff	0.620	0.536	0.083	0.745	0.662	0.083
Non Staff	0.035	0.028	0.007	0.042	0.165	- 0.123
Sub Total	**0.655**	**0.565**	**0.090**	**0.787**	**0.827**	**- 0.040**
Total	**- 0.627**	**- 0.497**	**- 0.130**	**- 0.720**	**- 0.720**	**0.000**

nVCC Key Highlights / Issues

The reported financial position for the nVCC Programme at the end of January 2025 is a **£0.130m** underspend with plans in place to utilise the spend before the financial year end to achieve a breakeven position.

The Division is carrying a couple of Vacances resulting in an underspend against pay.

Escrow bank interest is being brought into the position which is resulting in the year to date and forecast outturn surplus position.

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**1.378**	**1.412**	**0.034**	**1.654**	**1.688**	**0.034**
Expenditure						
Staff	1.418	1.399	0.018	1.701	1.683	0.018
Non Staff	0.106	0.158	(0.052)	0.127	0.179	(0.052)
Sub Total	**1.523**	**1.557**	**(0.034)**	**1.828**	**1.862**	**(0.034)**
Total	**(0.145)**	**(0.145)**	0.000	**(0.174)**	**(0.174)**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of January 2025 was **breakeven,** with a forecasted outturn position which will be managed to a **breakeven** position.

HTW is funded directly via WG other than the pay award which is passed through the Trust commissioners in the same way as the core Trust.

TRUST BOARD

TRUST RISK REGISTER UPDATE

DATE OF MEETING	27 March 2025
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, Risk and Assurance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The report: • highlights the current extract of risk registers for risks scoring 12 and above for Quality/Safety and 15 above for all other domains; • allows the Trust Board to have effective oversight and assurance of the way in which risks are being managed across the Trust; • updates the Trust Board with a summary of activity related to the status of the risks and associated movement.
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**

VCS SLT	06.02.2025
WBS SLT	12.02.2025
Executive Management Board	25.02.2025
Quality, Safety and Performance Committee	13.03.2025

This paper takes into consideration the feedback from VCC and WBS leadership teams on their respective risks. Further liaison with the relevant SLT leads has been undertaken since the meetings.

The Executive Management Board (EMB) noted the risks on the risk register and related activity.

In addition, there was discussion around:

- the appropriate allocation of domains for risk.
- How representative the Trust Risk Register of the Strategic Risk. Areas were identified for consideration of inclusion as strategic risks, culture, delivery infrastructure and financial sustainability.
- Static risks and the consideration of culture versus tolerance issues. Consideration of static risk will be considered moving through the March governance cycle.

The Quality, Safety and Performance Committee received the Trust Risk paper for assurance and have asked for a summary paper on the static risks to be presented at its next meeting.

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

APPENDICES	
1	Trust Risk Register

1. SITUATION

This report informs the Trust Board on the status of reportable risks in line with the Board approved risk appetite levels. The baseline information is drawn from Datix, with additional information provided by the Velindre Cancer Service (VCS) and Welsh Blood Service (WBS) monthly risk analysis reports, validated by their Senior Leadership Teams (SLT).

Risks reported in this paper are:

1. risks in the safety/quality domain with a risk level of 12 and above;
2. risks in the non-safety domain risk level of 15 and above.

2. ASSESSMENT

2.1 Trust Risk Register

The Public Trust Risk Register is available as Appendix 1.

At the beginning of the reporting period (1 February 2025) a total of 15 risks reported onto the Public Trust Risk Register in line with the Trust's risk appetite.

Since then:

- Two new risks have been included on the Trust Risk Register. They are:
  - 3562 - There is a risk to patient safety as a result of uncertainty around process and ownership of reviewing and actioning blood tests results which may lead to an omission or delay in undertaking a remedial clinical intervention
  - 3565 - There is a risk to patients, staff & visitors falling as a result of black ice being present on site leading to a potential accident as temperature is above 0.5C and therefore gritting contractor doesn't attend site

- Three risks were reviewed during February and their scores have been reduced and are reporting below the Trust Risk Register threshold. Details of these risks can be found in Section 2 of Appendix 1.
  - 3641 - *There is a risk that VCC Pharmacy will not be able to undertake aseptic dispensing of parenteral SACT as a result of the current ChemoCare module which supports this process no longer being supported by the supplier. This may lead to a failure of the module and increased cyber vulnerabilities and thus the inability to aseptically dispense parenteral SACT.*
    The risk level has reduced from 15 to 9 as mitigations have been implemented as detailed in Appendix 1.
  - 3468 - *There is a risk to the sarcoma service as a result of the single-handed consultant planning on retirement in May 2025 with no robust succession plan in place which will result in patient care being compromised.*
    The risk level has reduced from 16 to 12 as mitigations have been implemented as detailed in Appendix 1. Following review, the Director of Corporate Governance (Interim) queried the Domain assigned to Risk 3468 regarding the future delivery of the Sarcoma Service. As it stands, the Risk scores below the threshold because the Domain is noted as Workforce. All Workforce risks report to the Trust Risk Register when they score 15+. This Risk is currently scoring at 12. Should the Domain be considered to be Safety or Quality, the Risk would be reporting into the Trust Risk Register. EMB is asked to consider the appropriateness of the assigned Domain.

- 3350 - *There is a risk to performance and service sustainability due to the Welsh Blood Service transport function being unable to deliver services due to operating an aging fleet of commercial vehicles.*
  The risk de-escalated as the business case was approved by the Trust Board and submitted to Welsh Government for approval on 05.12.2025.

- Since the Risk Register was presented to the Quality, Safety and Performance Committee (13 March) two risks has been reviewed and removed from the register
  - Risk 3538 - *There is a risk that VUNHST will be unable to sustain demand for SACT in the nVCC due to insufficient capacity as a result of TrAMS 'go live' being delayed beyond the 'go live' date for nVCC leading to patient not receive timely treatment.* The live actions related to this risk have been captured in risk 3541.
  - Risk 3565: *There is a risk to patients, staff & visitors falling as a result of black ice being present on site leading to a potential accident as temperature is above 0.5C and therefore gritting contractor doesn't attend site.* This risk has been reviewed with the likelihood scoring at 2 and the impact score at 3. This is due to the change of season.

This means that the current Trust Risk Register is showing:
- a total of 12 risks reporting onto the public Trust Risk Register in line with the Trust's risk appetite.
- Five risks with a score of 12 or above reported in the safety/quality domain.
  - Four on the VCS register
  - One on the WBS register.
- Seven risks with a score over 15 or above reported in other domains.
  - Six on the VCS register
  - One on WBS register.

Risk Themes
During the reporting period, two areas of work reported multiple risks.

a. Medical Staffing

Risks relevant to Medical Staffing include:
- 3332
- 3270

The transition from the current consultant-delivered model to a consultant-led SACT model is underway, with some non-medical prescriber posts being appointed and others

out to advert. It is expected that this model of care will reduce the risk set out above by enabling SACT to be planned up front and protocol driven. This will significantly reduce the burden on consultant colleagues and provide mitigations against this risk group. The proposed model of care has been developed learning from other specialist cancer centres and benchmarking visits are planned to help the future development of the service. In addition, the introduction of the Caner PTL will provide a system for tracking patients and support communications regarding their care.

b. Transforming Access to Medicines (TrAMS)

Risks relevant to TrAMS include:

- 3538
- 3541

A number of TrAMS risks were raised on the register in December and mitigations have been delivered during the reporting period. These risks are included in Appendix 1. Further work is planned to mitigate these and manage residual risks.

2.4 Welsh Blood Service, based on January 2025 data and analysis by the WBS Senior Leadership Team on 12 February 2025

All WBS risks on the Trust Risk Register are scoring consistently with the scores reported in the January cycle i.e. they remain static.

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

DATIX RISK TRAINING

A Lunch and Learn session ran on 11.02.2025, attended by VCS Senior Leadership Team (SLT) members, looking at risk and Datix.

Three learning sessions are planned in March for Business Support Officers (BSO), two in VCS and one in Corporate, to extend the training from the SLT Lunch and Learn session and provide a practical session to enable BSOs to support with the update and management of Datix. Tools will be shared to assist onward use of the system.

WBS have a system in place whereby training is given to relevant staff to manage and update risk on Datix. Further training was offered but wasn't deemed necessary at this time.

Discussions regarding the capture, management and reporting of programme risks are ongoing in the context of a review of the Trust's Risk Policy. Regular updates are in place

to ensure the Risk and Assurance Manager works with project teams in the process of ensuring all risks reportable to Trust Board are on Datix. The focus for the next phase of this work are the VCS and WBS Futures programme risks.

A benchmarking exercise is in process comparing current and historic Trust risk reports against those compiled by other NHS Wales/England organisations, having met with the Company Secretary at The Royal Marsden as part of the benchmarking work, resulting in understanding how risk is reported in similar organisations.

All improvements are being captured in phase two of the Governance, Assurance and Risk Programme.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to:

- **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above in advance of the Trust Board's consideration of the Risk Register.

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒
	The risk register and associated risk framework are imperative to quality and safety in the organisation.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail belowNo - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST RISK REGISTER

TRUST BOARD – March 2025

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

To note, risk scores are calculated by multiplying the likelihood of the risk by the impact of the risk.

SECTION 1 – Current Trust Risk Register

No	ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	ACTIONS & DUE DATE	PROGRESS SINCE LAST REPORTING PERIOD
	Velindre Cancer Service										
	12+ Risks in the Quality and Safety domains										
1	2465 05.11.2021	Medical	Quality/ Safety	Director of Cancer Service	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	**16** (4 x 4)	**12** (3 x 4)	**4** (2x2)	→	1. T&F group continue to meet to address key actions. 2. Email guidelines and protocol to be produced for Trust.	07.01.2025 Action plan in place. Task & Finish group progressing actions. Key actions due to be complete April 2025. Next review is due on 01 April 2025

2	2187 14.09.2020	Radiation Service	Quality/ Safety/ Workforce	Director of Cancer Service	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	**25** (5x5)	**15** (3x4)	**8** (2x4)		1. Re-advertise IRS implementation lead for the development of novel techniques. 2. Work with new the Head of Engineering to develop scrutiny business case for engineering, pending retirements.	13.03.25 IRS implementation lead job is out to ad. 19.02.2025 1. The post is in matching with modifications. Further progress made: Proposal made to extend the life of LA7/8 to remove the pressure of completing all planning solutions prior to their End of Life 2. Case for Engineering section posts written. Current risk rating **has increased from 12 to 15** due to the Head of Radiotherapy Physics post put on hold. Additional work plan due to be picked by new Head of Department. Next review due 01 May 2025
3	3431 24.07.2024	Medical	Quality	Clinical Director VCS	There is a risk to performance and service sustainability as a result of increased demand which has now outstripped capacity in the skin/melanoma SST.	**20** (5 x 4)	**12** (4 x 3)	**4** (2x2)		1. Align risk with SACT prioritisation work. 2. Establish recruitment plan. 3. Patients prioritised for VAP Identified as one of 4 sites for the new ACP pre SACT assessment roles	24.01.2025 Wok has been undertaken with the SACT Improvement Lead to understand the capacity gap. Work is progressing with the SST through SACT Improvement Programme on remaining high throughput regimens and the capacity gap. 16.01.2025 1. Risk actions now included as part of SACT prioritisation work. Work undertaken to understand the capacity gap working with SACT improvement lead 2. New SCP pre-SACT assessment advanced practice roles – job out to advert, closing end of month. Applications have been received. 3. Patients transitioned to VAP.

4	3562 *New* 30.12.2024 Risk accepted 27.01.25	VCS Whole Service	Safety	Clinical Director VCS	There is a risk to patient safety as a result of uncertainty around process and ownership of reviewing and actioning blood tests results which may lead to an omission or delay in undertaking a remedial clinical intervention	**20** (4x5)	**12** (4x3)	**8** (4x2)	New To TRR	Develop options appraisal for process of reviewing and managing blood results by end of March 2025.	New risk to TRR. 17.02.2025 Email sent to leads to establish task and finish group to develop robust process for reviewing blood test results in a timely manner. Consideration given to possibility of support from service improvement. 27.01.2025 Agreed for Chief Pharmacist to develop options for process of reviewing bloods and to bring back to SLT March 2025.
	15+ Risks in other domains										
6	3270 23.11.2023	Velindre Cancer Service	Performance and Sustainability	Medical Directorate Business Manager	There is a risk to performance and service sustainability as a result of increased demand for SACT starting to exceed capacity in all clinics leading to the burnout of the medical and supporting workforce due to excessive workloads.	**16** (4x4)	**16** (4x4)	**4** (2x2)	→	1. Advertise Specialist Doctor posts on NHS Jobs by 17.02.2035	13.02.25. Following the unsuccessful recruitment process for the SAS Doctor posts the scrutiny case was reconsidered on 07.12.2025. Posts were approved at the Scrutiny Panel. Post were advertised on NHS Jobs on 17.02.2025.
7	3332 02.09.2024	Velindre Cancer Service	Workforce	Medical Directorate Business Manager	There is a risk to staff wellbeing as a result of consultants having insufficient time to undertake direct patient administration including prescribing and completion of OONs (Outpatient Oncology note) due to increase in patient clinic numbers, leading to increased email traffic and potential treatment delays	**16** (4x4)	**16** (4x4)	**4** (1x4)	→	1. Recruitment of x2 SAS doctors and support structure to provide additional clinics. 2. Recruitment of Independent prescribers to support wider outpatient workforce model as identified within the pre-SACT assessment and business case.	20.02.2025 Action 1: Independent prescribers have been recruited. Those successfully recruited to the roles are currently working notice periods in current roles. A period of training will be required before benefits of role realised. Action 2: Following the unsuccessful recruitment process for the SAS Doctor posts the scrutiny case was reconsidered on 07.12.2025. Posts were approved at the Scrutiny Panel. Post were advertised on NHS Jobs on 17.02.2025.
8	3392 16.05.2024	Velindre Cancer Service	Workforce	Head of Therapies	There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care.	**20** (5x4)	**16** (5x4)	**6** (2 x3)	→	1. Locum agency agreement to ensure stability of service 2. Workforce priorities to be presented to VCS SLT 19/02/25	05.03.2025 Recent recruitment of Band 8a Dietetic Professional Lead awaiting start date. Locum in post. Peer review in progress awaiting final report. Benchmarking visit to Clatterbridge complete findings to inform future workforce plan.

9	3448 14.08.2024	Velindre Cancer Service	Performance & Sustainability	Head of Therapies	There is a risk that the VCC Cancer Associated Thrombosis (CAT) service will not be able to continue as a result of 2 out of the 3 trained practitioners for VCC (medical and non-medical prescribers) having recently indicated that they may no longer be able to continue in the service. This will lead to a loss of the VCC CAT service which will result in a risk to patient safety and organisational reputation as the sustainability of the service is not secured. Patients diagnosed with CAT will not be able to access specialised services and therefore may be sub optimally treated, to include delays in their cancer treatments and longer term sequalae of VTE.	**16** (4x4)	**16** (4x4)	**4** (1x4)	→	1. Baseline review to be undertaken benchmarking against other cancer centres to be complete 2.Meeting with current palliative care team and SLT to discuss CAT and contact to be made with regional CAT lead 7th February 3. Develop potential options for short term management time in diary to meeting with regional and local leads to agree proposals	18.02.2025 Meeting took place on 7th February 2025 with palliative care team and regional CAT lead to look at option for alignment with regional provision.
11	3541 02.12.2024	Velindre Cancer Service	Multiple Risk Domains (Quality, Safety, Performance and Service Sustainability)	Chief Pharmacy Officer	There is a risk to performance and service sustainability as a result of national TrAMS project being delayed leading to insufficient capacity within pharmacy technical services to meet SACT production.	**20** (4x5)	**15** (3x5)	**10** (2x5)	→	1. Option appraisal being developed in response to potential delay in TrAMS project resulting technical pharmaceutical services not being available in advance of nVCC. 8th Jan 2025. Draft options appraisal discussed at Jan VCS TraMS programme board. Next step to discuss with Exec professional leads in process of being arranged.	13.02.2025 VCC TrAMS project continue to monitor. Planning permission is now understood to have been gained. National TrAMS Programme team update that, subject to no unexpected delays in business case approvals etc, that the service should be live Autumn 2026.
12	2249 27.02.2020	Velindre Caner Service	Financial Sustainability	Director of Cancer services	There is a risk to financial sustainability as a result of service disruption due to number of posts funded by time limited funding leading to financial instability, recruitment difficulties.	**16** (4x4)	**16** (4x4)	**6** (2x3)	→	1. At risks posts to be identified as part of IMTP 2025/26 and business cases developed as requested for discussion with commissioners	17.02.2025 1.Business cases submitted for initial discussion with Health Boards in January 2025, as part of the overall IMTP submissions. Outcome awaited.
	Welsh Blood Service										
	12+ Risks in the Quality and Safety domains										
13	2774 27/10/2024	WBS	Quality/ Safety	Director of WBS	There is a risk to quality and safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	**16** (4x4)	**12** (3x4)	**4** (1x4)	→	1. Discovery and planning Transformation Workstream: process redesign and system configuration. 2. Data workstream: migration of legacy data 3. Application workstream: build of environments, database and interfaces.	18/02/2025 The risk scoring remains unchanged until the replacement system is live to mitigate. No further controls/mitigations can be identified to reduce the risk prior to replacing the system. Configuration of HistoTrac system and migration of Legacy data is underway. Commencement of UAT delayed, re-scoping options for updates to key project milestones, requiring sign off and approval. Request for additional resource to support delivery to reduce overall impact to project timelines.
	15+ Risks in other domains										

14	3306 15/01/2024	WBS	Performance and Sustainability	Director of Welsh Blood Service	There is a risk of loss of performance and sustainability, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	**20** (4x5)	**15** (3x5)	**5** (1x5)	→	Review of risk assessment required by 18/08/2025 Controlled power shutdown of WBS TG site.	18/02/2025 Tender exercise completed for WBS electrical resilience (ACB replacement). Planned loss of power to WBS TG site to support replacement of Low Voltage (LV) Air Circuit Breakers (ACBs). Risk assessment and end to end plan drafted identifying critical list of equipment across site and identified mitigation to reduce impact to core operational service. Work estimated for completion mid-March 2025 pending WBS operational requirements and sign off by WBS SLT.

SECTION 2 - Risks Decreased below Board Threshold Since Last Report to Trust Board on 30.01.2025. This section is for assurance purposes and is not included in the current risk count reported in the paper.

No.	ID & DATE OPENED	DIRECTORATE	RISK DOMAIN	RISK OWNER		INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	PROGRESS SINCE LAST REPORTING PERIOD
	3461 30.08.2024	Velindre Cancer Service	Performance & Sustainability	Chief Pharmacist	There is a risk that VCC Pharmacy will not be able to undertake aseptic dispensing of parenteral SACT as a result of the current ChemoCare module which supports this process no longer being supported by the supplier. This may lead to a failure of the module and increased cyber vulnerabilities and thus the inability to aseptically dispense parenteral SACT.	**15** (3x5)	**9** (3x3)	**5** (1x5)	↓	11.02.2025 Chemocare Plan/Resourcing mtg scheduled for 20/02/25, after which action plan to be developed. VCS Defined worksheets and labels in use. 24.01.2025 Risk level reduced from 15 to 9. 16.01.2025 Product Specifications are complete. User Defined worksheet and labels complete. VCS Digital has identified a PM. CIS supplier have allocated a project manager, VCS awaiting CIS led PID. In terms of ChemoCare Upgrade Project Start, the date has not been confirmed.
	3468 12.09.2024	Velindre Cancer Service	Workforce	Consultant	There is a risk to the sarcoma service as a result of the single-handed consultant planning on retirement in May 2025 with no robust succession plan in place which will result in patient care being compromised.	**20** (5x4)	**12** (4x4)	**2** (1x2)	↓	16.01.2025 Proposed risk reduced from 16 to 12 due to Consultant agreement, in principle, to stay Dec 2025. Discussion with SBUHB to share sarcoma CNS. They have additional capacity Raised with Health Boards, CAV escalated to Executive Function to consider providing support
	3350 04/03/2024	WBS	Service Sustainability	Head of Transplantation Services	There is a risk to performance and service sustainability due to the Welsh Blood Service transport function being unable to deliver services due to operating an aging fleet of commercial vehicles.	**16** (4x4)	**12** (4x3)	**12** (3x4)	↓	18/02/2025 Risk de-escalated as business case approved by Velindre Trust Board and submitted to Welsh Government for approval on 05/12/2024 Risk assessment review required by 06/07/2025.

Section 3 - Summary of risk movement since Quality, Safety and Performance Committee review on 13 Match 2025.

Risk 10 – Following discussion at Velindre Cancer Centre Senior Leadership Team it was agreed to close the risk due to duplication and crossover with risk 3541.

5	3565 07.01.2025	VCS Operational Services	Safety	Operational Services Compliance Manager	There is a risk to patients, staff & visitors falling as a result of black ice being present on site leading to a potential accident as temperature is above 0.5C and therefore gritting contractor doesn't attend site.	**16** (4x4)	**6** (2x3)	**8** (4x2)		1. Ensure Whitchurch car park as appropriate signage 2. Ensure gritting procedures are in place for Whitchurch car park	18.02,2025 Initial review of current contract with gritting supplier has been completed, a further review will be required (Q1 25/26) post current contract window which is March 2025. Lessons learnt will drive contract requirements in readiness for winter period 25/26. Additional local measures have been implemented to support current contract arrangements. Adverse weather procedure has been reviewed and updated to reflect the additional measures that have been put in place at an operational level to support the mitigation therefore reducing the likelihood of this happening. With reference to action 1: working with estates & VCS Operations to procure and install appropriate signage in the Whitchurch Car park area. With reference to action 2: received quote from contractor, passed onto Estates colleagues for review and feedback as budget allowance for Whitchurch car park doesn't belong with VCS
10	3538 02/12/2025	Velindre Cancer Service	Performance and Service Sustainability	CSMO Project Manager	There is a risk that VUNHST will be unable to sustain demand for SACT in the nVCC due to insufficient capacity as a result of TrAMS 'go live' being delayed beyond the 'go live' date for nVCC leading to patient not receive timely treatment	**15** (3x5)	**15** (3x5)	**6** (2x3)		1. A contingency plan is being developed for consideration by VUNHST TrAMS Project Board and subsequently VCSF Board 2025. 2. The draft options appraisal is to be presented to Executive leads for input following a revised copy being presented to next Velindre Futures Board and subsequent Trust governance.	06.02.2025 Discussed and agreed at VCS SLT 6 March 2025 to close this risk, due to duplication and cross over with risk #3541. Closed. 10.02.2025 1. A contingency plan to address impact of TRAMS not being operational at opening of nVCC is being developed. 2. Paper being developed for EMB in February 2025. This will include current position and options for consideration to ensure provision of a sustainable aseptic unit and workforce for nVCC. Issues discussed at TrAMS Board 03/02/2025. Risk to remain at current score.

TRUST BOARD

TRUST ASSURANCE FRAMEWORK UPDATE

DATE OF MEETING	27 March 2025
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, Risk and Assurance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This paper provides the Trust Board with the latest updates to the Trust Assurance Framework.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the current status of the Trust Assurance Framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	**DATE**
Executive Management Board	25.02.2025
Quality, Safety and Performance Committee	13.03.2025
Strategic Development Committee	20.03.2025
Audit Committee	25.03.2025

The discussions at the Executive Management Board are incorporated into this report.

The Quality, Safety and Performance Committee considered the TAF and welcomed the inclusion of a narrative from the Executive Leads on their owned strategic risks. The Committee also noted and welcomed the inclusion of the levels of assurance throughout the TAF. The Committee asked for the consideration of patient voice in the lines of defence in future.

The Strategic Development Committee had not taken place at the time of submitting this report. The Audit Committee had not taken place at the time of submitting this report.	
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.
APPENDICES	
1	Trust Assurance Framework

1. SITUATION

1.2 Trust Assurance Framework

The Trust Assurance Framework (TAF) was established in 2020 and the refreshed framework, detailing eight strategic risks, was approved by Trust Board in March 2024.

2. ASSESSMENT

2.1 The table below has been developed to record movement within the TAF since the it was presented to Trust Board in January 2025.

2.2 During the current reporting period, strategic lead summaries for each TAF have been developed and are available in the table below

2.3 Work has started to transfer assurance ratings from the historic method used of partial assurance, inconclusive assurance, negative assurance and not assessed to the Seven Levels of Assurance.

Number	Risk Title	Movement since last reporting period
TAF 01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	**Operational Risks:** • 3541 added to TAF 01. **Actions:** • **01.02** - Paper produced by Blood Health National Oversight Group has been endorsed and presented to Welsh Government. Work is progressing UK wide to support delivery of recommendations in UK Interim Report. Resources will be required for delivery, both within the service and the wider system. Scoping is underway looking at digital requirement costs. • **01.03** – Business case discussions between the Trust and commissioners are taking place in February. The Business case supports sufficiency of supply whilst Welsh Blood Service moves forward with its transformation programme for collections. • **01.04** – Review of Outpatient activity is being taken forward as part of the an outreach project. A LEAN Practitioner commenced in role on 18.02.2025, they will be looking at pathways. Further appointments are planned to look at demand. • **01.05** – SACT Delivery Group is in place supported by SACT Improvement Manager with a focus on forecasting demand and capacity requirements.
Strategic Lead Summary: WBS position is stable. VCS has been under additional pressure due to the increase in SACT referrals and the downtime in radiotherapy, resulting in loss of capacity.		
TAF 02	There is a strategic risk of failure to align our strategic objectives and	**Actions:** • **02.01 -** Progress against PMF packages of work are tracked in Quality, Safety and Performance Committee and Trust Board

	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.	• **02.03 -** First Regional Cancer Programme Board held in September 2024. Initial programme of work agreed in November 2024, alongside review of collective cancer strategies and existing programmes of work. This was reported to Trust Board in Strategic Planning update in November 2024. Work progressing to next meeting in February 2025.
Strategic Lead Summary: Key actions to improve strategic partnership and system working continue to be delivered strongly, particularly since December 2024. This is being taken into account in the review of strategic risk being considered as part of the 2025-2028 Integrated Medium Term Plan.		
TAF 03	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain of an optimised workforce supply and shape, in order to effectively deliver quality services and achieve our medium to long term objectives.	**Sources of Assurance:** • Sources of Assurance have been reviewed and lines of defence updated. • All Assurance Ratings have been updated to use the Seven Levels of Assurance approach. **Actions:** • **03.07** – Professional Nursing Forum development of the Nurse Retention Plan is complete and was discussed at EMB on 28.01.25. • **03.08** - Business Cases for permeant workforce planning and attraction resource submitted as part of IMTP. New expected date for completion April 25. • **03.09** - HEIW limited capacity to support. Exploring other options for the Trust in respect of Train the Trainer. Due date updated to April 2025. • **03.11** – Supplier appointed and initial filming plan underway for the implementation of the Attraction and Resourcing Project.

		• **03.12** – Implementation of the Nurse Retention Plan is underway and the plan is currently in draft form. **Completed Actions**: • **03.10** – Senior Leadership Teams have relevant local data in relation to hybrid working to ensure fair and consistent application of hybrid working principles across the Trust. This data will support the development of local optimised workforce models aligned to the clinical model for delivery.
Strategic Lead Summary: There are many factors that impact on the current supply and shape of our workforce. These are external and internal to the organisation. We are currently mitigating the risk in this area through our work programme as described below. Our focussed areas of work are in recruitment, retention and operational workforce planning. in addition, we are attempting to maximise the capacity of the workforce through reduction in absence levels - wellbeing interventions and a focus on using workforce policies in a way that minimises harm to staff and teams.		
TAF 04	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes.	**Sources of Assurance:** • Sources of Assurance have been reviewed and lines of defence updated. • All Assurance Ratings have been updated to use the Seven Levels of Assurance approach. **Actions:** • **04.07** – A session was delivered to the Board on the Social Partnership Duty. A meeting with the Chair of the Strategic Development Committee is planned.
Strategic Lead Summary: This Strategic Risk brings together those elements of the culture of the organisation that can impact on the ability of the Trust to deliver its core purpose. There are work programmes underway to address the feedback that the Trust on this subject through a variety of mechanisms. The work considers systems, processes, values and		

behaviours through development, support, wellbeing and other interventions. There will be a particular focus in 25/26 on the organisational development plan to support the transition to nVCC.		
TAF 05	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	**Sources of Assurance:** • All Assurance Ratings have been updated to use the Seven Levels of Assurance approach. **Risks:** • Risk 3523 was added to TAF 05. **Actions:** • **05.01** – Digital Design Authority has met twice and terms of reference have been agreed. Digital Design Authority will guide digital will guide digital transformation. • **05.02** – Prioritisation paper was prepared for EMB Shape and Strategic Development Committee in February 2025, however both meetings were stood down, therefore no further actions to report. • **05.04** – Initial review undertaken and updates will be collated for March 2025 TAF. **Completed Actions:** • **05.03 –** Digital Strategy and plan approved by EMB in November 2024 and by SDC in December 2024.
Strategic Lead Summary: Work is ongoing on the key controls - no movement to overall current risk scoring. Assurance ratings moved to 7 levels of assurance.		

TAF 06	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	**Sources of Assurance:** • All Assurance Ratings have been updated to use the Seven Levels of Assurance approach **Actions:** • **06.06** - External advice on the Trust's governance arrangements has been commissioned. Benchmarking underway - WAST, CAVUHB, ABUHB and Hywel Dda, Royal Marsden and Christie, NHSBT). Activity to be ongoing to inform further improvements. • **06.07** - GAR group meeting on 20 January 2025. Further review with Independent Members of status of Phase 1 Objectives conducted January / February 2025. Refreshed plan to be presented to GAR group meeting for approval in March meeting. This includes reporting mechanisms. • **06.08** - Work progressing. First draft of new policy to be considered by working group on 11 April. **Completed Actions:** • **06.05** – Revised reporting mechanism has been consolidated into the refreshed GAR Programme.

Strategic Lead Summary:

Strategically, during January/February the Governance, Assurance and Risk work programme was further strengthened by a detailed review of Objectives and Outcomes of IMs. An external review of the Trust's Governance arrangements will further inform the GAR programme and allow for improvements over the coming weeks.

Operationally, training on Risk has been undertaken at VCS to strengthen reporting. During December 2024, the Governance, Assurance and Risk work programme was further informed by ongoing dialogue with VCS regarding their service's management of governance and risk. Whilst dialogue continues, assurance level to remain as is. with increased focus on describing the outcome to be achieved

TAF 07	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	**Risk Score:** • Current risk score for TAF07 has reduced from 16 to 12. **Risk:** • Risk 3562 has been added **Controls:** • Following the completion of actions new controls have been added, C3 and C12. • The wording of Controls 3/4/5 has been amended. **Sources of Assurance:** • Following discussion at the Quality, Safety and Performance Committee Sources of Assurance lines of defence have been updated, with the third line of defence strengthened with external sources. **Actions:** • **07.03** - Initial quality, safety and outcome metrics and implementation plan underway 12 week development programme - due to conclude 31/3/25 • **07.13** - Clinical & Scientific Board established. Clinical and Scientific Strategy has been approved by Trust Board (September 2024) Clinical & Scientific Board reinstated and clinical & scientific strategy delivery plan under development. Due to complete 31.03.2025 • .
Strategic Lead Summary: Following closing a number of key actions and their inclusion as controls, the overall risk score for TAF 7 has been reduced. Further assurances have been embedded into the TAF through external sources.		

TAF 08	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	**Sources of Assurance** • All Assurance Ratings have been updated to use the Seven Levels of Assurance approach **Actions:** • **08.03** - Final Audit Report was received at Dec '24 Audit Committee with reasonable assurance. Management actions agreed to respond to small number of recommendations: . Accruals & Prepayments - Create a clear audit trail evidencing segregation of duties for preparing/reviewing prepayments/accruals, e.g., through inclusion of these tasks in the month-end finance checklist. . Suspense Account Clearing - Identify an appropriate age for when aged items are to be removed from the suspense accounts. . Undertake an annual review of the suspense accounts to ensure no aged items remain in line with the timeframe. . Reach out to Audit Wales or Welsh Government to seek advice on the correct treatment and timeframes for writing back items within the suspense accounts. . **08.06** – Develop Scheme of Delegation and Governance Framework for nVCC - Trust Board approved n VCC Scheme of Delegation in Nov '24 meeting and WG approved n VCC FBC enabling the budgets to be delegated from the CEO to the Project Director and Workstream leads. . This financial scheme of delegation will sit alongside the updated MIM Governance protocol to provide the integrated governance framework for the n VCC

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Strategic Lead Summary:

During January 2025 progress on action to improve controls have been updated with key areas of progress being:
1) Final Audit Report for Key Financial Controls presented to Dec '24 Audit Committee with Reasonable Assurance with management actions agreed for small no. of recommendations

All changes within the TAF since January 2025 have been marked in red in Appendix 2.

4 IMPACT ASSESSMENT

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

	The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required.
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	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report

3 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the TAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
BY WHEN?	Ongoing
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 LEADS:	Anne Carey Rachel Hennessey Alan Prosser	**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.
RISK THEME:	Service Capacity	**STRATEGIC GOAL:**	1 - Outstanding for quality, safety and experience

CURRENT SUMMARY OF TAF 01

WBS position is stable
VCS has been under additional pressure due to the increase in SACT referrals and the downtime in radiotherapy, resulting in loss of capacity.

Risk score trend: The risk score has remained static since the last period.

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**

KEY CONTROLS — **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			**E**	Annual Service Level Agreement meetings with Health Boards to review supply and demand. Benchmarking against National and International standards. Blood Health Team review of Health Board supply and prudent use of blood annually. Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.	**Not Assessed**	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	**Not Assessed**	Welsh Government Quality, Planning and Delivery Review.	**Not Assessed**
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Regular meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			**E**	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	**PA**	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plans	**PA**	Welsh Government Quality, Planning and Delivery Review Internal Audit, Wales Audit Office, regulator audits.	**PA**
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director WBS	X			**E**	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	**PA**	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	**PA**	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government Emergency Preparedness, Resilience and Response (EPRR) for Health, Local Resilience Forum - Strategic Coordinating Group. Internal Audit, Wales Audit Office, regulator audits.	**PA**

C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB to review.	PA	QSP committee and Board and external stakeholders if required. Regulatory Inspections such as Medicines and Healthcare products Regulatory Agency and Human Tissue Authority Internal Audit, Wales Audit Office, regulator audits.	PA
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements, to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			E	Horizon scanning and representation at key forums including UK Forum, Joint Professional Advisory Committee (JPAC) for UK blood services, The UK advisory committee on the Safety of Blood, Tissues and Organs (SaBTO). Regular liaison with Blood Policy and Tissue, Cells and Organs Policy team in Welsh Government. 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 Planning to identify gaps within service delivery models	Director VCS	X	X		PE	Service area operational planning meeting	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand and patient outcomes. Addressing this gap would require digital systems to be in place which are out of WBS control. Projects are progressing externally as part of Infected Blood Inquiry recommendations.		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
3270	There is a risk that increased demand for SACT will exceed outpatient clinic capacity as a result of increase in referrals to VCS and new lines of therapy leading to potential delays in treatment and worsening patient experience.	16	Stable
3306	There is a risk of Loss of performance and sustainability, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	15	Stable
3431	There is a risk to performance and service sustainability as a result of increased demand which has now outstripped capacity in the skin/melanoma SST.	12	Stable
3392	There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care.	16	downward
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.	15	downward
3541	There is a risk to performance and service sustainability as a result of national TrAMS project being delayed leading to insufficient capacity within pharmacy technical services to meet SACT production.	15	stable

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Assurance Rating 1-7	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
01.01	The Infected Blood Inquiry (IBI) report was published in May 2024. Recommendation 7 (in part) outlines the need to improve patient outcomes post transfusion. Mapping work is ongoing with DHCW to understand how best to record the fating of blood products at the patient bedside, and will consider the opportunity of including this with the implementation of the Laboratory Information Management System (LIMS) 2.0. This will be reported into the Welsh Government IBI next steps working group. The fating of blood at the patient bedside in turn will enable Welsh blood Service to understand by hospital and specialty what blood group has been used to help complete the demand and supply picture of blood component usage across Wales.	Alan Prosser	Dec-24		Work is ongoing with WBS and DHCW to understand the digital requirements of fating blood components at the patient bedside. Paper to scope out requirements and solution due for submission to Welsh Government by December 24.	02.12.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry	
01.02	Following publication of the Infected Blood Inquiry Report in May 2024 the Blood Health National Oversight Group has produced a paper for consideration by the Welsh government IBI next steps working group to help align the inquiry recommendations against the National Blood Health plan which should in turn improve prudent use of blood across Wales which in turn supports demand and supply for the Welsh Blood Service.	Alan Prosser	Jan-25		Paper has been endorsed by National Blood Oversight Group on October 8th and was presented to Welsh Government IBI next steps working Group in November. UK Interim report was published in December and work progresses at a UK wide and Welsh level to support delivery of the recommendations. The service has flagged that delivery of these recommendations will require resourcing within the service and to the wider system including digital requirements. As such, a resourcing paper is being prepared for consideration by Welsh Government.	27.01.25	No current funding route identified within the current LIMS DHCW are scoping and costing the digital requirements identified by the Blood Health National Oversight Group in order to support the resourcing request to Welsh Government.	
01.03	Collection capacity within the Welsh Blood Service has struggled for a number of months due to a number of operational variables. A resourcing plan to improve this position is being completed by the service for consideration of commissioners to sustain the sufficiency of supply of blood for the patients of Wales	Alan Prosser	Jan-25		Business case discussions between the Trust and commissioners are due to take place in February 2025.	27.01.25	The case supports sufficiency of supply for the patients of Wales whilst the Welsh Blood Service moves forward with its transformation programme (WBS Futures) for collections.	
01.04	Review of outpatient activity to determine what could be repatriated back to Health Boards releasing capacity within the outpatient facility and providing care closer to home for the patient	Rachel Hennessey	Jan-26		Work to be taken forward as part of outreach project. LEAN Practitioner starts in post on 18.02.2025 look at pathways and further appointment made to look at demand. some breast patients repatriated to YYF. Engaging through the new SST model.	18.02.25		
01.05	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 appropriate	Rachel Hennessey	Ongoing		SACT Delivery Group in place supported by SACT improvement manager with a focus on forecasting demand and capacity requirements. Radiotherapy capacity and Demand meeting schedule for 18.02.2025.	18.02.25		

SECTION 6

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

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE

Strategic Goal 1 Outstanding for quality, safety and experience	1. Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) 2. Implementation of Integrated Radiotherapy Solution Programme by 2026/27 3. Implementation of Outreach Programme by 2025-26 4. Implementation of the Transforming Access to Medicines (TrAMs) Model at Velindre Cancer Services 5. Implementation of Regional Acute Oncology Delivery Model and Network Structure 6. Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services 7. Implementation of the Approved Full Business case for the Development of the New Velindre Cancer (nVCC) 8. Implement Relevant Standards of the National Pre-habilitation to Rehabilitation / 3 Ps Deliverables 9. Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25		
	11. Implement Recommendations from Peer Review of SACT Treatment Helpline 12. Expand capacity and capability of VAP (Virtually Assessed Patient) Clinics 13. Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy Transformation Programme 14. Design, Commission and Deploy Revised Patient Transport Model 15. Undertake Digitisation of Medical Records 16. Respond to Low / Limited Audit Assurance Findings 17. Implementation of Centre for Collaborative Learning and Innovation		
	WELSH BLOOD SERVICE	**WELSH BLOOD SERVICE**	**WELSH BLOOD SERVICE**
Strategic Goal 1 Outstanding for quality, safety and experience	1. Implement improved donor interaction by 2026/27. 2. Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model and its ambition by 2026/27. 3. Implement new donor strategy by 2025/26. (platelet, blood, bone marrow, plasma) 4. Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25. 5. Develop and implement a platelet strategy by 2025/26. 6. Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25. 7. Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology by 2025/26. 8. Implementation of Foetal DNA typing by 2024/25. 9. Review and Develop strategy for Nucleic Acid Testing (NAT).		
	10. Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. 11. Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26.		

SECTION 1

RISK ID	02		
RISK LEADS	**Lauren Fear**	**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.
RISK THEME	Partnership Alignment	**STRATEGIC GOAL**	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations

CURRENT SUMMARY OF TAF 02

Key actions to improve strategic partnership and system working continue to be delivered strongly, particularly since December 2024. This is being taken into account in the review of strategic risk being considered as part of the 2025-2028 Integrated Medium Term Plan.

Risk score trend: The risk score has remained static since the last period.

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: PE

7 Levels of Assurance(see definitions tab)

RATING

Overall Trend in Assurance

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight; new performance management framework implemented March 2023	E	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Audit Wales/ Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in place with LB partners; regional/national arrangements in place for blood and cancer services; will be enhanced by creation of Executive Function in Welsh Government in April 2023	E	Strategic Development Committee/ Quality Safety and Performance Committees; introduction of Executive Function in WG will support effective system commissioning; Executive Function in WG from April 2023 will enhance arrangements	PA	Regulatory scope re MHRA tbc; clear standards for services understood and supported by commissioning arrangements across NHS Wales	E
3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	E	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Audit Wales	E
4.1	Regional Cancer Programme Board			X		PE	Established and initial programme of work agreed and being progressed via assigned leads	PA	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Audit Wales/ Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;			X		E	Agreed to model for each organisation	PA	Strategic Development Committee/ Quality Safety and Performance Committee	PA	Audit Wales/ Welsh Government	E
5.2	Partnership with other stakeholders e.g. WAST, HEIW and University partnerships.		X			E	Good working relationships with regular communication	E	HIW	E	Regulatory scope	E
5.3	Effective regional /national commissioning of Trust services		x			PE	Regional commissioning groups in place and effective	PA	EMB; Strategic Development Committee; Quality, Safety and Performance Committee		Audit Wales/ Welsh Government	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line and second lines of defence assurance are in place to a certain extent	1.9; 1.7; 1.8
Agreement of need for improved regional cancer Commissiong (core services)		1.6; 1.8
Need for improved data/quality metrics to track performance	Provision of improved metrics to EMB; QSP and Trust Board	1.3; 1.4

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	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 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
02.01	Phase 1 complete in 2022. Development of next phase agreed by Executive Management Board in September 2024 and reported through to QSPC and Trust Board in packages of work with associated timeframes for completion of all by March 2025.	Director of Transformation - Interim	~~01/03/2024~~ March 2025	Progress against PMF packages of work are tracked in Quality, Safety and Performance Committee and Trust Board	3.2.25 - Update remains extant	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
02.03	Regional Cancer Programme Board to be established and operating effectively	Director of Transformation - Interim	Mar-25	First Regional Cancer Programme Board held in September 2024. Initial programme of work agreed in November 2024, alongside review of collective cancer strategies and existing programmes of work. This was reported to Trust Board in Strategic Planning update in November 2024. Work progressing to next meeting in February 2025.	3.2.25 - Update remains extant	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangements and the quality of cancer services	The level of assurance will be revised in next reporting period.

SECTION 6

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

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

SECTION 1

RISK ID	03		
RISK LEADS	Sarah Morley	**RISK TITLE**	There is a strategic risk to the Trust's ability to effectively deliver quality services and achieve our medium to long term objectives if we are unable to develop and maintain of an optimised workforce supply and shape, in order to effectively deliver quality services and achieve our medium to long term objectives.
RISK THEME	Workforce Supply and Shape	**STRATEGIC GOAL**	1 - Outstanding for quality, safety and experience

CURRENT SUMMARY OF TAF 03

There are many factors that impact on the current supply and shape of our workforce. These are external and internal to the organisation. We are currently mitigating the risk in this area through our work programme as described below. Our focussed areas of work are in recruitment, retention and operational workfroce planning. in addition we are attempting to maximise the capoacity of the workforce through reduction in absence levels - wellbeing interventions and a focus on using workforce policies in a way that minimises harm to staff and teams.

Risk score trend: The risk score has remained static since the last period.

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		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	People and Development Steering Groups	4	Performance reporting to Executives and Trust Board	4	Internal Audit Reports	4
C2	Approved Workforce Planning Methodology aligned to Trust Values and Beahviours	Susan Thomas	X			E	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	5	Reports to EMB , Committees and Trust Board	5	Internal Audit Reports	5
C3	Workforce planning - skills development	Susan Thomas	X			PE	Provide operational managers with skills and capabilities to undertake effective workforce planning. Provide formal training and produce a suit of workforce planning tools.	4	Reports to EMB , Committees and Trust Board	4	Internal Audit Reports	4
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in Workforce Planning skills	Susan Thomas	X			E	The Trust has a robust programme of evaluation to support the delivery of all trianing programmes, ensuring a continious learning and development system is in place.	5	Reports to EMB , Committees and Trust Board	5	Internal Audit Reports	5

C5	Educational pathways in place to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE	People and Development Steering Groups	2	Reports to EMB , Committees and Trust Board	2	Internal Audit Reports	2
C6	Widening Access Programme to support development of new skills and roles	Susan Thomas	X			PE	People Development and Education Steering Group	2	Reports to EMB , Committees and Trust Board	2	Internal Audit Reports	2
C7	Monthly dashboard reports are provided to divisional SLTs to monitor performance, identify and manage any issues. Hotspot areas are identified and managed accordingly, such as establishment of Task and Finish Groups.	Susan Thomas	X			E	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	6	Regular performance reports and Supply and Shape paper are submitted to EMB and QSP	6	Internal Audit Reports - Managing Attendance at Work, Recruitment and Retention and Education Strategy Audit (ongoing)	6
C8	Consistent recruitment and selection process	Sarah Morley	X			PE	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	4	Reports to EMB , Committees and Trust Board	4	Internal Audit	4

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	Current Risk Rating	RISK TREND
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.	12	Stable
3392	There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care.	20	Stable

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Assurance Level	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
03.06	Development of a Trust Workforce Plan	Susan Thomas	Sep-25		18.09.2024 An initial plan was presented to EMB in September 2024, where short and medium term actions were agreed. These actions will be reflected in Workforce Supply and Shape paper in November QSP. 02.12.2024 A number of the actions outlined in the Trust's Workforce Plan, were scrutinised at QSP on 14.11.2024 through holistic Workforce and Finance Supply and Shape Paper. Assurance ratings were reviewed against each deliverable area, in detail, and amended as discussed and agreed by the committee. QSP will continue to receive the paper and define the assurance levels related to actions in the plan.	02.12.2024	The impact will be reduced once the short and medium term actions are completed	

03.07	Development of a Nurse Retention Plan	Amanda Jenkins	Complete	25.06.2024 The Nurse Retention Plan was agreed to be taken forward by EMB with accountability for developing the plan being lead within the Professional Nursing Forum. 24.09.2024 The Nurse Retention Plan (developed in partnership with service leads) was discussed at PNF. The group agreed to take away the plan to review and comment on by the next meeting on 05.12.2024. It is anticipated this will be approved at this meeting. 28.01.2025 Approved at EMB	27.01.2025		
03.08	Embed workforce planning progress into monthly Divisional Senior Leadership Team Workforce reports	Amanda Jenkins	Oct-25 Apr-25	30.10.2024 A review of the current position was completed however it is clear from this work that further capacity and skilled resource is needed to embed this into the monthly reviews. 02.12.2024 Finance meeting to discuss and agree next steps for building additional resource and capacity. Agreed to take forward as part of the IMTP business case aligned to the opportunity pipeline of workforce re-design. 27.01.2025 Business Cases for perm workforce planning and attraction resource submitted as part of IMTP. New expected date for completion April 25 aligned to resource.	27.01.2025		
03.09	Staff educators to undertake HEIW train the trainer on workforce planning	Amanda Jenkins	Oct-24 Apr-25	29.11.2024 in contact with HEIW to scope train the trainer programme and costs 27.01.2025 HEIW limited capacity to support. Exploring other options for the Trust 20.02.2025 HEIW and Trust have developed progreamme of WFP traning for the Trust through CIPD with a Train the Trainer course for building capacity within the Trust of workfroce planning resource.	27.01.2025		
03.11	Implementation of the Attraction and Resourcing Project	Amanda Jenkins	Mar-25	01.10.2024 New Attraction and Resourcing Lead appointed to take actions from the project forward. 14.10.2024 Options paper for recruitment campaign agreed to EMB. 27.01.2025 Supplier appointed. Inital filming plan underway.	27.01.2025		
03.12	Implementation of the Nurse Retention Plan through the Professional Nursing Forum	Nicola Williams / Divisional Heads of Nursing	Apr-26	Nurse Retention Plan currently in draft 27.01.2005 EMB endrced the NRP, implementation underway	27.01.2025		
				CLOSED ACTIONS			
03.13	Utilise the learning from implementation of the Nurse Retention to develop a Trust Retention Plan	Amanda Jenkins	COMPLETE	Completed	30.10.2024	Learning and engagement in Nurse retention plan utilised to develop Trust Retention Plan	

03.01	The Healthy and engaged workplan to be implemented to support workforce capacity within the Trust	Sarah Morley	COMPLETE	The Healthy and Engaged workplan 2024-25 was agreed at the Healthy and Engaged Steering Group on 09.03.2024. The Healthy and Engaged Workforce Steering Group reports quarterly to EMB.	14.05.2024		Impact on assurance level was updated in the Supply and Shape paper presented to QSP on 09.05.2024.
03.02	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	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	
03.03	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	COMPLETE	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.	
03.04	Develop and Implementation Plan for the People Strategy	Susan Thomas	COMPLETE	A plan to implement the People Strategy will be presented to EMB in December.	21/12/2023	Presented to EMB Shape	
03.05	Review Exit Interview Process	Susan Thomas	COMPLETE	The Exit interview process has been rewritten. There is a new dashboard and automated process and engagement sessions have been delivered. A new procedure will be submitted to EMB	20.03.2024		
03.10	Embed Hybrid working principles in training and reporting	Amanda Jenkins	COMPLETE	02.12.2024 People analytics team have developed a process for recording flexible working applications and outcomes via ESR. This is to be rolled out to managers in the month of December and the data will be used from January 2025 in reporting monthly to divisional SLT's. 27.01.2025 Completed	27.01.2025	SLT's have relevant local data in relation to hybrid working to ensure fair and consistent application of hybrid working principles across the Trust. This data will support the development of local optimised workforce models aligned to the clinical model for delivery.	

SECTION 6

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

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

SECTION 1

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

CURRENT SUMMARY OF TAF 04

This Strategic Risk brings together those elements of the culture of the organisation that can impact on the ability of the Trust to deliver its core purpose. There are work programmes underway to addess the feedback that the Trust on this subject through a variety of mechnisms. The work considers systems, processes, values and behaviours through development, support, wellbeing and other interventions. There will be a particular focus in 25/26 on the organisational development plan to support the transition to nVCC.

Risk score trend: The risk score has remained static since the last period.

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			E	Reports to EMB	5	Trust Board reporting on strategy and controls via cycles of business	5	Welsh Government reporting via JET and IMTP	5
C2	Approved Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			E	People Development and Education Steering Group	4	Reports to EMB , Committees and Trust Board	4	Internal Audit Reports	4
C3	Management and Leadership development programmes in place based on compassionate leadership principles	Susan Thomas	X			PE	People Development and Education Steering Group	4	Reports to EMB , Committees and Trust Board	4	Internal Audit Reports	4
C4	Trust Values and Behaviour Framework	Susan Thomas	X			PE	Healthy and Engaged Steering Group	4	Reports to EMB , Committees and Trust Board	4	Internal Audit Reports	4
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff including employee voice	Non Gwilym/ Sarah Morley	X			PE	Healthy and Engaged Steering Group	2	Reports to EMB , Committees and Trust Board	2	Internal Audit Reports	2
C6	Health and Wellbeing infustructure for the Trust to support physical and psychological wellbeing of staff	Susan Thomas	X			E	Healthy and Engaged Steering Group	5	Reports to EMB , Committees and Trust Board	5	Internal Audit Reports	5
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Non Gwilym	X			PE	Reports to EMB	3	Reports to Committees and Trust Board	3	Internal Audit Reports	3

C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	5	Reports to EMB, Committees and Trust Board	5	Internal Audit Reports	5
C9	Clear safe, effective and efficient service models to support role clarity aligned to compassionate leadership principles	Anne Carey	X			PE	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	3	Reports to EMB, Committees and Trust Board	3	Internal Audit Reports	3
C10	Operational workforce plans developed to support agreed service models	Anne Carey	X			PE	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	3	Reports to EMB, Committees and Trust Board	3	Internal Audit Reports	3
C11	Avoidable employee harm prinicples are embedded into the management of beahviours within the Trust	Sarah Morley	X			PE	Healthy and Engaged streerting group and Local Partenship Forum	5	Reports to EMB, Committees and Trust Board	5	Internal Audit Reports	5

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3332	There is a risk to the health and wellbeing of the medical workforce due to increasing demand resulting in prescribing and the completion of Outpatient Oncology Notes being done outside of job plan hours	16	Stable

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
04.05	Undertake analysis of current employee voice mechanisms and develop an engagment action plan to improve voice mechanisms and encourage a culture of speaking up across the Trust.	Claire Budgen		Mar-25	06.12.24 Culture Framework is in development. Engagement sessions took place with senior leaders in November 2024. Culture Framework encompasses the speaking up safely mechanisms.	06.12.24		
04.07	Embed the prinicples of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business	Amanda Jenkins		Apr-25	06.12.2024 Session planned at Board Development on 17.12.2024. A Social Partnership update will be included. Following session a meeting will be planned with the Chair of Strategic Development Committee to plan governance routes. 27.01.2025 Session delviered to Board on the Duty. Meeting with SDC Chair set up	27.01.2025		
04.08	Implement the Compassionate Leadership Pledge and action plan within the Trust	Claire Budgen		Mar-25	06.12.2024 Compassionate Leadership Pledge was signed on 26 September 24 by leaders in the Trust. Action plan is in development and will be goverened by the People Development and Education Steering Group	06.12.24		
04.09	Develop outcome measures for the monitoring and analysis of Health and Wellbeing activies within the Trust	Claire Budgen		Dec-24	06.12.2024 Paper being submitted to Healthy and Engaged Steering Group on 19.12.2024. Complete	19.12.2024		
04.10	Implement the actions of the Trust Strategic Equality Plan, incuding embedding the Anti-Racist Wales Action Plan in the Trust	Claire Budgen		Mar-25	06.12.2024 Regular updates have been submitted to EMB, committees and Trust Board. An assurance level of 3 was agreed.	06.12.24		

SECTION 1

RISK ID	05		
RISK LEADS:	Carl Taylor	**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
RISK THEME:	Digital Transformation	**STRATEGIC GOAL:**	All

CURRENT SUMMARY OF TAF 05

Feb '25 Work is ongoing on the key controls - no movement to overall current risk scoring. Assurance ratings moved to 7 levels of assurance.

Risk score trend: The risk score has remained static since the last period.

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

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	Risk reporting arrangements at divisional, project/programme level	4	QSP/Audit Committees, Trust Board	4	Internal Audit Reports	4
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	6	EMB Shape	6	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	6
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	4	EMB Shape / National Programme Boards	4	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ National Programme Governance	4
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital Officer	X			PE	Staff feedback - KLAS Survey - Mandatory Training stats	4	EMB Shape	4	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	4
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback Trust Digital Inclusion Plan	3	EMB Shape / Digital Communities Wales	3	Strategic Development Committee/ QSP Committee/ Internal Audit	3
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board Digital IMTP Trust Capital Programme Digital Spend included in PMF (Current 2.6%)	3	EMB Shape / EMB Run	3	Strategic Development Committee/ QSP Committee/ Internal Audit	3

C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board Digital Programme Board	4	EMB Shape	4	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ Centre for Digital Public Services	4
C7	Digital inclusion in wider community	Chief Digital Officer	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales	6	EMB Shape	6	Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales Accreditation	6
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	6	EMB Shape	3	Strategic Development Committee/ QSP Committee/ Internal Audit	3
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting Digital Programme Board	4	EMB Shape / EMB Run / Cyber Action Plan	4	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Cyber Resilience Unit	4
C11	Trust digital Governance	Carl James		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	6	EMB Shape	6	Wales Audit OfficeSIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	6
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	4	EMB Run	4	SIRO Reports/ QSP Committee/ Internal Audit / WG IQPD	4
C13	Cyber Assurance Controls in place	Chief Digital Officer		X		E	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	3	EMB Shape / EMB Run	4	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS	4
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE	Digital Programme Board Digital Design Authority being established	3	EMB Shape	3	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	3

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
2774	There is a risk to **Quality and Safety** as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	12	Stable

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Assurance Level	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
05.01	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	Mar-25		Terms of reference drafted for approval at Aug Digital Programme Board Digital Design Authority has now met twice and terms of reference have been agreed.	Feb-25	Digital Design Authoriy will guide digital transformation	The level of assurance should increase from 3-4 for C14
05.02	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Chief Digital Officer IA	Feb-25		Data and Insight formative paper due at SDC in Feb '24 Prioritisation paper presented to EMB in Nov '24 Data and Insight incuded as part of the Change Advisory Board for C9 Additonal band 8a resource recruited Prioritisation paper prepared for EMB Shape/SDC in Feb '25 - Both meetings were cancelled to no follow on actions	Feb-25	Will contribute to reduction in likelihood of risk	C9 would move to Effective
05.04	Reviewing control framework with Head of Information Governance for cross-check and alignment	Chief Digital Officer IA	Mar-25		Initial review undertaken and updates will be collated for March 25 TAF	Feb-25	Will contribute to reduction likelihood of risk	Assitional assurance for C11 and C13
					CLOSED ACTIONS			
5.05	Introduce a Change Advisory Board (CAB) to manage digital changes to service.	Chief Digital Officer IA		Complete	Scope fror CAB has been established CAB is now meeting regularly Action will close from Oct '24 once operating effectively	Oct-24	Will contribute to reduction likelihood of risk	Assurance controls better represent best practice, around C9
05.03	Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment	Chief Digital Officer IA		COMPLETE	Digital strategy and plan approved by EMB Nov '24 and on Dec '24 SDC agenda Went to SDC in Dec 24, where the paper was noted.	Jan-25	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice

SECTION 6

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

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 5 **A sustainable organisation that plays it part in creating a better future for people across the globe**	**1. "Agile" Delivery Squads introduced to Digital target operating model** **2. New Patient Reported Outcome Measures (PROMS) system for Value Based Healthcare** **3. Digital Inclusion - digitally connect our donors, patients, and carers and staff to our services 24/7** **4. Deploy a range of preventative cyber security tools and services, including staff education programme, to reduce likelihood of cyber breach – Cyber Security Strategic Development Plan (CSSDP)** **5. Introduce new Digital Training Platform**		
	6. Performance Management Framework (Quality Measures) dashboard **7. National Data Resource roadmap** **8. Trust wide Data and Insight plan** **9. New Velindre Cancer Centre (nVCC) digital enablement** **10. Digital enablement of the integrated Radiotherapy Solution Programme by 2026/27** **11. Implementation of electronic prescribing and medicines administration (ePMA) for Use by Velindre Cancer Services** **12. Digital Enablement of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital)**		

SECTION 1

RISK ID	06		
RISK LEADS:	Non Gwilym	**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.
RISK THEME:	Organisational and Clinical Governance	**STRATEGIC GOAL:**	1 - Outstanding for quality, safety and experience

CURRENT SUMMARY OF TAF 06

Strategically, during January/February the Governance, Assurance and Risk work programme was further strengthened by a detailed review of Objectives and Outcomes of IMs. An external review of the Trust's Governance arrangements will further inform the GAR programme and allow for improvements over the coming weeks.

Operationally, training on Risk has been undertaken at VCS to strengthen reporting.During December 2024, the Governance, Assurance and Risk work programme was further informed by ongoing dialogue with VCS regarding their service's management of governance and risk. Whilst dialogue continues, assurance level to remain as is. with increased focus on describing the outcome to be achieved.

Risk score trend: The risk score has remained static since the last period.

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)	Non Gwilym		X		PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Risk reporting arrangements at divisional, project/programme level	4	QSP/Audit Committees, Trust Board	6	Internal Audit Reports	4
Annual Board Effectiveness Survey		Audit Committee		Internal Audit Reports	

C2	Annual Assessment of Board Effectiveness	Kay Barrow			X	E	Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	6	Trust Board	6	Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Non Gwilym	X			E	Internal Audit Review	4	Audit Committee Trust Board	4	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements	4
C4	Board Development Programme	Non Gwilym	X			PE	Programme established	4	Trust Board in Board Development	4	Specialist external input as required, for instance on Socio-economic Duty	4
C5	Quality of assurance provided to the Board	Non Gwilym	X			PE	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	4	Trust Board assessment via formal annual and additional effectiveness review exercises	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4
C6	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Non Gwilym	X			PE	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	4	Governance, Assurance & Risk Steering Group and Trust Board in Board Development input	4	Benchmarking input	4
C7	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework	Non Gwilym	X			PE	Exercise completed.	1	Trust Board in Board Development	1	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	3

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/
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

06.06	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Non Gwilym	3	Nov-24	External advice on the Trust's governance arrangements has been commissioned. Benchmarking underway - WAST, CAVUHB, ABUHB and Hywel Dda, Royal Marsden and Christie, NHSBT). Activity to be ongoing to inform further improvements.	20.02.25	Benchmarking will provide further assurance to the Board.	Delivery of the action will provide assurance to the Board on the quality of GAR programme output. □ Output to be considered as accessible to all staff and as an enabler to service improvement. □
06.07	Develop new plan for phase 2 GAR programme	Non Gwilym	2	Dec-24	GAR group meeting on 20 January 2025. Further review with Independent Members of status of Phase 1 Objectives conducted January / February 2025. Refreshed plan to be presented to GAR group meeting for approval in March meeting. This includes reporting mechanisms.	13.02.25	Activity during January / February 2025 significnatly reduces the risk of the lack of clarity of business priorities and focus. A consolidated plan has been developed and progress to implement where there is agreement on actions isn't impeded by the approval of the overarching programme.	The delivery of the GAR programme will provide the Trust with assurance on its governance arrangements. This will impact the risk score significantly.
06.08	Review Trust Risk Policy	Non Gwilym	2	Apr-25	Work progressing. First draft of new policy to be considered by working group on 11 April.	17.02.25	Updated policy with updated flowcharts and educational assets available for all Trust staff.	Refreshed process for Risk management, reporting and training. Positive impact on strategic risk related to governance of Trust risks.
	CLOSED ACTIONS							
06.01	Refresh of Trust Assurance Framework risks	Lauren Fear	6	Complete	Project TAF 2.0 within the GAR Programme is due to complete in January 2024 Trust Board, risks then to be reviewed on a monthly basis and reported through governance routes accordingly	11.4.24	Requirement for C7 to be put in place	
06.02	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Complete	Work is complete to map Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board	11.4.24	Requirement for C7 to be put in place	
06.03	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework to be completed and agreed with Trust Board	Lauren Fear	6	Complete	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	11.4.24	Impact to be assessed when delivered	
06.04	Develop and implement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Non Gwilym	4	Complete	Phase 2 GAR programme in development for EMB consideration in October 2024 following endorsement of GAR Steering Group. August 2024 update: Phase 2 GAR refresh underway. Initial thoughts captured at GAR group meeting in August. Refreshed phase two for GAR group consideration in October 2024.	21-Oct-24	Impact to be assessed when delivered	The Governance, Assurance and Risk programme was established as part of the wider Building our Future Together organisational programme in October 2023. The action is effectively complete, and I suggest that we reword with the draft proposed as 06.07.
06.05	Revised reporting mechanism to be developed	Non Gwilym	4	Oct-24	Action being consolidated into the refreshed GAR programme. Propose to close the action on this basis.	18.01.25		

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks			
IMTP 2024.25 to 2026.27 Service Area	**2024.25**	**2025.26**	**2026.27**

Strategic Goal 1 Outstanding for quality, safety and experience	**Our Strategic Delivery Framework provides us with a structured approach to the translation and delivery of our strategic goals and priorities within the organisation** **Trust Purpose and Vision, aligned to** **• Trust Strategic Goals** **• VCS Strategy and Priorities and Service Plans** **• WBS Strategy and Priorities and Service Plans** **• Support Functions Strategies and Plans**		
	Building our Future Together 'Destination 2033' BOFT is an organisational development approach which is designed to identify and develop the leadership, culture, behaviours, processes and systems that we want to be. **Delivery of the BOFT Programme:** **1. Ensure that we are organised appropriately to support delivery of strategy, which has the safety and quality of care for our patients and donors as its golden thread** **2. Provide a way of working and shape to the organisation which enables us to maintain focus** **3. Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future** **4. Draw together our organisational developments with a common sense of purpose** **5. Improve our effectiveness, efficiency and value based approach** **6. Develop the mechanisms which enable us to prioritise where and when we focus our efforts** **7. Provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition** **8. Support realistic, authentic and compassionate leadership**		

SECTION 1

RISK ID	07			CURRENT SUMMARY OF TAF 07	Following closing a number of key actions and their inclusion as controls, the overall risk score for TAF 7 has been reduced. Further assurances have been embedded into the TAF through external sources. Risk score trend: Score has reduced since the last reporting period.
RISK LEADS:	Jacinta Abraham Nicola Williams Anne Carey	**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.		
RISK THEME:	Patient Outcomes	**STRATEGIC GOAL:**	1 -Outstanding for quality, safety and experience		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS — **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence (Operational Management)	Assurance Rating	2nd Line of Defence (Executive Management)	Assurance Rating	3rd Line of Defence (Board Management)	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 C7									
C3	Multiprofessional Workforce Planning which includes a workforce tool and the practice of benchmarking and incorporating Royal College guidance.	Interim Director VCS / Director OD & Workforce	X	X		PE	Velindre Cancer Service Senior Leadership Team	IA	Executive Management Board & Quality, Safety & Performance Committee Peer Benchmarking	IA	Internal Audit, HIW, & HEIW	Not Assessed
C4	Quality and safety monitoring (Via PMF & AMaT Quality & Regulatory Tracker)	Interim Director VCS / Exec Director Strategic Tranformation, Planning and Digital / Exec Director Nurisng, AHP & HCS			X	PA	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	IA	Executive Management Board & Quality, Safety & Performance Committee Peer benchmarking	IA	Internal Audit, Wales Audit Officer & IQPD	IA
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). Including Head & Neck Regional Pathway revision & revised risk based admission criteria	Interim Director VCS / COO	X			PE	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	PE	Executive Management Board & Quality, Safety & Performance Committee Benchmarking Peer Review	NA	Regional Cancer Board, JET & IQPD	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	PE	Executive Management Board & Quality, Safety & Performance Committee	IA	Internal Audit, IQPD & JET	IA

C7	Mortality review process and monitoring	Interim Director VCS / Exec Medical Director			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	PE	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	IA	Internal Audit & WRP Audits	IA
C8	Patient reported outcome monitoring (SST level to Board)	Interim Director VCS / Exec Medical Director / Exec Director Finance			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	NA	Internal Audit	NA
C9	Velindre Oncology Acadamy establishment	Exec Director Nursing, AHP & HCS	X	X		PE	VOA Implementation Group	IA	Executive Management Board & Quality, Safety & Performance Committee Benchmarking	IA	HEIW Commissionng Audit, UWTSD Accreditation Audits	IA
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 & Quality, Safety & Performance Committee Benchmarking	IA	Internal Audit & Wales Audit Officer Audits	IA
C11	Quality & Safety Tracker (improvement monotoring)	Interim Director VCS / Exec Director Nursing, AHP & HCS		X	X	PA	VCS Quality & Safety Group / VCS SLT & Intergrated Quality & Safety Group &	PA	Executive Management Board & Quality, Safety & Performance Committee	IA	Internal Audit & Wales Audit Officer Audits	IA
C12	SACT Transformational Programme established to deliver the SACT Improvement Plan aligned to TAF1 C7	Exec Director of Nursing, AHP &HCS, Executive Medical Director, Chief Operating Officer and Director of Cancer Service.		x		PA	SACT Delivery Group	PA	SACT Steering Group & Quality, Safety & Performance Committee Benchmarking Peer Review	IA	IQPD & JET	IA

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
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.	15	Stable
3448	There is a risk to patient safety as a result of the VCC Cancer Associated Thrombosis (CAT) service not continuing due to inability to recruit to key posts following the pending retirement of key individual 2025 leading to patients diagnosed with CAT unable access specialised services and therefore may lead to sub optimal treatment, delays in their cancer treatments	16	Stable
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.	12	Stable
3431	There is a risk to performance and service sustainability as a result of increased demand which has now outstripped capacity in the skin/melanoma SST.	12	Stable
3270	There is a risk that increased demand for SACT will exceed outpatient clinic capacity as a result of increase in referrals to VCS and new lines of therapy leading to potential delays in treatment and worsening patient experience.	16	Stable
3562	There is a risk to patient safety as a result of uncertainty around process and ownership of reviewing and actioning blood tests results which may lead to an omission or delay in undertaking a remedial clinical intervention	12	new to Trust Risk Register
3392	There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care.	16	down

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								
7.01	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	1	~~01/09/2024~~ Jan-25	~~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 Oct 24- Discussions remain underway with VCC~~ paper supported by SLT to utilise AMAT to support monitoring of	20/02/2025	Change will reduce risk through having enhanced mechanisms to implement new clinical changes in a timely manner	Enhanced control and assurance
7.03	Intergrated Quality and Safety dashboards to be developed that align with PMF	Exec Director Transofrmation, planning, performance and digital	2	~~01/08/2024~~ 31.03.2025	Initial quality, safety and outcome metrics& implementation plan underway 12 week development programme - due to conclude 31/3/25	02.02.25	Should reduce risk	Enhanced control and assurance
7.04	Value Based Healthcare patient reported outcome plan to be fully delivered (PROM measures across all SSTs agreed and electronic system implemented)	Exec Medical Director / Exec Finance Director	2	Mar-26	Implementation Working Sub-Group established within VCS. Contract signed with Promptly Health in January 2025. User stories and triggers complete for Neuro-Oncology and nearing completion with Prostate and Lung. Work underway with clinical teams to agree SST specific PROM sets where national PROMS have not been set. The programme is collaborating with WCN on this. Breast national set nearing sign-off. Triggers to be defined. When PROMS data is collected digitally it will be available within the data warehouse for analytical and reporting purposes, including at Board level. This is expected in Q1 25/26 for the phase 1 areas.	20/02/2025	Should long term reduce risk by enabling consistent capture of outcomes	Enhanced assurance
7.05	Single electronic patient referral system into the Cancer Service to be developed and implemented	Interim Director VCS / Head of Operations VCS	1	Mar-25	Conversations commenced with DHCW re: hospital initiated referrals, including COO and Chief digital officer. DHCW inidcated potential date of April 2025. Interim position is to adopt internal supported system. Finalisation of position to be confirmed w/c 9th December 2024 moving forward within implementation working in conjunction with health board partners	20/02/2025	Reduce risk	Enhanced control
7.06	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Interim Director VCS / Head of Operations VCS / Head of Nursing	1	Sep-24	General Outpatient Booking, process reviewed and pre and post clinic checks supported by SOP, data quality report to support management of activity, esclation process in post-clinic checks if outcome has not been provided on WCP, aligned booking clerks to SSTs to increase level of knowledge, compliance and contingency for support arrangements, co-location of SACT schedulers and outpatient bookers	06/12/2024	Reduce risk	Enhanced control
7.07	Recommendations from SACT treatment helpline peer review to be fully implimented	Interim Director VCS	1	Sep-24	New workforce model in place, relocation of helpline complete, amendments to clinical tool complete, funding secured for 12 months to develop patient education,.	05/11/2024	~~Change will reduce risk by further enhancing safety of the SACT Telephone helpline~~ Reduce risk	Enhanced control
7.08	Transformational multi professional workforce plans across all areas of the cancer service	Rachel Hennessey	1	Mar-26	Workforce plans to support RSU being implemented with move to medical light model workforce planning takign place as part of IRS/SRU programmes	20/02/2025	Reduce risk	Enhanced control
7.09	Finalise the delivery of BI solution to ensure robust service level to board mortality data monitoring in line with legislative and best practice standards	Exec Director Transofrmation, planning, performance and digital	1	Jun-24	Significant work undertaken in respect of mortality review oversight - SACT mortaliy added to PMF - Work remains underway	02.12.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced control and assurance
07.10	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	As above	02.12.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced assurance

7.11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corportae Governance	1	Mar-25	phase 1 roll out to radiotherapy to commence January 2025. Phase 2 roll out to wider Division April 2025	05/11/2024	This enhanced document management system will reduce risk by having far greater governance in respect of SOP's, policies procedures, guidelines etc	Enhanced control and assurance
7.12	Implementation of the patient engagement framework	Director Corporate Governance e	2	Mar-25		22.3.24	Reduce risk	Enhanced control and assurance
7.13	Fully embed a robust Clinical & Scientific infrastructure including establishment of a robust multi-professional Clinical & Scientific Board	Exec Medical Director / Exec Director Nursing, AHP & HCS	2	Mar-25	Clinical & Scientific Board established. Clinical and Scientific Strategy has been approved by Trust Board (September 2024) Clinical & Scientific Board reinstigated and clinical & scientific strategy delivery plan under development	02.02.25	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effectve prioritisation and decision making.	Enhanced control
7.14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Exec Medical Director / Exec Director Nursing, AHP & HCS	1	~~01/06/2024~~ 31.03.25	As above -Clinical & Scientific Manager in post - implementation plan under development	02.12.2024	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	Enhanced control
7.15	Establish a regional delivery group to support the work from the Regional Cancer Meeting	Interim Executive Director strategic planning	2		Regional Cancer Board re-established, active participation by VUNHST	05/12/2024		
7.16	Implement a cancer PTL to track and bring together information from all clinical information systems to ensure visibility across the entire patient pathway to ensure efficient management of care pathways	chief Operating Officer/Interim Director VCS	1		paper to EMB outlining proposal, funding identified and in process of going to procurement for identified system system procured, workign group takign forward implementation, live demonstration to VCS team	20/02/2025	risk will be reduced by having single version of patient pathway	
CLOSED ACTIONS								
07.02	AmAT Quality & Safety Tracker to be fully embedded as the tracker across VCS	Interim Director VCC	COMPLETE	Mar-24	Oct 24- AmAT Quality & Regulatory Tracker fully rolled out across both divisons	05.11.24	Change will reduce risk by having effective mechanisms to ensure that identified quality and safty improvements have been implemented and had the desired impact	Enhanced control and assurance (Added to controls)
7.15	Undertake a review of the management of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	COMPLETE	Aug-24	Oct 24 - Work concluded revised pathways and risk stratefication processes in place - An assurance external Peer review being aranged	05.11.2024	Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways	Enhanced control (Added to controls)

SECTION 6

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

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	**Clinical Quality and safety Priorities:** **1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.** **2. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.** **3. To Integrate Clinical Audit within VCS Quality and Safety function** **4. Development of robust Site- Specific Quality Metrics** **5. To improve incident and risk management.** **6. Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System** **7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service.** **8. Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma-derived medicines.** **9. Review and improvement of donor selection and screening processes** **10. Introduction of all Wales foetal D Screening for RhD negative pregnant women.** **11. Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT which will reduce risk of manual transcription of results.** **12. Achieve JACIE accreditation for the WBMDR** **13. Commencing rollout of live connectivity of the BECS at community- based donation clinics** **14. Implement an outcome recording system for patients (digital PROMS)**		

SECTION 1

RISK ID	08		
RISK LEADS:	Matthew Bunce	**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.
RISK THEME:	Financial Sustainability and Long-Term Value	**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

CURRENT SUMMARY OF TAF 08

During January/February 2025 progress on action to improve controls have been updated with key areas of progress being:
1) Final Audit Report for Key Financial Controls presented to Dec '24 Audit Committee with Reasonable Assurance with management actions agreed for small no. of recommendations. Strengthened controls have been put in place for accruals, prepayments and suspense accounts.

Risk score trend: The risk score has remained static since the last period.

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: **7 Levels of Assurance(see definitions tab)**	**RATING**	E	**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
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E	Budget holders, reports and training	6	Divisional Finance Reports and Performance; Finance Business Partners	6	Internal Audit / External Audit	6
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE	Directorate Level Budget holders, reports and training	6	Divisional Finance Reports and Performance; Finance Business Partners	6	Internal Audit / External Audit	6
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE	Divisional Senior Leadership Teams, reports	6	Executive Finance Reports; Senior Finance Team	6	Internal Audit / External Audit	6
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	6	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	6	Internal Audit / External Audit	6
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	7	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	7	Welsh Government / NHS Executive (FP&D) / External Audit	7
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE	Executive Budget Holders / Programme SROs	4	Trust Board Finance Reporting; Senior Finance Team	4	Internal Audit / External Audit	4
FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE	Directorate Level Budget holders, reports and training	4	Collective Commissioning Group LTA reporting Weakness in controls identified in relation to LTA activity data capture and mapping to appropriate currencies to ensure Trust recovers all income due for work undertaken	4	LHB Commissioners	4
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planing & Digital	X			PE	Executive Budget Holders / Programme SROs	4	Capital Planning and Delivery Group; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	4	LHB Commissioners / Welsh Government / Internal Audit / External Audit	4

FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			E	Executive Budget Holders / Programme SROs	6	Trust Board and Committees	6	LHB Commissioners / Welsh Government / Internal Audit / External Audit	6
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	4	Trust Board and Committees; Delegated Financial Limits	6	Internal Audit / External Audit	4
FSLTV11	Value Based Healthcare programme	Executive Director of Finance / Executive Medical Director	X			PE	Value Based Healthcare project leads; VBH programme SROs	6	Value Based Healthcare steering committee / Executive Management Board, Strategic Development Committee	6	LHB Commissioners / Welsh Government / Internal Audit / External Audit	6
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Requisitioners / Budget Holders	6	PSPP Group; Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	6	Internal Audit / External Audit	6
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Budget Holders; Private Patients lead; reports	6	Debtors Reporting; Senior Finance Team;	6	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit	6
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	6	Capital Planning and Delivery Group; Executive Management Board; Fixed Assets Register Reporting	6	Internal Audit / External Audit	6
FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	PE	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	4	Capital Planning and Delivery Group; Executive Management Board	4	Internal Audit / External Audit	4
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations		X		E	Budget Holders, reports and training	4	Counter Fraud Reports; Audit Committee	6	Internal Audit / External Audit	6
FSLTV17	Tax management	Deputy Director of Finance / Head of Financial Operations			X	E	Budget holders, requisitioners, reports and training	4	Financial Operations Team; VAT working group	6	External Advisory (EY) / Internal Audit / External Audit / HMRC	6
FSLTV18	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			PE	Exec Directors, Divisional Directors, Budget Holders, reporting and training	4	Procurement Compliance reporting; Audit Committee	6	Internal Audit / External Audit	4

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	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
There are issues with the processes around LTA activity capture and mapping to currencies with some activity currently not being identified and charged to commissioners.	LTA Activity performance monitoring process currently not providing assurance that all activity is being captured and monitored against Commissioner contracts	F7

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
2249	There is a risk to financial sustainability as a result of service disruption due to number of posts funded by time limited funding leading to financial instability, recruitment difficulties.	16	Stable
3537	This is a private TCS risk in the Financial Sustainability domain.	16	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

08.01	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / EMD / COO	4	Delivery over 2024/25 to 2026/27	"VBH Programme of work for 2024-25 - 2025-26 agreed by Trust Board overseen by the VBH Steering Group. Assurnace provided through review at SDC and QS& P Committees. 2024-25 Objectives: • Digital PROMS platform Business Case approved by Trust Board and procurement complete. Currently commencing implementation. • PROMS Questionnaires agreed for use in Prostate, Lung and Neurology. Good progress with national questionnaires for CUP and Breast • SST Data Insights Dashboard launched in March 2023 with development improvements made during 2024 through development group to ensure benefits maximised • Data quality group mobilised focussing on improving data quality in arease of clinical and financial risk • Training, communication & engagement - communication strategy in place, x14 training & engagement sessions undertaken in past 12 momths; x4 members of staff undertaken Swansea University Value in Health course" Digital PROMS Business Case approved by Trust Board PROMs digital system contract has been signed. A pre-kickoff meeting was held with the supplier on the 20th Dec to discuss priorities, next steps, and preparations for th eproject kick-off. Formal kick-off meeting scheduled for 13th Jan '25.Implementation due to be completed by end of Mar '25	08.1.2025	Identification of opportunities to reduce unwarranted variation and improved allocation and utilisation of resources will support financial sustainability	Control 11 - VBHC effectiveness will improve from PE to E and assurance will be enhanced further
08.02	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	Delivery over 2024/25 to 2026/27	"Savngs / Efficiencies opportunity Pipeline presented at April 2024 EMB Shape identified 4 areas being progressed or explored - Pre-operative anaemia pathway expansion (implementation), Medicines Management - NWSSP medicine unit suppy (underway) & furthe rareas to be identified through Medicnes Strategy Group, Workforce re-design - service divisions to identofy all areas of workforce model and pathway review to enable a Trust wide assessment of opportunities for efficiency and porductivty imporvement, Procurement reviews of non pay spend to identifiy opprotunities for cost improvement ir income recovery. EMB agreed SROs for each of the 4 areas to take accountability at Exec level to oversee the development and delivery. Pharmacy review has been conducted and was presented to Exec Management Board early in 2024. An Internal Audit review of medicines management governance (including financial aspects) was conducted in July / Aug 2024 and reported to Audit Committee in Sep '24 with substantial assurance. Medicines Strategy Group established by SRO (Medical Director) for Medicines Group with first meeitng to be held Jan '25. "	08.01.2025	Identification of opportunities for new savings initiatives and disinvestments / choices will support financial sustainability and reduce risk	Control 6 - Finance & Investment enhanced monitoring will improve from PE to E and assurance will be enhanced further
08.03	Development and review of Financial Control Procedures	EDoF / DDoF	6	Ongoing Delivery in 2024/25 and annually as part of IA programme	"Capital financial control procedure approved by Audit Committee. Financial Control Procedure update plan and pipeline for review in development. Internal Audit scope of review for Key Financial Controls has been agreed. The indicative timeline suggests that fieldwork will commence in September and the report will be presented to Audit Committee in December 2024. " The final Audit Report was received at Dec '24 Audit Committee with reasonable assurance. Management agreed to respond to a small number of recommendations: Accruals & Prepayments - Finance teams will create a clear audit trail evidencing segregation of duties for preparing/reviewing prepayments & accruals, e.g. through inclusion of these tasks in the month-end finance checklist. Suspense Account Clearing - Senior Finance Team (SFT) agreed a timeframe of 2 years for the removal of aged items from the Unidentified Income suspense account. This approach has been agreed with Audit Wales & the Welsh Government.The account will be reviewed on a monthly basis by SFT and action taken at the year end to ensure no aged items exceeding 2 years remain.	28.01.2025	Strengthened control procedures will support risk mitigation	Control 10 - Scheme of Delegation and Delegated Financial Authority will improve from PE to E and assurance will be enhanced further
08.04	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Investment appraisal process & prioritosation framework developed by April 2025	"Presentation made to April 2024 EMB Shape for the development of criteria for assessing investment opportunities. This included Strategic Fit, Deliverability and Value and Sustainability. Next steps are to develop criteria and an evaluation process aligned to the 3 areas identified. Progress delayed due to lack of finance resource, but aim to have agreed criteria and process for investment appraisal and prioritisation by April 2025 . " Investment appraisal process, prioritisation framework and busines case templates have been obtained from AB and C&V Health Boards and will be used to help inform developemtn of the Velindre process.	08.01.2025	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	Control 6 - Finance & Investment enhanced monitoring and Control 8 - Investment Appraisal effectiveness will improve from PE to E and assurance will change from IA to PA

08.05	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	4	Mar-25	"Cardiff Cancer Research Hub market engagement exercise completed. Programme plan drafted and in the process of being reviewed. Private patient cash collection and pricing continues to be developed and progress being made in the backlog of cash collection. " Liaison Financial external consultants have been re-engaged for Jan - Mar '25 to support the Trust in completion by 31.03.5 of the remoaning financial / commercial actions in the private patient improvement plan which are to negotuate new contracts with thre three main insurance companies revisions to tariffs, addiitonal activity charging separately for pathology and negotiation around payment of old debts. This work will also include negotiation with the Trust CAG sharing of the financial risk around PP credit loss (bad debts) and agreeing consistent charges for PP support to consultant private practice .	08.01.2025	Attracting external / alternative sources of income will decrease pressure on reliance on exchequer income thereby supporting financial sustainability and reducing overall finanical risk	Control 6 - Financial Strategy / Medium Term Financial Plan / Budget Setting will become more effective and financial plans more sustainable further enhancing overall financial asurance
08.06	Develop Scheme of Delegation and Governance Framework for the nVCC	EDoF / DDoF	4	Nov-24	A draft Scheme of Delegation and Governance Framework has been developed for nVCC, which has cross refernecd findings from PwC and Gateway reviews as well IA reviews. Draft Scheme of Delegation considered by Scrutiny Committee and Trust Board in Sep '24 with some improvement ammendments recommended which are being made. Updated version to be presnted to November Board for approval. Trust Board approved the n VCC Scheme of Delegation in Nov '25. Scheme of Delegation has been inplemented in the n VCC Project with delegate dbudgets issued to each Workstream lead. Further work to update the Scheme of Delegation with links to relevant section sof MIM Governance Protocol and Deleagtion Framework for other decisions around quality & Time Trust Board approved n VCC Scheme of Delegation in Nov '24 meeting and WG approved n VCC FBC enabling the budgets to be delegated from the CEO to the Project Director and Workstream leads. This financial scheme of delegation will sit alongside the updated MIM Governance protocol to provide the integrtaed governance framework for the n VCC	19.02.2025	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	Control 15 - Major Capital Programmes monitoring will improve from PE to E and assurance will change from IA to PA
08.07	Data & Insights team working with Finance team and service leads to investigate where data capture and mapping to contract currencies is not working correcty. Once the issues with the process have been identified corrective action can be taken both in the short term and longer term to ensure all activity is correctly captured and charged for. Risk to be added to Datix to reflect the control weakness in activity data capture and mapping to contract activity to ensure Trust recovers all income for work undertaken.	EDoF / EDoSTP&D / COO	1	Dec '24 to Mar '25	Initial actions focussed on Radiotherapy treatment activity to understand the differences bewteen the treatment activity recorded in the Aria planning system, Data Warehouse and the LTA performance monitoring. Actions being taken to ensure all RT treatment activiy is recorded in the Warehouse and charged for through LTA performance monitoring. Work completed to ensure RT treatment activiy is all being recorded in the data Warehouse and charged to LTA's. Work ongoing in relation to review of RT Treatment planning activity and mapping of that activity to LTA chargeable currencies. Due to be completed by 31.01.25. However, initial assessment is that all planning activity is being charged for, but the allocation of some planning activity to the planning currencies may change. An assessment of the impact on income will be made by 31.3.25	08.01.2025	Initial actions have led to additional activity being captured in the data warehouse and charged to LTAs. Next action will focus on RT Planning activity to assess if all activity is appropriatley being captured and charged for and following that other service areas based on a high level review of total activity per source clincial systems, data warehouse and charged throuugh LTA.	Control 7 Collective Commissioners Review - Weakness in control systems around data capture and mapping to LTA currencies will be mitigated leading to this control effectiveness being changed from Partially Effective to Effective and Control assurance through second line of defence LTA Performance Monitoring improving from Inconclusive Assurance to Positive Assurance

SECTION 6

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

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 **Outstanding for quality, safety and experience**	The Trust will continue to review and integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. More specifically, this will include: • Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit. • VBH Pre-operative anaemia pathway work with Health Boards will release bed capacity and plans for further expansion of the pathway to include other patient cohorts will further increase Health Board bed capacity freed-up. • Plasma for Medicine Business case if approved and funded by WG / WHHSC has potential to save c £1.5m in phase 1 on blood derived medicines used by Health Board and if phase 2 approved up to £2m saving to Health Boards. • Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach. Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre 1. Pre-op anaemia programme: This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10 procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG).		

TRUST BOARD	
Bi-Annual Trust Values and Culture Report	
DATE OF MEETING	27th March 2025
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	Claire Budgen, Head of Organisational Development
PRESENTED BY	Susan Thomas, Deputy Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	This paper sets out the Trust's progress with developing its organisational culture. It includes feedback from Board members and senior leaders regarding our current culture, our desired culture and ideas for the way forward. It ends with an action plan for this programme of work.
RECOMMENDATION / ACTIONS	The Trust Board is asked: 1. To agree the level of assurance. 2. To endorse the three conclusions and the next steps in Section 4 as the way forward in designing a programme for the continued development of an effective culture in the Trust.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive management Board – Shape	10/03/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
APPENDICES	

1. SITUATION

1.1 The Trust adopted a new set of organisational values and a supporting behaviour framework in 2024 in line with the objectives for the Values and Culture workstream within Building Our Future Together. A progress report against those original actions is included at Section 2 of this paper.

1.2 A key action emerging from the end of that phase of development was the need to, and benefit of, describing our desired culture to provide a destination for the journey of developing as an organisation. Consequently, an engagement exercise took place between October and December 2024 with Board members and senior leaders which identified a range of perspectives on our current culture, our desired culture and how to move forward. It must be noted that this was seen as just the first steps towards developing our desired culture and the programme of engagement would need to be continued and cover staff in all

areas of the Trust.

1.3 An effective culture is a product of a combination of attitudes, norms, expectations and practices. Section 4 sets out how to start designing and implementing the work required.

2. BACKGROUND

2.1 In 2022, a Culture and Values workstream was included within the Building Our Future Together programme. There were four objectives agreed. Progress against these is shown below.

Building Our Future Together
Culture and Values Workstream

	Objective	**Progress December 2024**
a.	Review and refine the values of the organisation.	A programme of work was undertaken throughout 2022-23 reviewing the organisational values which saw the Trust move from Accountable, Bold, Caring and Dynamic to Caring, Respectful and Accountable. These were agreed and adopted in January 2024.
b.	Have a picture of how people feel about the organisation which will be utilised by other elements of BOFT work programme	The approach towards developing the values in a. above was to involve our people as much as possible to hear how they felt about values and behaviours. Surveys, team discussions and focus groups were used to gather the thoughts and feelings of staff, patients and donors. Board members contributed through a detailed interview using the NHSE Culture and Leadership Programme framework. The findings from these processes were used to shape the values and behaviour framework and

		also to inform other areas of work such as building psychological safety at work.
c.	Develop a Behaviours Framework	The Behaviours Framework was issued in March 2024. This was derived from the stakeholder feedback gathered in b. above and therefore allows staff to more easily relate the behaviours to their own work environment.
d.	Embed Values and Behaviours Framework within Trust process such as recruitment, appraisal and team working.	The new Trust values have been embedded into our recruitment processes, our PADR process and form a backdrop for all our management and team development work.

2.2 The table above demonstrates that these objectives have been achieved. However, people's experiences in the Trust show that our culture can still hold us back in terms of delivering the excellence that we aspire to. Whether it is feedback from the NHS Staff Survey, informal conversations with staff or our own individual reflections it is clear that we have further to go. It is on that basis that Assurance Level 3 has been selected.

2.3 Developing an organisation's culture is not straightforward. Culture is not 'owned' by any one part of the organisation. It spans every part of the service, every project, every process that we do. It is hard to measure as it touches on values, behaviours, beliefs, systems; what we tolerate and what we call out.

2.4 Pragmatically, we pulled together a range of different areas of work whilst working on the feedback in the ten themes of the 2023 NHS Staff Survey. This work will continue to develop through the medium of the Staff Survey Group which has been constituted to disseminate the 2024 results and to build action plans for change at Trust and Divisional levels. Through this collaborative approach, SLTs and subject matter experts are addressing specific aspects of the experience of working in the Trust which will cumulatively help build a more positive culture. However, there is opportunity to take a whole-organisation

approach, which involves everyone, to creating the positive organisation that we aspire to have.

3. ASSESSMENT

3.1 Since September 2024, a series of discussions and engagement sessions have taken place to start to shape what the next phase of work should be for building an effective culture including:

- Healthy and Engaged Steering Group 25 September 2024
- Discussions with Communications, Clinical and Equalities leads
- Executive Management Board, 19 October 2024
- WBS Senior Leadership Team and colleagues, 22 November 2024
- VCS Senior Leadership Team and colleagues, 25 November 2024
- VCS/Executive development sessions, December 2024 to February 2025
- Board Development Session, 13 February 2025

3.2 Key thoughts raised during this initial engagement exercise were:

3.2.1 **The need to define the parameters of the next phase of work**
The imperative to define the scope of the term culture and to delineate the outputs and outcomes we seek from any work undertaken to develop the culture. To respond to this a Culture Framework has been proposed to capture the range of relevant work which can be used to align work previously initiated through Building our Future Together into one planning and reporting framework. The current version of this framework is as below.

Culture Framework	
	**Strategic 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 and learning for all. A sustainable organisation that plays its part in creating a better future for people across the globe.

3.2.2 **Our current culture**

We heard from feedback that our current culture feels fractured, disjointed and bureaucratic, including subcultures and silos. Heavy workloads and doing extra hours seem normal. Negative feelings include frustration with the bureaucracy, anxiety linked to risk aversion and disengagement through not feeling heard. Systems don't always work very well to help people do their jobs. On a positive note, the Trust seems welcoming friendly and small enough to have personal connections. Leaders need to acknowledge this with staff and this must be communicated with honesty, transparency and consistency.

3.2.3 **Our desired culture**

There is a need to describe our desired culture by being explicit about 'What we do around here' and more deeply 'Who we are around here'.

Work to date had focused on values and behaviour at individual level. The next phase can explore what the values and behaviours mean at shared levels in the organisation and how to build a collective culture aiming for shared outcomes.

Feedback gathered during the engagement sessions described the desired future culture as vibrant, uplifting, welcoming, honest and transparent. People wanted to have a sense of pride in working for the Trust by recognising the strengths of what is achieved, not just focussing on the problems. Values are central to the future culture and they need to be central to what we do.

Health and wellbeing are seen as central to an effective culture, including work-life balance and addressing excess hours. From a psychological safety perspective, the culture needs to be one where people have trust in each other and in their leaders.

Success depends on staff at all levels engaging in positive behaviours and in particular, in active role modelling by senior leaders. This will be reflected in all staff having access to development time and opportunities and being listened to when issues are raised.

The Trust's services mean that we have two very distinct service delivery arms. It is possible to have different cultures within the Divisions, so long as the culture enables people to do their jobs well in line with the Trust values. Over and above these Divisional level cultures, there will be a number of overarching norms that

are owned by everyone in the organisation.

4. CONCLUSIONS AND NEXT STEPS

4.1 Three themes emerge as essential in designing the next programme of work.

Valuing Difference
Absolutely core to a positive culture is creating a comfortable space for everyone, where difference is valued. This principle leads us towards an approach of co-production for the next phase of developing the culture. People need to see how the positive culture relates to them for it to become part of their way of being at work. This includes the use of plain language and relevant communications.

Generating a vision
The engagement sessions emphasised the need to generate a vision, a destination or a description of the desired culture. This is not finished as yet, given that the co-production principle means that everyone needs to have a chance to contribute to what that vision is.

Applying Compassionate Leadership principles
NHS Wales has adopted Compassionate Leadership as its model. We can use the four elements to design and deliver this work, by seeking to Attend, Understand, Empathise and Help our teams and individuals when considering culture. Put simply, we need to 'walk the talk'.

4.2 There are many initiatives in hand which are designed to nurture a positive working environment, such as:

- Reviewing the impact of the Values and Behaviours framework and our Speaking Up Safely arrangements.
- Supporting Staff Networks, Equity Hub and Wellbeing Champions to include and represent staff.
- Engaging with staff around how to minimise negative behaviours including bullying, harassment and discrimination.
- Developing proposals for strengthening employee voice.

These actions will run alongside the Trust-level and Divisional-level Staff Survey Action Plans which will be developed during Q1 based on the 2024 NHS Staff Survey results. The three priorities for shared effort in response to the NHS Staff

Survey are:

- PADR, increase participation and making it a meaningful experience.
- Team time, so that staff are working in supportive environments where they can plan, review and discuss their work openly.
- Increasing psychological safety through addressing bullying and harassment.

4.3 To turn this aspiration into a reality, we need to provide the infrastructure to allow the culture to develop. This means coordinating all five themes into one programme, with simple reporting against objectives. These five topics are at different stages of development in the Trust but can be pulled together into a single place for planning and reporting.



4.4 In terms of communications, right from the beginning there needs to be honesty from the top of the organisation acknowledging the reality of the current culture and a clear commitment to working together to create an improved working environment.

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)	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Organisational culture encompasses all aspects of quality and safety.
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: Choose an item	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ • A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic, and ecological resilience. ☐ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of Cohesive Communities - Attractive, viable, safe, and well-connected communities. ☐ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage, and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☒ • Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
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 Valuing difference has been identified as one of the underpinning themes for this work. Completion of an Equality Impact Assessment with input from our stakeholders will be one step within the programme of developing the culture.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
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	
NHS Staff Survey 2024	
DATE OF MEETING	27 March 2025
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	Claire Budgen, Head of Organisational Development
PRESENTED BY	Susan Thomas, Deputy Director of Organisational Development and Workforce.
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The NHS Staff Survey 2024 shows progress in all Themes compared with 2023. However, there are below average scores in six of the ten Themes. A Staff Survey Group has been established as the approach to developing action plans at Trust and Divisional levels. Three topics are suggested for common focus over the course of 2025-26, PADR, Team Time and increasing psychological safety.
RECOMMENDATION / ACTIONS	**Trust Board** is asked to **NOTE** the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB Run	25/02/2025
Quality, Safety and Performance Committee	13/03/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

The Staff Survey Group was agreed as the way to disseminate the results at Divisional and Departmental levels and for developing action plans. The free text comments were released by HEIW after the EMB meeting had taken place. Therefore, only generalised themes have been reflected in this paper. More detailed analysis will take place through the development of action plans via the Staff Survey Group.

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 2 - Symptomatic issues being addressed

APPENDICES	
Appendix 1	VUNHST NHS Staff Survey Report 2024
Appendix 2	Terms of Reference NHS Staff Survey Group

1. SITUATION

A new NHS Staff Survey was introduced across NHS Wales in 2023. This report presents the Trust level results from the second year, 2024. See Appendix 1 for the VUNHST report.

2. BACKGROUND

The results of the NHS Staff Survey 2023 were used within the Trust to lay the foundations for more effective approaches to PADR, retention, wellbeing and reducing and bullying, harassment and discrimination. Given it was the first year of running the survey, there were limitations on the reporting capabilities. Over the past 12 months, Staff Survey Leads across Wales have worked with the Business Intelligence Team in HEIW to create an effective reporting platform. This has enabled the Trust to access the results sooner and in a more meaningful format. In addition, as it is the second year of running the question set, it has been possible to track movement across Themes and questions.

These improvements mean that it is now possible to agree priorities for action and also for Divisions and Departments to access their own results for action at a local level.

The data is accessed in two ways: a dashboard and a paginated, or standard, report. The paginated report is the format used in Appendix 1. Extracts from the dashboard have been included in the paper to highlight some points that are not captured in the standard report.

3. ASSESSMENT

NHS Wales Average

Two different methods have been used in the survey to provide NHS Average. When looking at Response Rate and Employee Engagement Index, the comparator group is all NHS organisations. When looking at agreement scores and individual questions, the comparator group is Trusts and Special Health Authorities, not including Health Boards.

Response rate

The Trust achieved a response rate of 34%, which is the same as 2023. The NHS average was 22%. As the workforce grew during the period the numbers of responses increased from 570 to 619. This gives a stable base for comparison between the years since the same proportion of people responded. In total, 24,833 people contributed across Wales which means we have a substantial data set describing the experience of working in the NHS in 2024.

Response rates by Tier 1

**rates highlighted green and pink indicate rates higher and lower than the overall NHS Wales response rate.*

Tier 1 (Organisation)	Sample size	Responses	Response rate*	vs. 2023 rate	2023 rate
Aneurin Bevan University Health Board	15,318	2,030	13.3%	▼ -4.87%	18.1%
Betsi Cadwaladr University Health Board	20,591	3,577	17.4%	▼ -2.84%	20.2%
Cardiff and Vale University Health Board	17,295	4,639	26.8%	▲ 5.40%	21.4%
Cwm Taf Morgannwg University Health Board	13,269	3,560	26.8%	▲ 8.70%	18.1%
Digital Health and Care Wales	1,271	792	62.3%	▲ 1.78%	60.5%
Health Education and Improvement Wales (HEIW)	506	438	86.6%	▲ 11.40%	75.2%
Hywel Dda University Health Board	12,160	2,396	19.7%	▲ 7.68%	12.0%
NHS Wales Executive	455	237	52.1%	▼ -5.71%	57.8%
NHS Wales Shared Services Partnership	6,182	936	15.1%	▼ -5.26%	20.4%
Powys Teaching Health Board	2,577	780	30.3%	▲ 2.28%	28.0%
Public Health Wales	2,149	1,301	60.5%	▲ 6.79%	53.8%
Swansea Bay University Health Board	15,601	2,008	12.9%	▼ -5.97%	18.8%
Velindre University NHS trust	1,837	619	33.7%	▼ -0.25%	33.9%
Welsh Ambulances Services University NHS Trust	4,314	1,520	35.2%	▲ 12.08%	23.2%
NHS Wales Total	**113,525**	**24,833**	**21.9%**	**▲ 1.13%**	**20.7%**

Employee Engagement Index

The Employee Engagement Index is the single score that can be compared between organisations. It is a composite measure of seven questions and is a reliable indicator of feelings of autonomy, belonging and contribution. The Trust score for this increased from 76% to 77% from 2023 to 2024. The NHS Wales average was 72%.

Staff Engagement Index scores by Organisation (Tier 1)

**scores highlighted green and pink indicate scores higher and lower than the overall 2024 NHS Wales engagement index score.*

Tier 1	2020	2023	2024	vs. 2023
Aneurin Bevan University Health Board	76%	72%	71%	▼ -1.4%
Betsi Cadwaladr University Health Board	73%	72%	71%	▼ -1.1%
Cardiff and Vale University Health Board	74%	73%	71%	▼ -1.9%
Cwm Taf Morgannwg University Health Board	71%	71%	70%	▼ -0.6%
Digital Health and Care Wales	82%	80%	76%	▼ -4.5%
Health Education and Improvement Wales (HEIW)	81%	79%	80%	▲ 0.9%
Hywel Dda University Health Board	76%	72%	71%	▼ -0.7%
NHS Wales Executive	n/a	75%	76%	▲ 1.2%
NHS Wales Shared Services Partnership	79%	76%	77%	▲ 1.4%
Powys Teaching Health Board	78%	76%	75%	▼ -1.1%
Public Health Wales	76%	75%	74%	▼ -0.6%
Swansea Bay University Health Board	75%	73%	71%	▼ -1.8%
Velindre University NHS Trust	78%	76%	77%	▲ 0.5%
Welsh Ambulances Services University NHS Trust	72%	67%	66%	▼ -1.2%

Themes

On every one of the ten Themes, the Trust's scores have gone up since 2023. Whilst these positive results are true, there is a more nuanced picture across some of the other aspects of the survey. Out of the ten Themes, the Trust scored below the NHS average on six of them:

1. Morale
2. We are continuously learning and improving
3. We are stronger together
4. We champion flexible working
5. We nurture healthy working environments
6. We recognise everyone's contribution

Positivity scores (%) by theme: 2024 NHS Wales Staff Survey: Velindre University NHS Trust: All Tier 2: All Tier 3: All sites: All occupational groups

Green bars indicate scores above the NHS Wales organisational average, pink bars indicate scores below the NHS Wales organisational average*. Hover over table for scores by sub-theme.*



	Morale	Patient safety	Staff engagement	We are all able to speak up	We are compassionate and inclusive	We are continuously learning and improving	We are stronger together	We champion flexible working	We nurture healthy working environments	We recognise everyone's contribution
Selection above	61.3%	70.1%	70.6%	72.1%	77.9%	70.2%	74.4%	66.6%	64.2%	68.8%
NHS Wales average*	61.9%	63.9%	67.0%	70.5%	74.6%	72.1%	75.8%	75.0%	66.4%	70.7%
Highest performing organisation	69.2%	75.9%	75.9%	76.5%	79.4%	79.7%	82.5%	86.3%	72.6%	78.8%
Lowest performing organisation	48.6%	52.3%	50.8%	55.6%	65.1%	60.2%	62.3%	52.6%	51.7%	52.8%

**For the purpose of benchmarking, organisations have been grouped and a separate NHS Wales organisational average has been calculated for 'Health Board' organisations and 'Trust/Authority' organisations. The highest and lowest performing organisations have also been calculated separately for these groups.*

Themes by Division

The development of the NHS Wales dashboard means that data is available for Divisions, Departments and Staff Groups. This will require further analysis with representatives of those areas. In advance of that detailed work, the overview of responses at Divisional level is offered below.

Comparison of positivity scores (%) by theme: 2024 NHS Wales Staff Survey: Velindre University NHS Trust

With scores highlighted green and pink to indicate scores above and below the NHS Wales organisational average, for which organisations have been grouped and a separate NHS Wales organisational average has been calculated for 'Health Board' organisations and 'Trust/Authority' organisations. Blank rows represent instances where the data has been suppressed because the total number of survey responses was less than 10.

Tier 2	Morale	Patient safety	Staff engagement	We are all able to speak up	We are compassionate and inclusive	We are continuously learning and improving	We are stronger together	We champion flexible working	We nurture healthy working environments	We recognise everyone's contribution
120 Corporate Division	62.5%	67.8%	74.9%	74.8%	80.7%	75.4%	79.8%	81.6%	66.9%	75.4%
120 Health Technology Wales Division	61.5%		65.5%	58.0%	57.4%	67.0%	66.7%	89.4%	77.7%	66.7%
120 Research, Development and Innovation Division	57.1%	72.3%	58.2%	68.6%	79.0%	71.7%	75.7%	60.7%	63.2%	60.0%
120 Transforming Cancer Services Division										
120 Velindre Cancer Centre	59.0%	68.8%	69.2%	72.6%	79.2%	69.5%	73.6%	58.7%	60.8%	67.5%
120 Welsh Blood Service	65.3%	73.7%	70.5%	69.4%	73.0%	66.9%	70.9%	68.0%	67.9%	65.1%
Entire organisation	**61.3%**	**70.1%**	**70.6%**	**72.1%**	**77.9%**	**70.2%**	**74.4%**	**66.6%**	**64.2%**	**68.8%**

Demographic analysis

The Trust now has access to the demographic profile of respondents and in many cases this can be compared between 2023 and 2024. The data on Age, Gender and Grade will be particularly useful as the large numbers in each category means that there are no gaps in the data. When looking at Ethnicity, Disability or Sexual Orientation, there are more categories where the data has been supressed due to numbers being below 10.

Free text comments

One-hundred and seventy-two people gave written comments in support of their responses. Four main themes are clear in the first instance, although further analysis will be beneficial:

1. Long hours, working too much and some reports of feeling burnt out.
2. Management not listening, at a variety of levels in the organisation.
3. Bullying is occurring in some areas.
4. People feel there is better pay and better opportunities elsewhere in the NHS.

4. SUMMARY OF MATTERS FOR CONSIDERATION

A Staff Survey Group has been set up to disseminate these results and to support the development of actions and changes for staff. The Executive Director of OD and Workforce is the Executive Sponsor to the Group and will ensure the understanding of the results and the improvements achieved will support the cultural direction set by the Board. The Terms of Reference is attached at Appendix 2.

There will be NHS Staff Survey Action plans for the Trust and for WBS, VCS and Corporate functions. These will be developed in light of staff discussions within teams and departments where practical solutions will be identified and put into practice to meet local needs.

Alongside this, three topics have been chosen to be included in the Trust and Divisional level plans for 2025-26. This will achieve a commonality of effort leading to greater impact overall. The topics align with the Trust Values of Accountability, Caring and Respect.

	Topic	**Rationale**	**Measurement**
1.	PADR	This was one of only two sub-themes which showed a decline since 2023, falling from 82.1% to 78.9%. The Trust target is 85%. There are clear actions in hand to develop PADR in the Trust which makes this achievable and realistic.	The target already in place is for ESR to show an appraisal rate of 85% by 31.3.26. The NHS Staff Survey 2025 will measure feedback 7 months into this period, and therefore a pro-rata target of 82% will represent linear progress towards the year-end target.
2.	Team time	The second of the two sub-themes which declined was Inclusion, which covers how you feel valued by your team, that team members are kind to one another and treat each other with respect. This sub-theme sits within the broader theme of Compassionate and Inclusive which is where the questions relating to discrimination sit. Team time has been selected for focus as it can be addressed at local level. It is an open concept that teams can tailor to their own needs and as such will help with generating local changes and improvements using the Trust Values and Behaviours materials and workshop. The desired outcome is that staff are working in supportive environments where	To see an increase in the scores for the theme of Compassionate and Inclusive in the 2025 Staff Survey from the current rate of 76%.

		they can plan, review and discuss their work openly.	
3.	Psychological Safety	There is no one direct measure of psychological safety but it is reflected in a number of questions and themes throughout the survey. This has been selected as a topic for concerted attention, at Divisional and Trust levels, in connection with reducing the incidence of bullying and harassment. Whilst the reported incidence of bullying and harassment through the staff survey has fallen between 2023 and 2024, it still features within the free text comments and therefore further work is needed to achieve a healthy working environment. Furthermore, new requirements regarding sexual safety at work are going to bring about changes in relation to policies and training which are intended to have a positive impact in this area.	Further reduction in percentages of staff reporting bullying and harassment via the NHS Staff Survey seen in the 2025 results. Qualitative feedback gained from staff relating to how the organisational culture has developed.

Recommendation

Trust Board is asked to note:

1. The introduction of the Staff Survey Group to drive improvements in relation to this feedback with the production of action plans at Divisional and Trust Level.

2. Three priorities for action to be embedded into Trust, Divisional and Departmental Action Plans are PADR, Team Time and increasing psychological safety.

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 ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* One of the ten Themes of the staff survey is patient safety and the results give a clear picture of staff experience in relation to reporting incidents and the support provided by the organisation. These results can shape improvements that will positively impact on Quality and Safety.
QUALITY IMPACT ASSESSMENT	**Choose an item**

	The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum. The QIA tool does not replace the need for the proposal; it accompanies it. As a minimum, decisions made by the Board or by Committees of the Board are considered strategic and should be assessed for their impact on Quality through the lens of the Health and Care Quality Standards. This culture and discipline of quality-driven decision-making should also permeate the organisation to more broadly promote good decision-making practice.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	**Choose an item**
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. **Click or tap here to enter text**

TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT

The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals:

Choose an item

If yes select the relevant goals:

- A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☐
- A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☐
- A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒
- A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒
- A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☐
- A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, ☐

encouraging people to participate in the arts, and sports and recreation. • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☐	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

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

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

Contents of report

This report contains information on the results of the 2024 NHS Wales Staff Survey for Velindre University NHS Trust, including:

1. **Survey response rate**
2. **Staff Engagement Index score**
3. **Summary of responses by theme and sub-theme**
4. **Summary of responses by question**
5. **Equality, diversity and inclusion (EDI) information on respondents**

For information

The 2024 NHS Wales Staff survey was open to all employees in NHS Wales for the 2 month period of between 1st October 2024 and 29th November 2024. The questions in the survey are organised by 10 themes and 20 sub-themes.

Data source

The data presented in this report has been been provided by IQVIA Inc., the organisation responsible for delivering the 2024 and 2023 NHS Wales Staff Surveys. The data is stored, and has been collected from, the Health Education and Improvement Wales (HEIW) data warehouse.

Methodology

To ensure the anonymity of survey respondents, the data in section 5 of this report has been suppressed for instances of less than 10 responses. For example, where less than 10 people with a particular characteristic completed a survey, the number and % of people completing a survey with this particular characteristic is not shown. Any blank responses to questions have also been excluded from the analysis.

Positivity scores have been calculated for each theme and sub-theme, and are based on the percentage of people that responded positively to each question included in each theme and sub-theme. To calculate the Staff Engagement Index score, responses to the 7 relevant questions were weighted based on their scale position from 1 to 5 (on a scale of strongly disagree to strongly agree, or Never to Always). The index score was then calculated as the average of: (i) the weighted percentage score for questions 22a, 22b, and 22c, (ii) the weighted percentage score for questions 23a and 23d, and (iii) the weighted percentage score for questions 23b and 23c. The higher the staff engagement index score, the higher the proportion of people that responded positively to the questions.

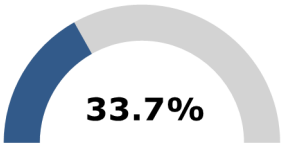
For the purpose of benchmarking, organisations have been grouped and a separate NHS Wales organisational average has been calculated for 'Health Board' organisations and 'Trust/Authority' organisations. The NHS Wales organisational average reported in this document therefore relates to Trust/Authority organisations. The organisations included in this benchmark group are: Digital Health and Care Wales, Health Education and Improvement Wales, NHS Executive, NHS Wales Shared Services Partnership, Public Health Wales, Velindre University NHS Trust, and Welsh Ambulance Services NHS Trust.

Contact details: This report has been developed by the Data and Analytics Team at Health Education and Improvement Wales (HEIW). Please contact HEIW.ATeam@wales.nhs.uk with any queries or feedback.

GIG CYMRU NHS WALES
Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

1. Survey response rate

619 people employed at Velindre University NHS Trust completed the survey in 2024. This equates to a response rate of **33.7%.** This is compared with the 21.9% overall NHS Wales response rate for 2024.



2. Staff Engagement Index score

Velindre University NHS Trust achieved **a Staff Engagement Index score of 76.5%** in 2024. This is compared with the 72% average NHS Wales Staff Engagement Index score.

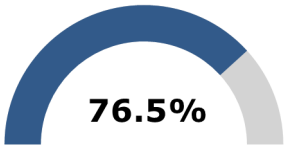


Table 1: Responses to Staff Engagement Index questions in the 2024 survey for Velindre University NHS Trust, with questions asking "On a scale of 1 to 5 (from strongly disagree to strongly agree), to what extent do you agree with the following statements?"

Sub-theme and statement	% agreed or strongly agreed	NHS Wales average
Ability to contribute towards improvements at work		
23a) I am able to make improvements in my area of work.	67.9%	69.2%
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.	58.9%	54.9%
Intrinsic psychological engagement		
22a) I look forward to going to work.	56.2%	54.0%
22b) I am enthusiastic about my job.	69.8%	65.5%
22c) I am happy to go the extra mile at work when required.	84.3%	81.1%
Staff advocacy and recommendation		
23b) I would recommend my organisation as a place to work.	69.1%	68.2%
23c) I am proud to tell people I work for my organisation.	84.3%	74.6%

About the Staff Engagement Index

The Staff Engagement Index score is calculated by weighting the responses to the seven questions based on their position on a 5-point scale (with 1 representing the least positive response, and 5 the most positive response). The Staff Engagement Index score therefore increases as the proportion of people responding positively to these questions increases. More information on how the Staff Engagement Index score is calculated is available ion page 1 of this report.

3. Summary of responses by theme and sub-theme

Table 2: Positivity scores by theme in 2024 for Velindre University NHS Trust (*with bars highlighted green and pink to indicate rates higher and lower than the NHS Wales organisational average for Trust/Authority organisations)*

Theme	Positivity score	NHS Wales average
Morale	61.3%	61.9%
Patient safety	70.1%	63.9%
Staff engagement	70.6%	67.0%
We are all able to speak up	72.1%	70.5%
We are compassionate and inclusive	77.9%	74.6%
We are continuously learning and improving	70.2%	72.1%
We are stronger together	74.4%	75.8%
We champion flexible working	66.6%	75.0%
We nurture healthy working environments	64.2%	66.4%
We recognise everyone's contribution	68.8%	70.7%

Table 3: Positivity scores by theme in 2024 and 2023 for Velindre University NHS Trust (*with rates highlighted green and pink to indicate rates higher and lower than the NHS Wales organisational average for Trust/Authority organisations)*

Theme	Year	Positivity score	Annual trend	NHS Wales average	Variance
Morale	2023	59.2%		60.8%	-1.6%
	2024	61.3%	2.1% ▲	61.9%	-0.6%
Patient safety	2023	64.9%		55.1%	9.8%
	2024	70.1%	5.3% ▲	63.9%	6.2%
Staff engagement	2023	68.6%		67.2%	1.3%
	2024	70.6%	2.0% ▲	67.0%	3.6%
We are all able to speak up	2023	70.2%		69.3%	1.0%
	2024	72.1%	1.8% ▲	70.5%	1.6%
We are compassionate and inclusive	2023	76.0%		73.2%	2.8%
	2024	77.9%	1.9% ▲	74.6%	3.3%
We are continuously learning and improving	2023	69.2%		72.2%	-3.1%
	2024	70.2%	1.0% ▲	72.1%	-1.9%
We are stronger together	2023	71.7%		74.7%	-3.1%
	2024	74.4%	2.7% ▲	75.8%	-1.4%
We champion flexible working	2023	63.3%		72.9%	-9.7%
	2024	66.6%	3.3% ▲	75.0%	-8.4%
We nurture healthy working environments	2023	61.4%		64.3%	-2.8%
	2024	64.2%	2.7% ▲	66.4%	-2.3%
We recognise everyone's contribution	2023	64.7%		70.0%	-5.3%
	2024	68.8%	4.0% ▲	70.7%	-1.9%

Table 4: Positivity scores by theme and sub-theme for Velindre University NHS Trust (*with rates highlighted green and pink to indicate rates higher and lower than the NHS Wales organisational average for Trust/Authority organisations)*

Theme	Sub-theme	Year	Positivity score	Annual trend	NHS Wales average	Variance
Morale	Stressors	2023	60.3%		62.9%	-2.5%
		2024	63.3%	3.0% ▲	63.6%	-0.3%
	Thinking about leaving	2023	59.2%		58.3%	0.9%
		2024	60.5%	1.3% ▲	59.3%	1.2%
	Work pressure	2023	57.0%		59.9%	-3.0%
		2024	58.4%	1.4% ▲	61.9%	-3.5%
Patient safety	No related sub-theme	2023	64.9%		55.1%	9.8%
		2024	70.1%	5.3% ▲	63.9%	6.2%
Staff engagement	Ability to contribute towards improvement at work (Involvement)	2023	62.5%		62.6%	-0.1%
		2024	63.5%	1.1% ▲	62.2%	1.3%
	Intrinsic psychological engagement (Motivation)	2023	68.8%		67.7%	1.1%
		2024	70.9%	2.1% ▲	67.2%	3.7%
	Staff Advocacy and recommendation (Advocacy)	2023	74.3%		71.2%	3.1%
		2024	77.2%	2.9% ▲	71.6%	5.5%
We are all able to speak up	Autonomy and control	2023	74.3%		73.9%	0.5%
		2024	76.8%	2.4% ▲	74.4%	2.4%
	Raising concerns	2023	66.2%		64.7%	1.4%
		2024	67.3%	1.2% ▲	66.6%	0.8%
We are compassionate and inclusive	Compassionate culture	2023	79.5%		70.8%	8.7%
		2024	81.1%	1.6% ▲	72.6%	8.5%
	Compassionate Leadership	2023	68.5%		75.9%	-7.4%
		2024	73.9%	5.4% ▲	77.8%	-3.9%
	Diversity and Equality	2023	68.9%		73.9%	-5.0%
		2024	69.8%	0.9% ▲	74.9%	-5.1%
	Inclusion	2023	75.1%		77.2%	-2.2%
		2024	74.9%	-0.2% ▼	77.0%	-2.1%
We are continuously learning and improving	Development	2023	63.8%		67.9%	-4.1%
		2024	67.3%	3.5% ▲	67.5%	-0.2%
	PDR/Appraisal	2023	76.9%		78.5%	-1.5%
		2024	74.6%	-2.4% ▼	78.6%	-4.1%
We are stronger together	Line management	2023	68.2%		74.9%	-6.7%
		2024	73.5%	5.3% ▲	77.1%	-3.7%
	Team working	2023	74.6%		74.6%	-0.1%
		2024	75.2%	0.6% ▲	74.8%	0.4%
We champion flexible working	Support for work-life balance	2023	63.3%		72.9%	-9.7%
		2024	66.6%	3.3% ▲	75.0%	-8.4%

Theme	Sub-theme	Year	Positivity score	Annual trend	NHS Wales average	Variance
We nurture healthy working environments	Burnout	2023	32.0%		36.5%	-4.5%
		2024	36.1%	4.2% ▲	39.7%	-3.5%
	Health and safety climate	2023	50.7%		55.9%	-5.2%
		2024	52.5%	1.8% ▲	57.0%	-4.5%
	Negative experiences	2023	85.5%		86.2%	-0.6%
		2024	88.1%	2.6% ▲	88.5%	-0.4%
We recognise everyone's contribution	No related sub-theme	2023	64.7%		70.0%	-5.3%
		2024	68.8%	4.0% ▲	70.7%	-1.9%

4. Summary of responses by question

Table 5: Percentage of people that responded positively and negatively to likert scale questions included in the 2024 survey for Velindre University NHS Trust, with questions organised by theme

Question	Year	Positive responses (%)	Positive responses (%) - NHS Wales average	Negative responses (%)
Morale				
02a) I have unrealistic time pressures.	2023	32.5%	36.2%	27.5%
	2024	33.7%	36.3%	25.4%
02b) I am able to meet all the conflicting demands on my time at work.	2023	54.7%	59.6%	14.6%
	2024	58.8%	61.1%	14.1%
02c) I have adequate supplies, materials and equipment to do my work.	2023	78.1%	75.8%	7.0%
	2024	76.8%	76.9%	6.7%
02d) There are enough staff at this organisation for me to do my job properly.	2023	40.8%	46.3%	25.0%
	2024	43.5%	47.7%	25.8%
04a) My immediate manager (line manager) encourages me at work.	2023	71.2%	77.7%	11.6%
	2024	76.8%	79.9%	10.4%
14a) I always know what my work responsibilities are.	2023	84.4%	80.4%	7.9%
	2024	83.4%	79.8%	8.6%
14d) I have a choice in deciding how to do my work.	2023	64.6%	71.5%	14.4%
	2024	74.8%	75.4%	9.4%
15f) Relationships at work are strained.	2023	48.9%	54.7%	25.1%
	2024	52.9%	54.5%	24.3%
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.	2023	60.9%	58.6%	20.5%
	2024	58.9%	54.9%	21.3%
24a) I am satisfied in my current role and intend to remain in it for the foreseeable future.	2023	58.1%	59.3%	18.2%
	2024	57.0%	58.3%	19.8%
24b) I often think about leaving this organisation.	2023	52.8%	53.6%	26.3%
	2024	52.8%	53.9%	25.9%
24c) I will probably look for a job at a new organisation in the next 12 months.	2023	57.5%	54.9%	20.9%
	2024	59.0%	55.5%	20.4%
24d) As soon as I can find another job, I will leave this organisation.	2023	64.4%	65.1%	12.8%
	2024	69.8%	67.7%	13.7%
Patient safety				
13b) My organisation treats staff who are involved in an error, near miss or incident, fairly.	2023	54.4%	47.1%	8.2%
	2024	66.9%	60.5%	9.1%
13c) My organisation encourages us to report errors, near misses or incidents.	2023	84.2%	73.0%	3.9%
	2024	86.0%	78.1%	5.5%

13d) When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	2023	68.2%	56.1%	6.5%
	2024	71.7%	62.8%	8.2%
13e) We are given feedback about changes made in response to reported errors, near misses and incidents.	2023	53.7%	45.4%	13.9%
	2024	55.0%	52.9%	17.2%
Staff engagement				
22a) I look forward to going to work.	2023	52.8%	54.3%	11.8%
	2024	56.2%	54.0%	13.5%
22b) I am enthusiastic about my job.	2023	69.5%	68.2%	6.0%
	2024	69.8%	65.5%	8.1%
22c) I am happy to go the extra mile at work when required.	2023	82.1%	81.4%	2.8%
	2024	84.3%	81.1%	2.3%
23a) I am able to make improvements in my area of work.	2023	64.4%	67.6%	13.5%
	2024	67.9%	69.2%	11.3%
23b) I would recommend my organisation as a place to work.	2023	65.4%	69.5%	13.3%
	2024	69.1%	68.2%	10.7%
23c) I am proud to tell people I work for my organisation.	2023	83.2%	74.0%	3.0%
	2024	84.3%	74.6%	4.6%
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.	2023	60.9%	58.6%	20.5%
	2024	58.9%	54.9%	21.3%
We are all able to speak up				
14a) I always know what my work responsibilities are.	2023	84.4%	80.4%	7.9%
	2024	83.4%	79.8%	8.6%
14b) I am trusted to do my job.	2023	86.1%	85.8%	6.0%
	2024	89.0%	86.6%	4.0%
14c) There are frequent opportunities for me to show initiative in my role.	2023	76.0%	74.6%	9.6%
	2024	77.2%	74.3%	9.5%
14d) I have a choice in deciding how to do my work.	2023	64.6%	71.5%	14.4%
	2024	74.8%	75.4%	9.4%
14i) I would feel secure raising concerns about unsafe clinical practice.	2023	76.3%	69.3%	6.3%
	2024	77.0%	73.9%	6.2%
14j) I would feel secure raising concerns about unethical behaviour.	2023	78.4%	79.1%	9.8%
	2024	78.5%	78.0%	9.5%
14k) I am confident my organisation would address my concern.	2023	58.9%	61.0%	16.3%
	2024	58.0%	60.4%	16.1%
17d) I feel safe to speak up about anything that concerns me in this organisation.	2023	64.2%	63.6%	15.1%
	2024	67.7%	65.3%	14.1%
17e) If I spoke up about something that concerned me, I am confident my organisation would address my concern.	2023	52.6%	53.1%	17.0%
	2024	53.6%	53.9%	18.3%
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.	2023	60.9%	58.6%	20.5%
	2024	58.9%	54.9%	21.3%

We are compassionate and inclusive				
01h) I feel valued by my team.	2023	69.6%	71.6%	12.8%
	2024	73.1%	71.9%	13.4%
01j) I'd feel able to speak up in my team if I noticed poor or incorrect practice.	2023	74.7%	75.3%	11.1%
	2024	78.1%	75.1%	10.6%
04f) My immediate manager (line manager) works together with me to come to an understanding of problems.	2023	68.2%	76.4%	14.4%
	2024	73.9%	77.5%	11.4%
04g) My immediate manager (line manager) is interested in listening to me when I describe challenges I face.	2023	70.2%	77.8%	14.2%
	2024	76.1%	79.2%	9.6%
04i) My immediate manager (line manager) takes effective action to help me with any problems I face.	2023	67.0%	74.8%	14.6%
	2024	71.0%	76.4%	12.3%
14l) I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas)	2023	68.2%	74.4%	7.9%
	2024	69.3%	74.8%	8.4%
15c) The people I work with are understanding and kind to one another.	2023	76.1%	80.2%	9.1%
	2024	74.8%	79.0%	10.3%
15d) The people I work with are polite and treat each other with respect.	2023	78.0%	80.8%	8.1%
	2024	74.3%	79.4%	10.4%
16a) People here are compassionate towards colleagues when they face problems.	2023	79.5%	81.1%	4.9%
	2024	78.3%	81.6%	6.8%
16b) People here give good support to colleagues who are distressed.	2023	79.8%	81.1%	6.1%
	2024	79.0%	81.1%	7.7%
16c) People here are compassionate in the way they behave towards patients/ service users.	2023	86.1%	74.7%	1.6%
	2024	88.2%	78.0%	2.0%
16d) People here take effective action to help patients/service users in distress.	2023	86.1%	72.2%	1.1%
	2024	87.4%	75.5%	1.0%
17a) Care of patients / service users is my organisation's top priority.	2023	82.4%	69.6%	3.5%
	2024	86.1%	70.8%	3.4%
17b) My organisation acts on concerns raised by patients / service users.	2023	78.1%	65.2%	3.3%
	2024	78.5%	66.2%	3.3%
17c) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	2023	82.6%	57.6%	4.0%
	2024	84.5%	58.1%	3.6%
17d) I feel safe to speak up about anything that concerns me in this organisation.	2023	64.2%	63.6%	15.1%
	2024	67.7%	65.3%	14.1%
We are continuously learning and improving				
18a) This organisation offers me challenging work.	2023	71.9%	77.6%	8.1%
	2024	75.3%	76.1%	7.2%
18b) There are opportunities for me to develop my career in this organisation.	2023	52.8%	59.5%	22.8%
	2024	56.9%	57.9%	17.7%
18c) I have opportunities to improve my knowledge and skills.	2023	70.7%	76.0%	14.0%
	2024	75.4%	75.2%	8.6%

18d) I feel supported to develop my potential.	2023	59.1%	64.0%	19.8%
	2024	64.4%	64.3%	16.4%
18e) I am able to access the right learning and development opportunities when I need to.	2023	62.5%	62.9%	15.4%
	2024	60.8%	62.6%	15.8%
19a) In the last 12 months, have you had an appraisal, PADR, annual review or development review?	2023	82.1%	83.8%	16.0%
	2024	78.9%	85.2%	18.2%
We are stronger together				
01a) The team I work in has a set of shared objectives.	2023	80.5%	81.3%	8.4%
	2024	81.8%	80.4%	8.3%
01b) The team I work in often meets to discuss the team's effectiveness.	2023	68.4%	70.2%	18.4%
	2024	67.8%	70.0%	18.6%
01c) Team members trust each other.	2023	71.9%	73.1%	13.3%
	2024	73.7%	72.2%	11.5%
01d) Team members understand each other's roles.	2023	76.8%	72.6%	13.0%
	2024	71.4%	71.6%	13.9%
01e) Team members take time out to reflect and learn.	2023	51.8%	57.4%	24.2%
	2024	52.5%	58.5%	22.9%
01f) Team members are able to communicate closely with each other to achieve the team's objectives.	2023	74.7%	75.4%	10.5%
	2024	75.7%	75.9%	11.1%
01g) I enjoy working with the colleagues in my team.	2023	83.9%	84.6%	5.1%
	2024	83.5%	83.9%	5.0%
01h) I feel valued by my team.	2023	69.6%	71.6%	12.8%
	2024	73.1%	71.9%	13.4%
01i) I feel able to ask other members of this team for help when I need it.	2023	87.9%	87.3%	4.7%
	2024	85.8%	85.6%	6.1%
01j) I'd feel able to speak up in my team if I noticed poor or incorrect practice.	2023	74.7%	75.3%	11.1%
	2024	78.1%	75.1%	10.6%
01k) Team members work well with other teams.	2023	74.7%	74.8%	8.8%
	2024	75.1%	74.0%	8.1%
04a) My immediate manager (line manager) encourages me at work.	2023	71.2%	77.7%	11.6%
	2024	76.8%	79.9%	10.4%
04b) My immediate manager (line manager) gives me clear feedback on my work.	2023	64.6%	71.2%	16.5%
	2024	68.4%	72.7%	14.9%
04c) My immediate manager (line manager) asks for my opinion before making decisions that affect my work.	2023	58.9%	66.8%	21.8%
	2024	63.9%	68.6%	19.6%
04d) My immediate manager (line manager) takes a positive interest in my health and well-being.	2023	71.1%	77.8%	12.6%
	2024	75.0%	79.7%	10.0%
04e) My immediate manager (line manager) values my work.	2023	72.1%	78.3%	11.8%
	2024	78.4%	80.1%	9.4%

04f) My immediate manager (line manager) works together with me to come to an understanding of problems.	2023	68.2%	76.4%	14.4%
	2024	73.9%	77.5%	11.4%
04g) My immediate manager (line manager) is interested in listening to me when I describe challenges I face.	2023	70.2%	77.8%	14.2%
	2024	76.1%	79.2%	9.6%
04h) My immediate manager (line manager) recognises the importance of staff emotional wellbeing.	2023	69.1%	77.9%	13.7%
	2024	75.2%	79.1%	10.6%
04i) My immediate manager (line manager) takes effective action to help me with any problems I face.	2023	67.0%	74.8%	14.6%
	2024	71.0%	76.4%	12.3%
We champion flexible working				
14e) I am satisfied with the opportunity for flexible working patterns.	2023	65.4%	76.2%	20.9%
	2024	68.3%	77.7%	14.6%
14f) My organisation is committed to helping me balance my work and home life.	2023	58.9%	69.6%	22.6%
	2024	59.4%	69.4%	16.7%
14g) I achieve a good balance between my work life and my home life.	2023	57.9%	68.9%	24.6%
	2024	62.9%	70.5%	17.0%
14h) I can approach my immediate manager (line manager) to talk openly about flexible working.	2023	70.7%	80.1%	15.1%
	2024	76.4%	82.2%	10.7%
We nurture healthy working environments				
02a) I have unrealistic time pressures.	2023	32.5%	36.2%	27.5%
	2024	33.7%	36.3%	25.4%
02b) I am able to meet all the conflicting demands on my time at work.	2023	54.7%	59.6%	14.6%
	2024	58.8%	61.1%	14.1%
02c) I have adequate supplies, materials and equipment to do my work.	2023	78.1%	75.8%	7.0%
	2024	76.8%	76.9%	6.7%
02d) There are enough staff at this organisation for me to do my job properly.	2023	40.8%	46.3%	25.0%
	2024	43.5%	47.7%	25.8%
09a) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Patients / service users, their relatives, or other members of the public	2023	86.0%	87.2%	12.8%
	2024	89.8%	90.9%	9.3%
09b) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Managers / Team leaders	2023	81.7%	83.9%	15.1%
	2024	87.8%	86.8%	9.3%
09c) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Other colleagues	2023	79.3%	83.2%	17.6%
	2024	81.0%	84.8%	16.1%
10a) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From patients / service users	2023	94.4%	95.1%	5.3%
	2024	94.8%	96.4%	5.2%

10b) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From staff / colleagues	2023	92.8%	94.3%	6.7%
	2024	96.1%	96.3%	3.9%
11a) In the last 12 months how many times have you personally experienced abuse at work from patients / service users, their relatives, or other members of the public?	2023	93.0%	92.3%	6.7%
	2024	89.9%	89.2%	9.8%
11b) The last time you experienced abuse at work (work from patients / service users, their relatives, or other members of the public) did you or a colleague report it?	2023	36.4%	36.2%	
	2024	50.0%	48.2%	
12a) In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives, or other members of the public	2023	98.6%	96.4%	1.1%
	2024	99.0%	97.9%	1.0%
12b) In the last 12 months how many times have you personally experienced physical violence at work from...? Managers / Team leaders	2023	99.1%	98.9%	0.5%
	2024	100.0%	99.7%	
12c) In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues	2023	99.5%	98.9%	0.2%
	2024	99.7%	99.6%	0.3%
20a) How often, if at all, do you find your work emotionally exhausting?	2023	28.4%	32.7%	34.0%
	2024	30.6%	35.2%	27.2%
20b) How often, if at all, do you feel burnt out because of your work?	2023	32.3%	36.4%	33.0%
	2024	34.3%	39.2%	24.2%
20c) How often, if at all, does your work frustrate you?	2023	18.4%	20.0%	39.1%
	2024	23.7%	23.5%	31.7%
20d) How often, if at all, are you exhausted at the thought of another day/shift at work?	2023	37.2%	43.4%	29.3%
	2024	46.2%	49.1%	22.8%
20e) How often, if at all, do you feel worn out at the end of your working day/shift?	2023	21.1%	26.6%	43.3%
	2024	24.0%	30.5%	31.5%
20f) How often, if at all, do you feel that every working hour is tiring for you?	2023	50.9%	58.2%	18.6%
	2024	59.8%	63.4%	13.3%
20g) How often, if at all, do you not have enough energy for family and friends during leisure time?	2023	36.3%	40.2%	26.3%
	2024	34.2%	34.7%	31.3%
21a) My organisation takes positive action on health and wellbeing.	2023	51.4%	65.0%	16.3%
	2024	56.0%	63.5%	16.7%
21d) In the last three months have you ever come to work despite not feeling well enough to perform your duties?	2023	50.0%	47.7%	50.0%
	2024	49.0%	47.3%	51.0%
21e) Have you felt pressure from your manager to come to work?	2023	78.2%	84.5%	21.8%
	2024	82.9%	84.9%	17.1%
We recognise everyone's contribution				
04e) My immediate manager (line manager) values my work.	2023	72.1%	78.3%	11.8%
	2024	78.4%	80.1%	9.4%
15a) I get recognition for good work.	2023	58.4%	66.3%	16.5%

15a) I get recognition for good work.	2024	64.8%	66.9%	15.8%
15b) The organisation values my work.	2023	53.2%	60.3%	18.1%
	2024	59.1%	59.4%	14.6%
15e) The people I work with show appreciation to one another.	2023	74.2%	77.1%	8.9%
	2024	71.0%	75.6%	10.3%

Table 6: Number and percentage of responses to each question for Velindre University NHS Trust. *%s are rounded so may not add up to 100%.*

Question and response	Total responses	%
01a) The team I work in has a set of shared objectives.		
Strongly agree	185	30%
Agree	320	52%
Neither agree nor disagree	61	10%
Disagree	33	5%
Strongly disagree	18	3%
01b) The team I work in often meets to discuss the team's effectiveness.		
Strongly agree	157	25%
Agree	262	42%
Neither agree nor disagree	84	14%
Disagree	85	14%
Strongly disagree	30	5%
01c) Team members trust each other.		
Strongly agree	180	29%
Agree	274	44%
Neither agree nor disagree	91	15%
Disagree	43	7%
Strongly disagree	28	5%
01d) Team members understand each other's roles.		
Strongly agree	145	23%
Agree	297	48%
Neither agree nor disagree	91	15%
Disagree	65	11%
Strongly disagree	21	3%
01e) Team members take time out to reflect and learn.		
Strongly agree	79	13%
Agree	245	40%
Neither agree nor disagree	152	25%
Disagree	103	17%
Strongly disagree	38	6%
01f) Team members are able to communicate closely with each other to achieve the team's objectives.		
Strongly agree	168	27%
Agree	296	48%
Neither agree nor disagree	81	13%
Disagree	48	8%
Strongly disagree	20	3%

Question and response	Total responses	%
01g) I enjoy working with the colleagues in my team.		
Strongly agree	267	43%
Agree	248	40%
Neither agree nor disagree	71	12%
Disagree	17	3%
Strongly disagree	14	2%
01h) I feel valued by my team.		
Strongly agree	102	33%
Agree	125	40%
Neither agree nor disagree	42	13%
Disagree	24	8%
Strongly disagree	18	6%
01i) I feel able to ask other members of this team for help when I need it.		
Strongly agree	281	45%
Agree	250	40%
Neither agree nor disagree	50	8%
Disagree	26	4%
Strongly disagree	12	2%
01j) I'd feel able to speak up in my team if I noticed poor or incorrect practice.		
Strongly agree	99	32%
Agree	141	46%
Neither agree nor disagree	35	11%
Disagree	19	6%
Strongly disagree	14	4%
01k) Team members work well with other teams.		
Strongly agree	175	28%
Agree	289	47%
Neither agree nor disagree	104	17%
Disagree	32	5%
Strongly disagree	18	3%
02a) I have unrealistic time pressures.		
Always	26	8%
Often	53	17%
Sometimes	126	41%
Rarely	85	27%
Never	20	6%
02b) I am able to meet all the conflicting demands on my time at work.		
Always	37	12%
Often	145	47%
Sometimes	84	27%

Question and response	Total responses	%
Rarely	37	12%
Never	7	2%
02c) I have adequate supplies, materials and equipment to do my work.		
Always	114	37%
Often	122	40%
Sometimes	51	17%
Rarely	16	5%
Never	5	2%
02d) There are enough staff at this organisation for me to do my job properly.		
Always	34	11%
Often	101	32%
Sometimes	95	31%
Rarely	60	19%
Never	21	7%
03a) How many hours a week are you contracted to work?		
30 or more hours	531	86%
I am a bank worker	6	1%
Up to 29 hours	78	13%
03b) On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours? Please include paid overtime, bank shifts, and additional paid hours on-call.		
0 Hours	459	75%
11 or more hours	24	4%
6-10 hours	27	4%
Up to 5 hours	99	16%
03c) On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours? Please include unpaid overtime and additional unpaid hours on-call.		
0 Hours	304	49%
11 or more hours	21	3%
6-10 hours	48	8%
Up to 5 hours	243	39%
04a) My immediate manager (line manager) encourages me at work.		
Strongly agree	117	38%
Agree	121	39%
Neither agree nor disagree	40	13%
Disagree	20	6%
Strongly disagree	12	4%

Question and response	Total responses	%
04b) My immediate manager (line manager) gives me clear feedback on my work.		
Strongly agree	184	30%
Agree	238	39%
Neither agree nor disagree	103	17%
Disagree	59	10%
Strongly disagree	33	5%
04c) My immediate manager (line manager) asks for my opinion before making decisions that affect my work.		
Strongly agree	191	31%
Agree	203	33%
Neither agree nor disagree	102	17%
Disagree	76	12%
Strongly disagree	45	7%
04d) My immediate manager (line manager) takes a positive interest in my health and well-being.		
Strongly agree	245	40%
Agree	218	35%
Neither agree nor disagree	92	15%
Disagree	33	5%
Strongly disagree	29	5%
04e) My immediate manager (line manager) values my work.		
Strongly agree	122	40%
Agree	120	39%
Neither agree nor disagree	38	12%
Disagree	16	5%
Strongly disagree	13	4%
04f) My immediate manager (line manager) works together with me to come to an understanding of problems.		
Strongly agree	106	34%
Agree	122	39%
Neither agree nor disagree	46	15%
Disagree	21	7%
Strongly disagree	14	5%
04g) My immediate manager (line manager) is interested in listening to me when I describe challenges I face.		
Strongly agree	121	39%
Agree	114	37%
Neither agree nor disagree	44	14%
Disagree	16	5%
Strongly disagree	14	4%
04h) My immediate manager (line manager) recognises the importance of staff emotional wellbeing.		
Strongly agree	242	39%

Question and response	Total responses	%
Agree	220	36%
Neither agree nor disagree	87	14%
Disagree	34	6%
Strongly disagree	31	5%
04i) My immediate manager (line manager) takes effective action to help me with any problems I face.		
Strongly agree	106	34%
Agree	114	37%
Neither agree nor disagree	52	17%
Disagree	23	7%
Strongly disagree	15	5%
05a) Does your organisation act fairly with regard to career progression/promotion, regardless of age, disability, ethnic background, gender, gender identity, religion or sexual orientation?		
Don't know	142	23%
No	58	9%
Prefer not to say	35	6%
Yes	378	62%
05b) In the last 12 months have you sought a progression opportunity in your workplace?		
Don't know	15	2%
No	360	59%
Prefer not to say	26	4%
Yes	213	35%
05d) In the coming 12 months would you consider applying for a progression opportunity in your workplace?		
Don't know	122	20%
No	194	31%
Prefer not to say	20	3%
Yes	281	46%
06a) In the last 12 months have you personally experienced discrimination at work from patients/service users, their relatives, or other members of the public?		
No	576	94%
Prefer not to say	17	3%
Yes	22	4%
07a) In the last 12 months have you personally experienced discrimination at work from a manager/ team leader?		
No	545	90%
Prefer not to say	32	5%
Yes	27	4%
08a) In the last 12 months have you personally experienced discrimination at work from other colleagues?		
No	537	89%

Question and response	Total responses	%
Prefer not to say	29	5%
Yes	35	6%
09a) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Patients / service users, their relatives, or other members of the public		
1-2	42	7%
3-5	11	2%
6-10	3	0%
More than 10	1	0%
Prefer not to say	5	1%
Never	548	90%
09b) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Managers / Team leaders		
1-2	39	6%
3-5	9	1%
6-10	3	0%
More than 10	6	1%
Prefer not to say	18	3%
Never	539	88%
09c) In the last 12 months how many times have you personally experienced harassment or bullying at work from...? Other colleagues		
1-2	60	10%
3-5	24	4%
6-10	4	1%
More than 10	10	2%
Prefer not to say	18	3%
Never	493	81%
09d) The last time you experienced harassment or bullying at work, did you or a colleague report it?		
Don't know	12	5%
No	111	49%
Yes, a colleague reported it	12	5%
Yes, I reported it	92	41%
10a) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From patients / service users		
1-2	27	4%
3-5	5	1%
Never	583	95%

Question and response	Total responses	%
10b) In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault. From staff / colleagues		
1-2	17	3%
3-5	3	0%
6-10	2	0%
More than 10	2	0%
Never	593	96%
11a) In the last 12 months how many times have you personally experienced abuse at work from patients / service users, their relatives, or other members of the public?		
1-2	46	7%
3-5	10	2%
6-10	3	0%
More than 10	1	0%
Prefer not to say	2	0%
Never	553	90%
11b) The last time you experienced abuse at work (work from patients / service users, their relatives, or other members of the public) did you or a colleague report it?		
Don't know	4	7%
No	30	50%
Yes, a colleague reported it	5	8%
Yes, I reported it	21	35%
12a) In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives, or other members of the public		
1-2	6	1%
Never	610	99%
12b) In the last 12 months how many times have you personally experienced physical violence at work from...? Managers / Team leaders		
Never	617	100%
12c) In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues		
1-2	2	0%
Never	615	100%
12d) The last time you experienced physical violence at work, did you or a colleague report it?		
Don't know	3	43%
No	2	29%
Yes, I reported it	2	29%

Question and response	Total responses	%
13a) In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?		
No	383	68%
Prefer not to say	17	3%
Yes	164	29%
13b) My organisation treats staff who are involved in an error, near miss or incident, fairly.		
Strongly agree	98	19%
Agree	241	48%
Neither agree nor disagree	122	24%
Disagree	29	6%
Strongly disagree	17	3%
13c) My organisation encourages us to report errors, near misses or incidents.		
Strongly agree	225	42%
Agree	241	44%
Neither agree nor disagree	46	8%
Disagree	16	3%
Strongly disagree	14	3%
13d) When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.		
Strongly agree	142	27%
Agree	235	45%
Neither agree nor disagree	106	20%
Disagree	30	6%
Strongly disagree	13	2%
13e) We are given feedback about changes made in response to reported errors, near misses and incidents.		
Strongly agree	94	18%
Agree	193	37%
Neither agree nor disagree	145	28%
Disagree	65	12%
Strongly disagree	25	5%
14a) I always know what my work responsibilities are.		
Strongly agree	95	31%
Agree	164	53%
Neither agree nor disagree	25	8%
Disagree	22	7%
Strongly disagree	5	1%
14b) I am trusted to do my job.		
Strongly agree	261	42%
Agree	290	47%

Question and response	Total responses	%
Neither agree nor disagree	43	7%
Disagree	17	3%
Strongly disagree	8	1%
14c) There are frequent opportunities for me to show initiative in my role.		
Strongly agree	198	32%
Agree	280	45%
Neither agree nor disagree	82	13%
Disagree	46	7%
Strongly disagree	13	2%
14d) I have a choice in deciding how to do my work.		
Strongly agree	97	31%
Agree	135	44%
Neither agree nor disagree	49	16%
Disagree	23	7%
Strongly disagree	6	2%
14e) I am satisfied with the opportunity for flexible working patterns.		
Strongly agree	206	33%
Agree	215	35%
Neither agree nor disagree	105	17%
Disagree	57	9%
Strongly disagree	33	5%
14f) My organisation is committed to helping me balance my work and home life.		
Strongly agree	151	24%
Agree	216	35%
Neither agree nor disagree	148	24%
Disagree	71	11%
Strongly disagree	32	5%
14g) I achieve a good balance between my work life and my home life.		
Strongly agree	141	23%
Agree	248	40%
Neither agree nor disagree	124	20%
Disagree	80	13%
Strongly disagree	25	4%
14h) I can approach my immediate manager (line manager) to talk openly about flexible working.		
Strongly agree	227	37%
Agree	246	40%
Neither agree nor disagree	80	13%
Disagree	44	7%
Strongly disagree	22	4%

Question and response	Total responses	%
14i) I would feel secure raising concerns about unsafe clinical practice.		
Strongly agree	196	32%
Agree	276	45%
Neither agree nor disagree	103	17%
Disagree	25	4%
Strongly disagree	13	2%
14j) I would feel secure raising concerns about unethical behaviour.		
Strongly agree	196	32%
Agree	285	46%
Neither agree nor disagree	74	12%
Disagree	38	6%
Strongly disagree	20	3%
14k) I am confident my organisation would address my concern.		
Strongly agree	112	18%
Agree	245	40%
Neither agree nor disagree	159	26%
Disagree	62	10%
Strongly disagree	37	6%
14l) I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas)		
Strongly agree	127	21%
Agree	301	49%
Neither agree nor disagree	138	22%
Disagree	37	6%
Strongly disagree	15	2%
15a) I get recognition for good work.		
Strongly agree	116	19%
Agree	285	46%
Neither agree nor disagree	120	19%
Disagree	64	10%
Strongly disagree	34	5%
15b) The organisation values my work.		
Strongly agree	88	14%
Agree	277	45%
Neither agree nor disagree	163	26%
Disagree	65	11%
Strongly disagree	25	4%
15c) The people I work with are understanding and kind to one another.		
Strongly agree	155	25%
Agree	308	50%

Question and response	Total responses	%
Neither agree nor disagree	92	15%
Disagree	50	8%
Strongly disagree	14	2%
15d) The people I work with are polite and treat each other with respect.		
Strongly agree	158	26%
Agree	301	49%
Neither agree nor disagree	95	15%
Disagree	52	8%
Strongly disagree	12	2%
15e) The people I work with show appreciation to one another.		
Strongly agree	140	23%
Agree	296	48%
Neither agree nor disagree	115	19%
Disagree	48	8%
Strongly disagree	15	2%
15f) Relationships at work are strained.		
Strongly agree	41	7%
Agree	108	18%
Neither agree nor disagree	140	23%
Disagree	221	36%
Strongly disagree	104	17%
16a) People here are compassionate towards colleagues when they face problems.		
Strongly agree	131	21%
Agree	350	57%
Neither agree nor disagree	91	15%
Disagree	30	5%
Strongly disagree	12	2%
16b) People here give good support to colleagues who are distressed.		
Strongly agree	144	23%
Agree	340	55%
Neither agree nor disagree	82	13%
Disagree	31	5%
Strongly disagree	16	3%
16c) People here are compassionate in the way they behave towards patients/ service users.		
Strongly agree	227	37%
Agree	309	51%
Neither agree nor disagree	60	10%
Disagree	9	1%
Strongly disagree	3	0%

Question and response	Total responses	%
16d) People here take effective action to help patients/service users in distress.		
Strongly agree	226	37%
Agree	302	50%
Neither agree nor disagree	70	12%
Disagree	5	1%
Strongly disagree	1	0%
17a) Care of patients / service users is my organisation's top priority.		
Strongly agree	251	41%
Agree	281	45%
Neither agree nor disagree	65	11%
Disagree	17	3%
Strongly disagree	4	1%
17b) My organisation acts on concerns raised by patients / service users.		
Strongly agree	183	30%
Agree	300	49%
Neither agree nor disagree	112	18%
Disagree	17	3%
Strongly disagree	3	0%
17c) If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.		
Strongly agree	237	39%
Agree	282	46%
Neither agree nor disagree	73	12%
Disagree	18	3%
Strongly disagree	4	1%
17d) I feel safe to speak up about anything that concerns me in this organisation.		
Strongly agree	75	24%
Agree	134	43%
Neither agree nor disagree	56	18%
Disagree	33	11%
Strongly disagree	11	4%
17e) If I spoke up about something that concerned me, I am confident my organisation would address my concern.		
Strongly agree	99	16%
Agree	232	38%
Neither agree nor disagree	173	28%
Disagree	81	13%
Strongly disagree	32	5%
18a) This organisation offers me challenging work.		
Strongly agree	150	24%

Question and response	Total responses	%
Agree	313	51%
Neither agree nor disagree	108	18%
Disagree	33	5%
Strongly disagree	11	2%
18b) There are opportunities for me to develop my career in this organisation.		
Strongly agree	118	19%
Agree	232	38%
Neither agree nor disagree	156	25%
Disagree	65	11%
Strongly disagree	44	7%
18c) I have opportunities to improve my knowledge and skills.		
Strongly agree	156	25%
Agree	307	50%
Neither agree nor disagree	98	16%
Disagree	33	5%
Strongly disagree	20	3%
18d) I feel supported to develop my potential.		
Strongly agree	136	22%
Agree	260	42%
Neither agree nor disagree	118	19%
Disagree	66	11%
Strongly disagree	35	6%
18e) I am able to access the right learning and development opportunities when I need to.		
Strongly agree	110	18%
Agree	264	43%
Neither agree nor disagree	144	23%
Disagree	72	12%
Strongly disagree	25	4%
19a) In the last 12 months, have you had an appraisal, PADR, annual review or development review?		
Can't Remember	18	3%
No	112	18%
Yes	487	79%
19b) If yes, to what extent do you agree with the following statements? It helped me to improve how I do my job.		
No	179	37%
Yes, definitely	77	16%
Yes, to some extent	231	47%
19c) It helped me agree clear objectives for my work.		
No	89	18%
Yes, definitely	166	34%

Question and response	Total responses	%
Yes, to some extent	231	48%
19d) It left me feeling that my work is valued by my organisation.		
No	124	26%
Yes, definitely	163	34%
Yes, to some extent	198	41%
20a) How often, if at all, do you find your work emotionally exhausting?		
Always	31	5%
Often	136	22%
Sometimes	259	42%
Rarely	144	23%
Never	44	7%
20b) How often, if at all, do you feel burnt out because of your work?		
Always	35	6%
Often	114	19%
Sometimes	255	41%
Rarely	151	25%
Never	60	10%
20c) How often, if at all, does your work frustrate you?		
Always	30	5%
Often	165	27%
Sometimes	274	45%
Rarely	114	19%
Never	32	5%
20d) How often, if at all, are you exhausted at the thought of another day/shift at work?		
Always	35	6%
Often	105	17%
Sometimes	191	31%
Rarely	184	30%
Never	100	16%
20e) How often, if at all, do you feel worn out at the end of your working day/shift?		
Always	50	8%
Often	143	23%
Sometimes	273	45%
Rarely	108	18%
Never	39	6%
20f) How often, if at all, do you feel that every working hour is tiring for you?		
Always	25	4%
Often	56	9%

Question and response	Total responses	%
Sometimes	164	27%
Rarely	233	38%
Never	132	22%
20g) How often, if at all, do you not have enough energy for family and friends during leisure time?		
Always	51	8%
Often	141	23%
Sometimes	212	35%
Rarely	138	22%
Never	72	12%
21a) My organisation takes positive action on health and wellbeing.		
Strongly agree	67	11%
Agree	275	45%
Neither agree nor disagree	167	27%
Disagree	81	13%
Strongly disagree	21	3%
21b) In the last 12 months, have you experienced musculoskeletal problems (MSK) as a result of work activities?		
No	497	81%
Yes	117	19%
21c) During the last 12 months have you felt unwell as a result of work-related stress?		
No	408	67%
Yes	205	33%
21d) In the last three months have you ever come to work despite not feeling well enough to perform your duties?		
No	303	49%
Yes	315	51%
21e) Have you felt pressure from your manager to come to work?		
No	261	83%
Yes	54	17%
22a) I look forward to going to work.		
Always	68	11%
Often	279	45%
Sometimes	187	30%
Rarely	61	10%
Never	22	4%
22b) I am enthusiastic about my job.		
Always	160	26%
Often	270	44%
Sometimes	136	22%
Rarely	37	6%

Question and response	Total responses	%
Never	13	2%
22c) I am happy to go the extra mile at work when required.		
Always	274	44%
Often	245	40%
Sometimes	83	13%
Rarely	8	1%
Never	6	1%
23a) I am able to make improvements in my area of work.		
Strongly agree	122	20%
Agree	297	48%
Neither agree nor disagree	128	21%
Disagree	56	9%
Strongly disagree	14	2%
23b) I would recommend my organisation as a place to work.		
Strongly agree	148	24%
Agree	277	45%
Neither agree nor disagree	124	20%
Disagree	42	7%
Strongly disagree	24	4%
23c) I am proud to tell people I work for my organisation.		
Strongly agree	238	39%
Agree	278	45%
Neither agree nor disagree	68	11%
Disagree	21	3%
Strongly disagree	7	1%
23d) I am involved in deciding on changes introduced that affect my work/area/team/department.		
Strongly agree	42	21%
Agree	79	38%
Neither agree nor disagree	41	20%
Disagree	29	14%
Strongly disagree	15	7%
24a) I am satisfied in my current role and intend to remain in it for the foreseeable future.		
Strongly agree	124	20%
Agree	227	37%
Neither agree nor disagree	143	23%
Disagree	83	13%
Strongly disagree	39	6%
24b) I often think about leaving this organisation.		
Strongly agree	53	9%
Agree	106	17%

Question and response	Total responses	%
Neither agree nor disagree	131	21%
Disagree	199	32%
Strongly disagree	126	20%
24c) I will probably look for a job at a new organisation in the next 12 months.		
Strongly agree	52	8%
Agree	73	12%
Neither agree nor disagree	127	21%
Disagree	174	28%
Strongly disagree	188	31%
24d) As soon as I can find another job, I will leave this organisation.		
Strongly agree	33	5%
Agree	51	8%
Neither agree nor disagree	102	17%
Disagree	164	27%
Strongly disagree	265	43%

5. Equality, diversity and inclusion (EDI) information on respondents

This section of the report provides demographic information on people employed at Velindre University NHS Trust that completed a survey in 2024. This includes a breakdown of the number and percentage of people who completed a survey in 2024 by the following characteristics:

- Age
- Gender
- Gender reassignment
- Sexual orientation
- Ethnicity
- Religion
- Disability
- Neurodiversity

Table 7: Number and percentage of responses to survey questions related to equality, diversity and inclusion (EDI) characteristics, for people employed at Velindre University NHS Trust that completed a survey in 2024

Question and response	Total responses	%
25) What best describes your gender?	**615**	
Female	427	69%
Male	135	22%
Non-binary	<10	<10
Prefer not to say	48	8%
Prefer to self describe (please specify)	<10	<10
26) Is this the same as the sex you were assigned at birth?	**613**	
No	<10	<10
Prefer not to say	39	6%
Yes	572	93%
27) Which of the following terms best describes your sexual orientation?	**617**	
Asexual	<10	<10
Bisexual	25	4%
Gay or lesbian	12	2%
Heterosexual or Straight	504	82%
Prefer not to say	65	11%
Prefer to self-describe (please specify)	<10	<10
28) Age	**617**	
21-30	94	15%
31-40	122	20%
41-50	149	24%
51-65	194	31%
66+	<10	<10
Prefer not to say	51	8%
29) Which race or ethnicity best describes you?	**616**	
Another race or ethnicity – please identify	<10	<10
Asian / British Asian: Bangladeshi	<10	<10
Asian / British Asian: Indian	<10	<10

Question and response	Total responses	%
Asian / British Asian: Other	<10	<10
Asian / British Asian: Pakistani	<10	<10
Black / British Black: African	<10	<10
Black / British Black: Caribbean	<10	<10
Mixed Race: Asian & White	<10	<10
Mixed Race: Black & White	<10	<10
Mixed Race: Other	10	2%
Prefer not to say	50	8%
White: British (British / English / Northern Irish / Scottish / Welsh)	503	82%
White: European	19	3%
White: Irish	<10	<10
30) What do you consider your religion to be?	**614**	
Christian	222	36%
Hindu	<10	<10
Muslim	<10	<10
No religion	297	48%
Prefer not to say	79	13%
Prefer to self-describe (please specify)	11	2%
31) Do you have an impairment that can affect day-to-day activities, this can be either a physical or hidden disability?	**616**	
No	471	76%
Prefer not to say	67	11%
Yes	78	13%
33) Do you consider yourself Neurodiverse or Neurodivergent? (E.g., Autism, ADHD, Dyslexia)	**601**	
No	491	82%
Prefer not to say	50	8%
Yes	60	10%

TERMS OF REFERENCE

Terms of Reference for NHS Staff Survey Group
3.3.25

Summary of Role	To disseminate NHS Staff Survey results and instigate change and improvement in Divisions and Departments as well as across the Trust.
Reports to	Healthy and Engaged Steering Group
Chaired by	Head of Organisational Development
Membership	• Executive Director of Organisational Development and Workforce (Executive Sponsor) • Head of Organisational Development • Workforce Development Manager • Equality, Diversity and Inclusion Manager • Health and Safety Manager • Quality and Safety Representative • Digital Services Representative • Velindre Cancer Service Representatives • Welsh Blood Service Representatives • Profession Representatives for Nursing and Medical • Trade Union Representative Other members can be added in line with Divisional requests.
Meeting Frequency	The group will meet monthly
Documentation required	• Action Log • Access to NHS Staff Survey platform • Membership of internal MS Teams group
Remit	• To disseminate NHS Staff Survey results in area of responsibility • To support Divisional and Departmental Managers to hold action planning conversations with their team and to review progress over time

TERMS OF REFERENCE

	• To contribute to Trust level change in relation to the NHS Staff Survey results
Inputs	Representatives for WBS and VCS Divisions will ensure that WBS and VCS Divisional SLTs are sighted on any matters for approval and provide feedback regarding that topic as relevant.
Outputs	• Staff Survey action plans for Departments and Divisions • Trust Staff Survey action plan
Secretariat	The Head of Organisational Development will organise meetings and produce the Action Log.
Review Date	February 2026

Trust Board

TRUST INTEGRATED MEDIUM TERM PLAN 2025-8

Date of meeting	27th March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	**APPROVAL**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Lauren Fear, Director of Transformation (Interim)
PRESENTED BY	Lauren Fear, Director of Transformation (Interim)
APPROVED BY	Lauren Fear, Director of Transformation (Interim)
EXECUTIVE SUMMARY	The Integrated Medium Term Plan 2025-8 sets out: **Section 1 - Context** **1.** Five key messages **2.** Foreword from our Chair and Chief Executive Officer **3.** Who we are **4.** Strategic context in which our Plan is being set: • Our Strategy • National • Health and Social Care • Blood services

	• Cancer services • Trust **5.** Our Clinical and Scientific Strategy **Section 2 – Delivering our Services** **6.** How we are developing our services to improve outcomes for our patients, donors and staff **7.** How our wider services are enabling this development **8.** Our transformation roadmap **9.** Our financial plan **Section 3 – Delivering our Strategy** **10.** How this Plan takes us towards our Destination 2033 long term goals, including our strategic risks In addition, the supporting slide deck provides assurance that all planning requirements have been appropriately considered and incorporated into the Plan where appropriate.

RECOMMENDATION / ACTIONS	The Trust Board is asked to approve the Integrated Medium Term Plan 2025-8

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	10th March 2025
Strategic Development Committee	20th March 2025

Summary and outcome of previous governance discussions:

The approach and template to the Integrated Medium Term Plan was agreed by Executive Management Board in October 2024 and also supported by the Strategic Development Committee.

In each Trust Board meeting since autumn 2024, there has been a Strategic Planning paper which has updated on the approach and development of the Plan.

Planning guidance was received by Welsh Cabinet Secretary and Welsh Government officials at the end of December 2024.

The senior leadership teams for the core service divisions and the enabling functions have all considered their input into the Plan, through their appropriate engagement and governance mechanisms. This input was then iterated to ensure alignment to the planning guidance.

The full draft document was discussed in Executive Management Board on 10th March and based on feedback, including informal reviews with Independent Members, a further version was circulated on 15th March. The version considered by Strategic Development Committee incorporated all comments from Executive Management Board member and informal Independent member feedback to date. This version was endorsed for Trust Board approval, subject to the changes discussed and the finalising of the Quality Impact Assessment and the Equality Impact Assessment. The approach to these assessments was discussed and assurance provided given the detailed work in the cross-reference slide deck.

APPENDICES	
1	**Integrated Medium Term Plan 2025-8 – Tracked change version post SDC**
2	**Cross reference to planning guidance assurance pack**

ACRONYMS and INITIALISM	
	Where possible, all acronyms have been written in full throughout the plan. An exception is some of the financial tables as this then increases the size of tables – however all have been defined in the document.

1. SITUATION/BACKGROUND

The Integrated Medium Term Plan 2025-8 is due to be submitted to the Welsh Government by 31st March 2025.

Following Strategic Development Committee consideration, a tracked change version has been circulated to the Trust Board.

The full designed version is still being finalised as at point of paper publishing and this will be sent to Board members when available. This is formatting only – all content for approve is included in the attached.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The cross reference pack explains how this Plan meets all of the statutory and planning guidance.

3. IMPACT ASSESSMENT

4.

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organization that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	Strategic risks are now aligned to strategic objectives in section 10.
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 ☒
	Quality Impact Assessment completed
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Yes

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	Well-being Future Generations Act section of Plan
FINANCIAL IMPLICATIONS / IMPACT	Financial Plan included
EQUALITY IMPACT ASSESSMENT	Equality Impact Assessment completed
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Cross-reference to relevant legislation included in supporting slide pack.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Strategic risks are now aligned to strategic objectives in section 10.

Velindre University NHS Trust

Integrated Medium Term Plan

2025-2028

What this document does:

Section 1 - Context

1. Five key messages
2. Foreword from our Chair and Chief Executive Officer
3. Who we are
4. Strategic context in which our Plan is set:
    - Our Strategy
    - National
    - Health and Social Care
    - Blood services
    - Cancer services
    - Trust
5. Our Clinical and Scientific Strategy

Section 2 – Delivering our Services

6. Welsh Blood Service and Velindre Cancer Service
7. How our wider services are enabling this development
8. Our transformation roadmap
9. Our financial plan

Section 3 – Delivering our Strategy

10. How this Plan takes us towards our Destination 2033 long term goals, including our strategic risks

DRAFT

Section 1 - Context

1. Five Key Messages

We set the focus of this Integrated Medium Term Plan, the "Plan", in autumn 2024, which has then driven its development:

1. Our Plan delivers on our vision of **"Excellent Care; Inspirational Learning; Healthier People"** through our values of **"Caring; Respectful; Accountable**."

2. This is to **deliver all core services consistently and reliably**, in line with commissioned and quality patient and donor facing standards and national best practice.

3. To achieve this the Plan is informed by current and predicted **demand, experience, safety and quality outcomes**.

4. The Plan demonstrates delivery on principles of **value in health and efficiency,** a **multi professional workforce** and a **digitally enabled** transformation.

5. This Plan will see **significant infrastructure investment**, including a new Cancer Centre, new Radiotherapy equipment and new facilities for our Blood Service.

2. Foreword from our Chair and Chief Executive Officer (draft to be finalised by 27th March)

We are proud to present the Velindre University NHS Trust Integrated Medium Term Plan for 2025/6-2027/8. Our Plan is an output of the excellent work undertaken by our teams from across the Trust and our continued engagement with our many stakeholders. We have set ourselves a set of ambitious priorities, all centred in improving the outcomes for our patients, donors and communities. In addition to our key messages above on what this plan will do. We would like to make three further specific commitments to you:

- We will continue to deliver and further develop this Plan in a way that **listens** to our patients, donors, communities and wider stakeholders.
- We will tirelessly focus on achieving the **outcomes** set out in this Plan and will regularly report on our progress to achieving them.
- This Plan can only be delivered in collaboration and working across all our partnerships, **together**.

We hope you enjoy reviewing our Plan and we, and our teams, look forward to discussing it with you at our various engagement opportunities over the course of the year.

Thank you.

Professor Donna Mead OBE, Chair

David Donegan, Chief Executive

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3. Who we are

Velindre University NHS Trust "the Trust"

Velindre Cancer Service:

- We are a treatment, teaching, research and development centre for oncology services to patients from across South-East Wales and wider.

Welsh Blood Service:

- We provide a range of essential and specialised services including the collection and production of blood and blood components to treat patients, provision of scientific support for transplantation within Wales and the global provision of stem cells for patients.

Hosted Services - We are responsible for hosting the following organisations:

NHS Wales Shared Services Partnership (NWSSP)

- Provide a range of professional, technical and administrative services to NHS Wales.

Health Technology Wales (HTW)

- Assesses non-medicine technologies and produces national guidance on their use in Wales.

Our workforce

- We employ 7, 834 staff across the Trust
- We also have 51 volunteers who deliver 'added value' roles across the Velindre Cancer Service.

Velindre Cancer Service

- We serve ~~the Welsh~~a population of 1.7 million.
- During 2024 we:
  - Delivered Radiotherapy treatments to 4321 patients.
  - Delivered Systemic Anti-Cancer Treatment (SACT) treatments to 5282 patients.
  - Delivered 16,650 Outpatient consultations.

Welsh Blood Service:

- We are a national service which covers ~~a~~ the Welsh population of 3.1 million.
- During 2024 we:
  - Collected approximately 100,000 units of blood.
  - We have more than 75, 000 volunteers on our stem cell registry.
  - Provided scientific support for 132 organ transplants and 36 stem cell transplants.

Velindre Charity

- The charity entity of our Trust, which in 2023-4 raised £11.8m from events, fundraising, grants and donations and £2.4m from legacies. This supports vital research, staff development and important services to enrich the lives and experience of our patients.

4. Strategic context in which this Plan is set

Our Strategy

Our Purpose: **To improve lives**

Our Vision: **Excellent Care. Inspirational Learning. Healthier People**

Our Values: **Caring. Respectful. Accountable**

Destination 2033 sets out our **strategic goals** to achieve this:

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

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National Context

The purpose of the Well-being of Future Generations (Wales) Act is to improve the social, economic, environmental and cultural well-being of the Welsh population. The Act requires public bodies to consider the long-term, work better with people, communities, and each other, look to prevent problems and take a more joined-up approach.

Trust Approach

We welcomed a review by Audit Wales in 2024 that recommended that there should be greater integration of the Well-being objectives into the Trust's strategic objectives and in this way, more clearly drive activity across the organisation. In addition, the Social Partnership and Public Procurement (Wales) Act now requires NHS bodies to consider the new social partnership requirements in our Well-being objectives.

Milestone Q3~***Year 1*** – Review Strategic Objectives to further embed the Well-Being Future Generation Act.

This Plan demonstrates action to make meaningful progress towards our existing objectives:

- Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.
- Improve the health and well-being of our staff and people across Wales, by striving to care for the needs of the whole person.
- Create new highly skilled jobs in Wales and attract investment by increasing our focus on research, innovation and new models of delivery.
- Deliver bold solutions to the environment challenges posed by our activities.
- Demonstrate respect for the diverse cultural heritage of modern Wales.
- Bring communities and generations, together through involvement in the planning and delivery of our services.
- Strengthen the international reputation of the trust as a centre of excellence, teaching research and technical innovation was also making a lasting contribution to global well-being.

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Health and Social Care Context

We are aligned to the vision of the Health and Social Care system in Wales, which is set out in "A Healthier Wales". It sets out the long-term future vision of a whole system approach to health and social care and focuses on health and wellbeing and preventing illness.

Following a nation-wide listening exercise in summer 2024, the Welsh Government published refreshed set of actions to support the delivery of A Healthier Wales. Through this Plan, we will deliver on many of these objectives directly and is ambitious on the role we can play across the whole agenda.

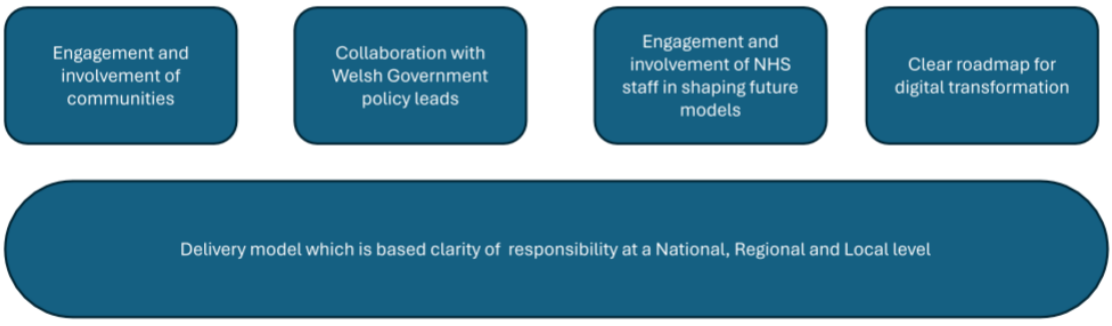
The Cabinet Secretary for Health and Social Care has asked that all NHS Wales organisations also deliver on the expectations across the following priorities:

- Timely access to care
- Population health and prevention
- Building community capacity
- Mental health access
- Women's health

In addition, this Plan sets out how the Trust will deliver on a series of "enabling actions", where each has an evidence base to demonstrate improved efficiency and/ or outcomes without driving additional cost. These actions will then be supplemented during 2025 with the findings of the Ministerial Advisory Group and the Trust will work collaboratively with all NHS Wales organisations to respond and implement these further recommendations.

Health organisations across Wales have come together over the last few months to consider the challenges facing the NHS in Wales and how we can collectively address these over the coming years. The aim is to build a service delivery blueprint which will describe **what the NHS in Wales will look like in 10 years' time**, and which will deliver improvements in health outcomes and performance and reduce inequalities. This will be a collaborative effort, bringing together the thinking from within NHS organisations in Wales and utilising external expertise and international insights, and will support and enhance the Welsh Government's work on a National Plan.

This will be a blueprint that describes an integrated primary and community care system focused on prevention and early intervention, a future model for hospitals, technology enabled care and a future-focussed and enabled workforce. It will also set out a plan for how these changes will be delivered.



As this national work develops, the Trust commits to aligning the thinking into our plans for service change and improvement.

Welsh Blood Services Plan Context

Infected Blood Inquiry

The Infected Blood Inquiry published its final report with recommendations in May 2024. The Infected Blood Inquiry was an independent public statutory inquiry established to examine the circumstances in which men, women and children treated by national health services in the UK were given infected blood and infected blood products, in the 1970s, 80s and very early 90s.

Learning the lessons and making change as blood services in the interest of public and patient safety will continue to be core to the planning of blood service provision. The experiences of the infected and affected will not be forgotten and will continue to underpin our approach to patient safety.

The Trust is part of a national Infected Blood Inquiry Next Steps Oversight Group to bring together organisations who are responsible for implementing the Inquiry's recommendations. Important aspects of this for the Trust include working with Digital Health and Care Wales on the digital solutions to ensure the traceability of blood and maintaining a strong safety culture in line with the Duties of Quality and Candour.

Plasma for Medicines

The opportunities for Plasma for Medicines could have a significant impact on the blood product collection and supply chain for Wales.

Plasma makes up 55% of our blood and contains antibodies which strengthen or stabilise the immune system. It is used to save lives during childbirth and trauma and is used to treat patients with life-limiting illnesses such as immune deficiencies.

The UK was unable to produce medicines from human-derived plasma between 1998 and 2021 as a legacy of Variant Creutzfeldt–Jakob disease, which meant the NHS relied on imported medicines. The lifting of the ban in 2021 followed a review by the Commission on Human Medicine and the Medicines and Healthcare products Regulatory Agency after a thorough review concluded it was safe to use UK-sourced plasma for manufacturing treatments. In 2021, UK Blood Services began collecting convalescent plasma for two major UK-wide coronavirus treatment trials.

The Trust already collects plasma through whole blood donation and is used for manufacturing fresh frozen plasma and cryoprecipitate, which typically helps treat patients with heavy blood loss. The Welsh Blood Service supplies fresh frozen plasma and cryoprecipitate to hospitals across Wales. Due to the increasing global clinical demands for Plasma-Derived Medical Products, we are working with Welsh Government to introduce a plasma for medicines approach in Wales to meet the future demand for these lifesaving products and reduce our reliance on international importation. This could build a more resilient and domestic medical supply chain, boost economic growth and make an important contribution to the development of Life Sciences in NHS Wales.

Velindre Cancer Services Plan Context

National Cancer Context

Our Plan for cancer services is underpinned by the *Quality Statement for Cancer*. Quality statements are part of A Healthier Wales and form the National Clinical Framework as the national planning framework for specific clinical services.

The National Clinical Network, part of the NHS Executive, published the Cancer Improvement Plan 2023-2026. This sets out the ambition for Wales to improve cancer patient outcomes and reduce health inequalities. It highlights the importance of planning for the future delivery of innovative new service models, treatments and technologies to secure recovery, sustainability and improvement in line with the 22 Quality Attributes set out in the Quality Statement for Cancer. There has been recent review of the Welsh system by Audit Wales in early 2025 also which will also support and inform our next steps as a cancer system.

This and further development of the national strategic direction in 2025, will provide the foundations for the next version of the Velindre Cancer Services Strategy.

Milestone ~*Year 1*– Development of the next version of the Velindre Cancer Services Strategy.

New Velindre Cancer Centre

In Spring 2024, we finalised the arrangements with the Acorn consortium," Project Co", to design, build and maintain the new Velindre Cancer Centre, scheduled to open in Spring 2027. The new cancer centre will deliver a vital facility within which we can deliver care and treatment for patients today and for future generations. This is a significant investment for NHS Wales and will be a regional facility to deliver our collective Cancer Services Strategy. This Plan demonstrated the journey to deliver the new hospital, the commissioning of and the transition to the new facility and the service transformation that will optimise the opportunities of the new facility.

Trust Context

Our Role in the Health and Social Care System

We are considering the role the Trust can play in the system to improve outcomes for cancer and blood services for Wales. Early thinking on this is included in some aspects of this Plan, for instance, in the refresh of our long-term strategic goals and our Cancer Services Plan, which have already been referenced. Additionally in aspects of the Strategic Planning section. We will continue to engage with our staff, patients and wider stakeholders on how we can add most value and this will be reflected in our plans as strategic decisions are made.

Hosted Services

We are reviewing the arrangements with our hosted organisations, NHS Wales Shared Service Partnership and Health Technology Wales. This ~~is also referenced in the NHS Wales Shared Services Integrated Medium Term Plan and~~ will be concluded by the end of Q2 2025/6.

Approach to Planning

Our Integrated Medium Term Plan starts with the actions to develop our core services across Blood and Cancer. It includes a mixture of transformation and on-going service development activities.

In our 2024-2027 Integrated Medium Term Plan, there were 171 actions. We report on progress against these actions quarterly, however for the most part these are actions which span over one year delivery and therefore are represented in this plan :

	2024-27 IMTP	Completed	On-going in this Plan or embedded in service activity
Blood Service	20	5	15
Cancer Service	29	1	28
Trust-wide Services	122	6	116~~20~~

We ~~report each quarter on our progress against the Plan and want to~~are therefore developing this ~~further~~ in two key ways:

- ~~. Firstly, to~~We will include reporting against outcomes;
- We will ~~and secondly,~~ report against our specific milestones to allow progress to be tracked clearly against longer-~~-~~term activities.

Engagement

As outlined above, this Plan continues for the most part, strategic transformation activities that that have been effectively engaged during design and decision-making. Where this Plan highlights further service design and development activity, we commit that our staff, patients, donors and communities will have a strong voice in creating effective, joined up services. In 2025, we will also strengthen our partnership with our Health Board partners in embedding a 'Community Delivery by Design' approach that aims to redesign existing services to deliver greatest value and improve patient experience.

In recent years, we have made important developments in our patient engagement approach, which was co-produced with Cwmpas, and also in our community engagement approach via Velindre Voices.

5. Clinical and Scientific Strategy

Our Clinical and Scientific Strategy was approved in 2024 and sets the clinical and scientific direction for all our services over the next five years. The strategy was written by, and for, our clinical and scientific workforce. We adopted a multi-faceted approach to engage with our clinical and scientific communities, partners, and stakeholders, calling on their wealth of knowledge, expertise, and forward-thinking ideas to inform our shared vision, ambitious strategic aims, and objectives.

Our vision is to "be at the forefront of clinical science delivering excellent, high-quality, person-centered care."

Our strategic aims and objectives are set out below and frame our service development and transformation agenda:

1. **Leadership & Collaboration**

Strategic aim: Strengthen clinical and scientific leadership and collaboration to drive the and scientific agenda.

Strategic Objectives:

- **Enhance our role** as a specialist provider at a local, regional, national, and international level
- Optimise opportunities for **collaborative working** to deliver person focused, sustainable, efficient, and effective services

Goals and Deliverables:

- Strengthen working relationships with Health Technology Wales, partnerships and maximise opportunities to collaborate with health boards, academia, third sector and supportive services supported by having a presence on the Wales Cancer Industry Forum.
- Collaborate with partners across the life science sector and undertake horizon scanning to keep abreast of technological, clinical, and scientific advances, ensuring preparedness for implementation.
- Optimise the effectiveness of the Blood Health National Oversight Group to deliver the NHS Wales Blood Health Plan and the recommendations from the Infected Blood Inquiry that fall within its remit.

2. **Quality**

Strategic Aim: Deliver high quality evidence-based, person-centred care to improve experience & outcomes.

Strategic Objectives:

- Through **service transformation** deliver high quality, equitable and sustainable services to meet the needs of our patients and donors
- Optimise patient outcomes, experience by embedding the principles of **value-based healthcare** within all services
- Deliver data driven, **evidence- based clinically led care** that is outcome focused and underpinned by research, expert clinical and scientific knowledge.

Goals and Deliverables:

- Build capacity and capability through development of the clinical infrastructure in preparation for delivering new treatments, with advanced therapies operational and strategic groups.
- Improve the safety and traceability throughout the supply chain for blood and transplantation products. Implementing a Platelet Strategy, Transplantation Laboratory modernisation, and establishing a Quality Assurance modernisation programme. Develop a clinically and digitally enabled workforce, optimising the use of digital solutions, including artificial intelligence to improve outcomes. Aligning with the Public Health Wales use of AI in Health and Social Care.

3. Research, Development and Innovation

Strategic Aim: Drive clinical & scientific advancements through innovation, research, & development.

Strategic Objectives:

- Empower the clinical and scientific workforce to drive **transformation and quality improvement** initiatives by engaging in research, development, and innovation.
- Keep abreast of the pace of change in science and technology, ensuring **preparedness for new developments.**

Goals and Deliverables:

- Maximise opportunities for collaborative research and clinical trials, providing a translational pipeline between the laboratory and clinical areas. Establishing a development forum of Velindre Cancer Service, Welsh Blood Service, Value Based Health Care and Health Technology Wales.

4. Workforce

Strategic Aim: Adapt, develop, and empower a sustainable, diverse, multi-professional clinical and scientific workforce.

Strategic Objectives:

- Build capacity and capability to deliver a multi-professional, **clinically led model** to ensure that the right professional has the right knowledge and skills to deliver the right care in the right time and place.
- **Equip the clinical and scientific workforce** with the knowledge and skills to respond to changes in care and treatment and harness the use of new equipment, systems, and technology.
- Create a professionally **equitable, fully engaged, empowered** workforce that can meet the delivery challenges working within supportive and **psychologically safe culture**

Goals and Deliverables:

- Adopt a multi-professional clinically led workforce model that focuses on maximising the use of specialist skills.
- Embed a psychologically safe and support culture of compassionate, inclusive, and collective model of clinical and scientific leadership. Implementing models such as Clinical Supervision and Schwartz Rounds.
- Adopt a multi-faceted approach to improve recruitment, retention, and succession planning across all clinical and scientific professions through developing a Strategic Workforce Transformation Plan.

Section 2 – Delivering our Services

6. *(i)* Welsh Blood Service

Our Vision: To be recognised by the people of Wales and our peers as a leader in transplant and transfusion services.

Strategic Themes in our Welsh Blood Service Five Year Plan:

1. Build a sustainable donor base that meets clinical need and represents the diverse communities we serve.
2. To provide a world class donor experience.
3. Drive the prudent use of blood across Wales.
4. Quality, safety and value: doing it right, first time.
5. Achieving excellence in research, development and innovation to improve outcomes for our donors and patients.
6. Sustainable services that deliver the greatest value to our communities.
7. Develop great people and a great place to work.

Transfusion Services Modernisation

To review *and develop service processes, practices and workforce requirements to support a transformational service model across all transfusion service areas.*

Milestones

- **Manufacturing and Distribution** – There are two core aims for this Plan. Firstly, to develop a processing model that allows the Welsh Blood Service to supply plasma for fractionation. Secondly to review and optimisation of testing processes and the use of technology including automation across all transfusion laboratories.
  - Development of a platelet strategy to optimise provision of routine and specialist platelet components – Q1 ~Year 1
  - Develop process for plasma ~Year 2
  - Implement stock management system for wholesale products ~Year 2
  - Review strategy Automated Blood Processing system ~Year 2
  - Review strategy X Ray technologies ~Year 2

- **Donor Testing** - The introduction of new tests and services in line with advances in clinical and scientific practices.
  - Implement Nucleic Acid Testing – Q2 ~Year 1
  - Introduction of Haemoglobin S Testing – Q2 ~Year 1
  - Review strategy Microbiology testing ~Year 2

- **Red Cell Immunoheamatology** - Review of the operating model of Red Cell Immunohematology services, to include skill mix and service provision
  - Review current contractual arrangements for laboratory staff – Q1 ~Year 1
  - Review requirements for Laboratory Automation – Q3 ~Year 1
  - Review current Phenotyping programme ~Year 2
  - Provision of alternative liquid nitrogen storage – Q4 ~Year 1
  - Implementation of Genotyping Service ~Year 2

Outcomes – delivered in line with our Values:

Caring	***Respectful***	***Accountable***

Increase in the retention and recruitment of staff. Increased opportunity for staff development aligned to workforce and succession planning	Operational efficiencies in the management and processing of blood and transfusion services. Platelet production efficiencies and reduction in wastage. Operating efficiencies in the testing process in transfusion services	Improved supply chain security for plasma derived medicines. Improved clinical outcomes for patients by utilising enhanced diagnostics and testing to support optimal treatment

Transplantation Services Modernisation

To review and develop service processes, practices and workforce requirements to support a transformational service model across all transplantation service areas including the Welsh Bone Marrow Donor Registry.

Milestones

- **Welsh Bone Marrow Donor Registry** - To facilitate the growth of the Welsh Bone Marrow Donor Registry to achieve and explore the opportunities to expand stem cell collection.
  - Develop a 5-year strategy for the registry – Q3 ~Year 1
  - Implement a new digital system ~Year 3
  - Expand Stem Cell collection services and explore opportunities for collection services for aligned registry services, Welsh transplant centres, other UK/International registries, and Advanced Therapy Medicinal Products (ATMP's) ~Year 2

- **External Quality Assessment (EQA) Service**
  - Provide a new digital solution for the specialist external quality assessment (EQA) service for laboratories around the world supporting organ transplantation. – Q4 ~Year 1

- **Transplant Laboratory modernisation** Provide transplantation laboratories **modernisation** opportunities to develop a service that is integrated, efficient, maximises the use of innovative technology and minimises duplication and waste.
  - Review and begin implementation antibody testing strategy ~Year 3

Outcomes – delivered in line with our Values:

Caring	***Respectful***	***Accountable***
For External Quality Assessment (EQA) Service: Increased productivity; Flexibility to develop service; Capacity to expand customer base.	A digital solution to support the increasing volume of data and users as the registry grows, ensuring that performance and functionality are maintained without degradation. Enhance efficiency and accuracy and decreased turnaround times in Transplant Laboratories	A clear strategic direction for the Welsh Bone Marrow Donor Registry Resilience in the stem cell supply chain at Welsh and UK level.

Collection Services Modernisation

To review and develop service processes, practices and workforce requirements to provide a transformational collection service. We will achieve this through excellent donor engagement, a clinically led collection team model and revising the blood collection clinic planning and logistics.

Milestones

1. Donor Engagement - Implement improved donor and advocate interaction functionality.

- Develop and implement new Donor and Advocate Strategy – Q4 ~Year 1
- Introduce a donor experience hub – Q3 ~Year 1
- Implement omni-channel software to provide a single platform for managing donor interactions – Q4 ~Year 1

2. Operations - Implement a clinically led collection team model, enable live connectivity to donation clinics and introduce enhancements to donor safety and experience.

- Undertake a workforce review of collection teams and introduce a new nurse-led model – Q4 ~Year 1
- Implement a new process for haemoglobin testing utilising HemoCue devices in place of copper sulphate – Q2 ~Year 1
- Enable live connectivity between blood collection clinics and the Blood Establishment Computer System (BECS) ~Year 3

3. Resource, Planning & Logistics - Revise the blood collection clinic portfolio, develop a fleet strategy that meets the future needs of the service and provide robust and effective rostering processes.

- Introduce blood clinics involving overnight stays (tours) for North Wales collections teams - Q1 ~Year 1
- Develop a fleet strategy that meets the current and future demands of the service ~Year 2
- Introduce enhanced rostering systems for Collections and Transport & Logistics staff ~Year 3

Outcomes – delivered in line with our Values:

Caring	***Respectful***	***Accountable***
Increased donor retention for the blood groups in demand. Increased opportunities for donors and supporters to engage and support as needed	Greater choice of donation locations and times for donors. Improved collection efficiency: - Reduction in manual data entry and paper usage - Reduction in vehicle maintenance costs and carbon footprint - Reduced volume of manual data entry and steps within the rostering process	Improved clarity of roles and responsibilities, providing a clear scope of practice

Talbot Green Infrastructure

Strategic infrastructure improvements to create a fit-for-purpose, resilient building with robust mechanical and electrical infrastructure, supporting modern transfusion and transplant laboratories that are future proofed and efficient.

Milestones

- Develop integrated Outline/ Full Business Case to recommend construction to commence in 2026/7. Q3 ~Year 1

Outcomes – delivered in line with our Values:

Caring	***Respectful***	***Accountable***
A reduction in carbon emissions and energy consumption.	Ability to sustain and grow service delivery in line with NHS requirements.	Operational efficiencies in the management and processing of blood and transfusion and transplantation services.

Digital Modernisation

To modernise the existing software systems within the Welsh Blood Service to include the Blood Establishment Computer System (BECS), the current Welsh Histocompatibility and Immunogenetics Service IT (WHAIS IT) system and Welsh Laboratory Information Management System (WLIMS) 2.0.

Milestones

1. **Blood Establishment Computer System (BECS)** - Procure, implement, validate and transition to a new Blood Establishment Computer System for use by the Welsh Blood Service to replace the current solution. A new Blood Establishment Computer System will provide the blood service with unrivalled functionalities using the latest technology to provide a service that meets the needs of the population of Wales.
   - Implement Blood Establishment Computer System ~Year 3
2. **Welsh Histocompatibility and Immunogenetics Service (WHAIS)** - Replace the Welsh Histocompatibility and Immunogenetics Service digital system which has been in operational use for approximately 30 years and is no longer fit for purpose. The new system will allow for future service development
   - Implement Welsh Histocompatibility and Immunogenetics Service digital service – Q3 ~Year 1
3. **Welsh Laboratory Information Management System (WLIMS 2.0)** - To work with the National WLIMS 2.0 programme to make sure the needs of the Welsh Blood Service are delivered through the National system.
   - Implement Welsh Laboratory Information Management System – Q3 ~Year 1

Outcomes – delivered in line with our Values:

Caring	***Respectful***	***Accountable***
BECS - Improving Patient outcomes by ensuring a sustainable service, driving the use of blood and building our donor base	**WHAIS** Reducing reliance on transcription, manual data entry, and on paper records, while improving sample management, traceability and turnaround times. Also making the service more adaptable to service user needs, and future changes. **WLIMS** - Reducing reliance on transcription, manual data entry, and on paper records, while improving sample management, traceability and turnaround times. Also making the service more adaptable to	

	service user needs, and future changes. Compliance with transfusion and digital guidelines.	

6. *(ii)* Velindre Cancer Service

Our strategic priorities for 2020-2025 have been:

Strategic Priority 1:	Equitable and consistent care, no matter where; meeting increasing demand.
Strategic Priority 2:	Access to state-of-the-art, world-class, evidence-based treatments
Strategic Priority 3:	Improving care and support for patients to live well through and beyond cancer
Strategic Priority 4:	To be an international leader in research, development, innovation and education
Strategic Priority 5:	To work in partnership with stakeholders to improve prevention and early detection of cancer.

As already noted, **a Q3~year 1 milestone** for this plan is to develop the next version of the Velindre Cancer Services Strategy.

Radiation Services

There has been significant investment in radiation services in South East Wales. There will be an additional location for Velindre Cancer Service Radiotherapy provision with the Velindre@Nevill Hall Radiotherapy Unit, in Abergavenny, opening in Year 1 of this Plan. We are also in the process of replacing our existing fleet of Linear Accelerators as part of the Integrated Radiotherapy Solution programme. We continue to advance our service in line with latest clinical and technological developments.

Milestones:

1. **Velindre@ Nevill Hall Radiotherapy Unit** – New unit set to open in June 2025.
    - Implementation of clinical service at Velindre@ Nevill Hall Radiotherapy Unit – Q1 ~Year 1

2. **Integrated Radiotherapy Solution** - Investment in state-of-the-art radiotherapy equipment, with eight of the machines replaced at the centre in Whitchurch, Cardiff and two more housed in the Velindre@ Nevill Hall Radiotherapy Unit.
    - Deployment of Integrated Radiotherapy Solution Programme. Phase 2 to conclude Q2 ~Year 1, Phase 3 conclude ~Year 3.
    - Deploy Linear Accelerator replacement capacity plan. In progress, concludes ~Year 3.
    - Develop and deploy brachytherapy transition plan to support transition to new Velindre Cancer Centre. To start Q3 ~Year 1. Transition plan development will follow.

3. **Radiology Informatics System** - Supports the improvement and future development of our PACS and RIS systems to align data, further improving the accuracy of treatment and supporting cross Health Board boundary working and streamlining patient care.
    - Implement Radiology Informatics System (RISP) – Q1 ~Year 1
    - Fully implement new all-Wales RIS and PACS solution for radiology and nuclear medicine. Milestone?

4. **Implementation of new Molecular Radiotherapy Services** - Radioactive medication which is administered orally or intravenously.

- Peptide Receptor Radionuclide Therapy - Finalise new treatment pathway and commence treatment of patients. Milestone? ~Year 1
- Scope implementation of Lutetium-177 Prostate Specific Membrane Antigen (PSMA) therapy treatment and develop business case for prospective new service. Milestone? ~Milestones awaiting NICE guidance.

5. ***Other Service Developments***
    - Review current model, undertake benchmarking, develop and implement a sustainable model for Palliative Radiotherapy. Q3 ~Year 1

Outcomes – delivered in line with our Values:

Caring	***Respectful***	***Accountable***
Radiotherapy treatments commenced in optimal timescales	*Sustainable and effective multi-professional workforce model*	*Transformation milestones delivered on time, on budget and to quality standards*

Acute Care and Palliative Medicine

There will be significant development over the course of this Plan in our evolving model for acute care and acute oncology. A key focus will be on strengthening the clinical model and our ability to support our patients with toxicities from treatment, within the regional Health Board unscheduled care system. This includes our contribution to the national delivery of effective emergency care and development of our strategy for systemic therapies to enable delivery and the management of the next generation of immunotherapies . We will continue to work with our system partners to deliver our commitments to our patients and their families and carers under the Quality Statement for Palliative and End of Life Care.

Milestones:

- **Acute Oncology Services (AOS) -** This includes people who receive an emergency cancer diagnosis at the front door of the hospital, as well as those people living with cancer who suddenly become seriously ill, either because of their illness itself or because of complications with their treatment, including from immunotherapies, as per below.
    - Develop plan for next stage for our Acute Oncology Services with our Health Board partners - Q3 ~Year 1
    - Re-develop the cancer telephone helpline service – considering options for regional helpline provision – Q4 ~Year 1

- **Same Day Emergency Care (SDEC), implementing the Six Goals Programme** – National programme of '6 Goals for Urgent and Emergency Care' which sets out expectations for health, social care and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health.
    - Same Day Emergency Care pathways, including re-modelling of the Assessment and ambulatory care Units, including moving to 7 day working. – Q2 ~Year 1
    - Optimal hospital care and discharge practice (from the point of admission) – Q2 ~Year 1
    - GoHome first approach and reduce the risk of readmission – Q2 ~Year 1

- **Introduction of Next Generation Immunotherapies** – Immunotherapy utilises the body's immune system to find and destroy cancer cells. The innovation, complexity and breadth of options of these treatments will continue to accelerate.

There are several major developments in cancer therapeutics that are set to move from experimental to routine therapy. The advances are in cancer immunotherapy and comprise tumour infiltrating lymphocytes (TILs), chimeric antigen receptor T cells (CAR-T cells) and BITES (bispecific T cell engagers).

These therapies are complex, need specific dates of treatment, require longer chair time and some may require an admission as opposed to day case treatment, they have a high level of expected and unexpected toxicity and will be new to the large majority of the involved oncology clinical team.

- Develop pathways, identify and introduce support structures to facilitate administration of bispecific T-Cell engagers (BiTEs) and other complex and advanced therapies when approved for clinical use. This will be led by newly established Acute Clinical Model Strategic Group – Q2 ~Year 1

Outcomes – delivered in line with our Values:

Caring	***Respectful***	***Accountable***
Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard.	*Delivery against the Palliative and End of Life Care Quality Statement*	*Effective strategic development and implementation of acute clinical model*

Systemic Therapies

The Velindre Cancer Service clinical model is based on a networked delivery of services across Southeast Wales. Currently, our Systemic Anti-Cancer Therapies (SACT) service is delivered in a number of settings: in the Prince Charles Hospital in Merthyr Tydfil and Neville Hall in Abergavenny; within a mobile unit; and at patients' homes. This Plan requires the next stage of this model to be in place by 2027. In addition, there will be important technological and model change in the way in which pharmacy services are delivered over this period.

Milestones

1. ***Systemic Anti-Cancer Therapies (SACT) Outreach Services -*** The principle of the clinical model is to move more care being delivered closer to patients' home so that by 2027 care is delivered 10% at home, 45% in the new Velindre Cancer Centre and 45% in outreach settings.
    - Agree the number of hubs, location and staffing to deliver per Site Specific Site and overall facilities, in context of Velindre@ Model. Q3 ~Year 1
    - Implement ~Year 2.

- **Transforming Access to Medicines** - Programme to set up a shared pharmacy technical service for Wales, for the sterile preparation of medicines also known as aseptic services.
    - Approach agreed to Transforming Access to Medicines (TrAMS) Model to Velindre Cancer Services. Q2 ~Year 1

- **Electronic Prescribing and Medicines Administration** – To deliver a fully digitised prescribing system across Velindre Cancer Service that will improve safety, efficiency, audit and better access to information.
    - Implement Electronic Prescribing and Medicines Administration (ePMA) system for use in Velindre Cancer Services. ~Year 2.

- **Virtually Assessed Patient (VAP) Clinics -** Virtual Nurse Prescriber led pre-assessment clinic for patients on routine well-tolerated SACT regimens, creating capacity in outpatients for more complex patients. There is opportunity to considerably expand the VAP service to cover all suitable patient groups across all common tumour sites.
    - Expansion of the model of a virtual nurse prescriber led pre-assessment clinic for patients on SACT. Q2 ~Year 1

Outcomes – delivered in line with our Values:

Caring	***Respectful***	***Accountable***
On 90% of days planned care capacity should be protected from unscheduled care pressures and outlying of patients by the end of Q1. *Ensure effective utilisation of theatre capacity through: reducing late starts to less than 20%; reducing early finishes to less than 10%; and increasing session utilisation to the GiRFT standard of 85% by March 2026.*	*Sustainable and effective multi-professional workforce model*	*Effective strategic development and implementation of SACT and pharmacy models for South East Wales.* *Medicines Management - ensure full implementation of the high value medicines Value & Sustainability Board programme, which includes delivering opportunities against each of the four programme areas (maximise use of biosimilars, switch to generics, preferential use of medicines in primary care, restrict low value prescriptions)*

Across Velindre Cancer Service

This Plan also includes a comprehensive transformation review in 2025 to inform our next Velindre Cancer Services Strategy, which will ensure readiness for transition to the new Velindre Cancer Centre. This will also enable the Velindre Cancer Service to optimise the value it can provide to cancer outcomes for the people of Wales.

There are also specific milestones across our planned care to improve timely access to care, shift to virtual consultations and remote assessments and reduce unwarranted variation in clinical productivity.

Milestones:

1. **Velindre Cancer Service Transformation** – The current Velindre Cancer Service Five Year Plan concludes in 2025 and therefore a refreshed transformation strategy is required from 2026 onwards. Q3 ~ Year 1.

Planned Care

2. **Outpatients -** Ensure monitoring of DNA/CNA rates is in place for every Outpatient clinic. When DNA/CNA as a combined rate is greater than 5%, overbooking additional patients should be implemented and monitored. Q3 ~Year 1
    - Agree target and plan for virtual / remote assessment / consultation Q2 ~Year 1

3. **Clinical Implementation Network** - Implement national guidelines with thresholds by Clinical Implementation Network (CIN) and procedure. Individual CINs will establish See on Symptom (SOS)

and Patient Initiated Follow-up (PIFU) targets by specialty & sub-specialty on an ongoing basis by March 2025. We will assess implementation timeline once received for cancer services. Q1 ~Year 1

4. **Therapies Services Review -** Rehabilitation following a diagnosis of cancer is recommended to help people retain their functional independence before, during and after oncology treatment.**-** Q3 ~Year 1
    - Recent peer review of Therapies service will inform development of appropriate workforce model.
    - Develop plan to ensure the on-going viability of the neuro-oncology service.
    - Develop plan for prehabilitation services.
    - Develop plan for robust rehabilitation service.
    - Develop plan to ensure therapy provision aligns with enhanced ambulatory and assessment functioning

5. **Clinical Psychology –** The team treats issues such as coping with diagnosis and treatment, cancer-related anxiety and depression, the impact of cancer on relationships.
    - Review of clinical psychology service, including funding strategy for palliative psychology service and staff psychology working with our Velindre Charity. - Q3 ~Year 1

6. **Patient Communications**
    - Communication delivery models to improve patient experience: electronic referral, booking process, telephony system, work with communications team to review and update patient information across Velindre Cancer Services. .**-** Q3 ~Year 1
    - Commission replacement video consultation system. Q1 ~Year 1

Outcomes – delivered in line with our Values:

Caring	***Respectful***	***Accountable***
12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route), building toward a national target of 80% by 31 March 2026.	*Consistent clerical and clinical validation should be in place on an ongoing basis and reported quarterly for impact.*	*Effective strategic development for Velindre Cancer Service.*

New Velindre Cancer Centre

The current Velindre Cancer Centre is more than 68 years old and in spring 2024, the build of the new Velindre Cancer Centre began, due to complete for opening in spring 2027. The new Velindre Cancer Centre will provide a range of cancer service facilities for the South East Wales region in partnership with Aneurin Bevan, Cardiff and Vale, Cwm Taf Morgannwg University Health Board Partners and Powys Teaching Health Board.

The award-winning design of the new cancer centre is both patient and staff-centred and one of the most sustainable hospitals in the UK. It will combine a state-of-the-art facility for treatment and research alongside an outdoor space that is calming, encourages improved biodiversity, and gives back to the environment and community.

The new Velindre Cancer Centre is funded through a Mutual Investment Model (MIM) with the support of the Welsh Government. The Mutual Investment Model is a Welsh Government designed model to finance major capital projects, for example social and economic infrastructure projects, to improve public services in Wales.

The Acorn consortium have designed and are building the new cancer centre. They will also be responsible for the maintaining of the hospital for 25 years after completion. As part of the readiness planning, the model for the management of the relationship and the interaction between the hard, provided by Acorn, and soft, provided by the Trust, facilities management will be in place.

The structure of the project work for the Trust until opening in 2027 is:

- **Design and Construction**
  - Completion of the final detailed design (through the Reviewable Design Data process).
  - An effective programme of monitoring and quality control of construction and commissioning of the new cancer centre by Acorn to the design, time and cost agreed.
  - Completion of the Enabling Works, which includes access and utilities to the site.
  - Implementation and monitoring of European Protected Species Licence.

- **Equipment, Commissioning and Migration**
  - Ensuring all the required equipment for the functioning of the cancer centre is in place and operational when the centre opens, through the specification, procurement, installation and commissioning.
  - Delivering a cancer centre that is commissioned (in respect of site commissioning, operational commissioning, equipment commissioning) and is operational for the delivery of services.
  - Coordinating a physical move from the current hospital to the new cancer centre that is safe, efficient and to the planned timescales.

- **Digital**
  - Design, build or procure, install, test and support the hardware, networks and software for the new cancer centre.

- **Engagement**
  - Programme of community engagement (“Hefyd”) alongside the construction works that includes the MIM community benefits and our response to the Well-being of Future Generations (Wales) Act 2015 and Environment (Wales) Act 2016.
  - Development and implementation of communications and engagement strategies that ensured all stakeholders, including our patients, staff and communities are informed, engaged and heard.

Regional and National Strategic Planning

Women’s Health

Women’s Health Plan for Wales was launched in December 2024 and illustrates a 10-year vision to improve healthcare services for women. Research shows that while women live longer than men, they live fewer years free from disability, wait longer for pain relief and many women report having their symptoms dismissed. Key matters for our services:

Blood Services

- The Blood Health National Oversight Group (BHNOG) is responsible for ensuring delivery of the NHS Wales Blood Health Plan, a key workstream of which is anaemia management that has identified as

significant opportunity in supporting the Women's Health Plan. The anaemia rates for patients undergoing major elective surgery of which the incidence rate of anaemia is twice as high in women than men (39% vs 19%).

- The anaemia workstream aligns with five of the eight priority areas, menstrual health, endometriosis and adenomyosis, preconception health, menopause and ageing well.

Cancer Services

- The Women's Health Plan highlights that as part of National Cancer Recovery Programme, as part of Planned Care on the five cancer types with the poorest cancer waiting-time performance. Two of the five chosen cancer types primarily affect women, (gynaecology and breast), as well as inequalities of outcomes also in the three other pathways, (skin, lower gastrointestinal (GI) and urology cancer). One-year survival outcomes for women with bladder cancer, for instance, is significantly lower than men (75% v 59%).

- It also highlights the impact of intersectionality and vulnerability, on outcomes in cancer care and survival. There is published research that shows that increased intersectionality leads to worse patient outcomes with respect to cancer.

Women's Hubs

- Each Health Board is establishing a Women's Hub by March 2026.
- We will work with our Health Board partners as part of the scoping exercises in Q1; business case development in Q2; approval and communication in Q3; and delivery in Q4 2025/6.

Milestones:

- For both blood and cancer services, adopt a multi-disciplinary approach, including Trust national leadership, to scope the way in which the Trust can add most value to improving outcomes for women and feed this into the development of Women's Hubs. Q1 ~Year 1.

Population Health and Prevention

We commissioned the Life Sciences Hub for a report on Future demand for cancer care in Wales which was received in February 2025 and will provide one of the important foundations for our long-term demand planning.

We recognise that we have a collective responsibility to maintain good health for individuals, communities and the health and social care system with a focus on preventing the onset of poor health and disease and on identifying and intervening early where disease occurs.

For our blood services we want to ensure we are maximising the value of every contact and for our cancer service, we want approach the meaningful moments with have with patients for engagement and education in a consistent and value adding way for Wales cancer outcomes.

Across all our services, we also recognise that the Trust has an important role to strengthen the health protection system to prevent, prepare and respond to existing and future health protection threats, including pandemics, on an 'all hazards' basis.

Milestones:

- Continuing with the multi-disciplinary approach established for the Women's Health plan in Quarter 1, agree our Population Health and Prevention strategy and implementation plan in Quarter 2 - Q2 ~Year 1.

Benchmarking and Excellence

We have been reflecting on how to strengthen our organisational approach to benchmarking and excellence, which will further strengthen our culture to be a reflective and learning organisation.

Milestones:
We have identified a number of work packages, including for instance, our approach to peer benchmarking and international centres of excellence accreditations. This work will be led by a Trust-wide community of practice, building on the maturity in various parts of the organisation already, and will be established in Quarter 1 - Q1 ~Year.

Regional Cancer Programme

The South East Wales Regional Cancer Programme was fully established in autumn 2024. With our system partners, the NHS organisations reviewed the current regional performance against nationally optimised pathways, existing cancer plans as well as the Quality Statement and Improvement Plan for Cancer. We collectively agreed on an initial programme of work:

- Shared Regional Cancer Patient Tracking List (PTL)
- Regional Multi-Disciplinary Team governance and support
- Regional workforce modelling
- Sustainable haemato-oncology model
- Regional model for prehabilitation and rehabilitation.

Milestones:
The full delivery plans are being worked up by each appointed lead and will be incorporated into the Trust's key milestones going forwards - Q1 ~Year 1.

Joint Academic Health Science Programme
The purpose of the Joint Academic Health Science Programme (JAHS) is to drive collaborative innovation, research and education that enhances patient outcomes and reduces health inequalities. By strategically aligning the expertise and resources of Cardiff University, Cardiff & Vale University Health Board and Velindre University NHS Trust (VUNHST), JAHS aims to deliver transformative care, reduce health inequalities and create lasting improvements in healthcare for future generations. The purpose and structure has been agreed by partners in March 2025 and this will also be aligned to:

- Development of an Advanced Therapies Innovation Hub, with linkages with Advanced Therapies Wales and/or Precision Medicine Programme(s)
- Cardiff Cancer Research Hub
- Child Health Services Transformation

Milestones:
The full delivery plans will be developed under this Programme and incorporated into the Trust's key milestones going forwards. – Q2 ~Year 1.

Quality

Duty of Quality and delivery across the 12 health and Care Quality Standards drives and underpins the Trust's decisions and planning of services. The Duty aims to:

- Improve the quality of health services
- Help people in Wales have more years in good health
- Listen more to people and patients and act on what is shared

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Priority 1 - Improve patient & donor communications

What will we do to achieve this:

1. Ensure 100% of letters following appointments are sent out to patients (unless the patient has opted out).
2. Ensure 100% of letters on the document management system (DMS) are approved and sent within 30 working days.
3. To improve patient communications regarding disease management and treatment.
4. To improve patient and donor appointment communications.

Priority 2 - Strengthen quality and safety infrastructure

What will we do to achieve this:

1. Ensure all levels of patient / donor safety investigations are robust and undertaken by trained investigators at the appropriate levels.
2. Ensure feedback and support is provided to all staff involved in the incident.
3. Develop a Trust wide accreditation plan – with clear trajectory to having nationally / internally recognised accreditation across all core services.
4. Strengthen the quality and safety infrastructure at a service level, including the development of core quality standards and metrics and clinical risk management.
5. Continue to strengthen the quality and safety culture across the organisation, including psychological safety.

Priority 3 - Improve patient & donor safety

What will we do to achieve this:

1. Reduce the harm from sepsis through early identification and treatment.
2. Reduce harm related to urgent clinical information being circulated via email.
3. Fully implement ‘Call for Concern’ in Velindre Cancer Service.
4. Ensure that 100% of bloods taken within Velindre Cancer Service are reviewed within 48 hours.
5. We will introduce Haemoglobin S testing to detect the presence of sickle-cell trait in specific whole blood donations.
6. Welsh Blood Service to review specialist red cell immunohaemotology (RCI) services.

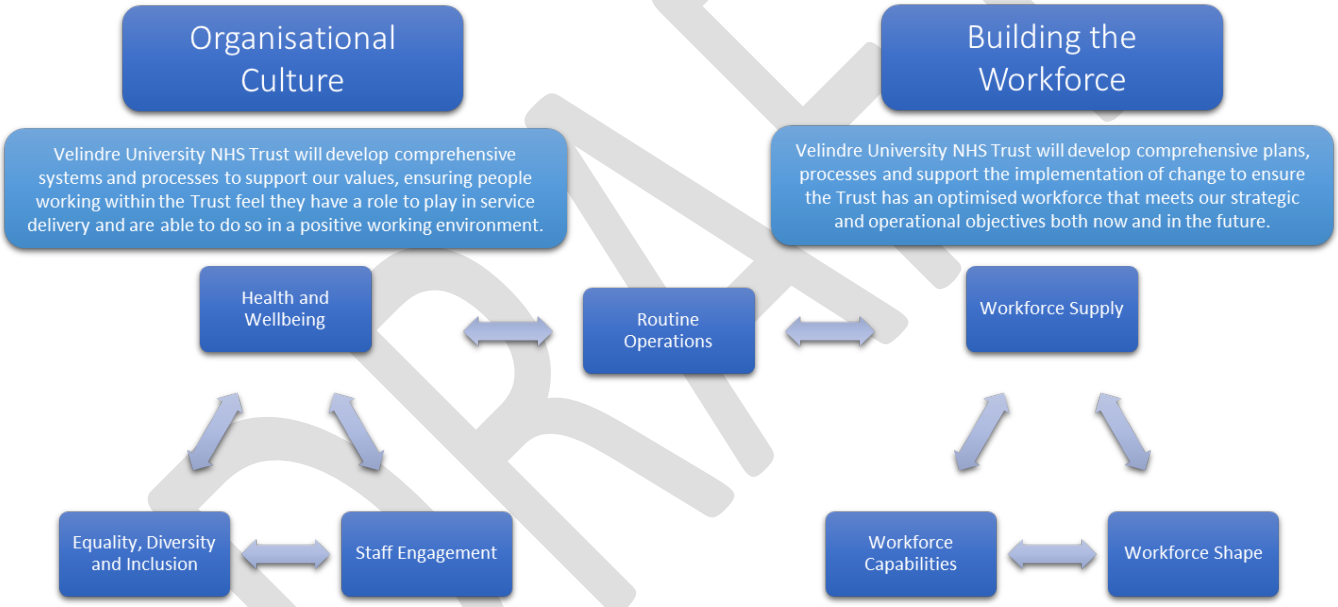
Priority 4 - Improve opportunities to gather and learn from peoples feedback

What will we do to achieve this:

1. Focus on people with additional needs to improve patient and donor experience.
2. Improvements to the mechanisms for staff to support people to speak up safely and with confidence.
3. Increase opportunities to gather patient and donor feedback through utilising SMS messaging.

Workforce and Culture

The Workforce and Culture plan outlines how we plan to attract, retain and develop our workforce by focusing on the two priorities of workforce and culture. Our vision is to have an engaged, motivated and high-performing organisation that is underpinned by our values and behaviours and resourced with people delivering exceptional services. Our People Strategy sets out the long-term ambition to be the employer of choice for those working in or considering a career in specialist blood and cancer services and this iteration of the Integrated Medium Term Plan demonstrates how we are proactively working towards this ambition. We are ensuring the Trust is resourced to maintain and continue to deliver exceptional work class services to our patients and donors.



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Milestones:

1. We will conduct a comprehensive review of all **Workforce Polices** ensuring documents are up to date with current legislation and best practice. This will involve engaging with key stakeholders, benchmarking and ensuring documents are easily accessible to all staff. Q4 ~Year 1

2. We will design and implement a **structured learning and development framework** by that enhances the skills and capabilities of the workforce as well as ensuring there are adequate leadership and management capabilities. ~Year 2

3. The People and Organisational Development Team will develop a **well-being and engagement framework** to support staff and ensure they feel valued and supported within the culture of the organisation. Q4 ~Year 1

4. The People and Organisational Development Team will support the Trust to develop a **workplace culture** for our people that is truly inclusive by developing compassionate frameworks aligned to statutory requirements for improving equality and diversity within Wales. ~Year 2

5. We will support the Trust to develop **workforce plans, both strategic and operational** based on the changing needs of the labour market and service delivery. Divisional plans will ensure detailed analysis of key workforce data ensuring any actions implemented will bridge gaps and challenges within the workforce. The final plans will be delivered by March 2026 with the next phase being implementation and change management from April 2026 to March 2028. ~Year 3

6. We will develop and implement a comprehensive talent attraction and retention by. This will include design and roll out of employer branding and attraction campaigns, development of career pathways and supportive access to work initiatives that improve workforce diversity as well as dedicated retention plans where needed within hard to fill roles. ~Year 2

Outcomes, delivered in line with our Values:

Caring	***Respectful***	***Accountable***

- Ensure a reduction in sickness absence in 2025/26 in comparison to 2024/25, through maximising adherence to the requirements of agreed attendance at work policies and adhering to the all-Wales Occupational Health minimum service levels.	- Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular. - Ensure effective implementation of job planning policy, to include ensuring that > 90% of all Consultants have an agreed job plan in place at all times by 30 September 2025.	- Deliver a further continued and sustained reduction in agency expenditure, with a target 30% reduction in 2025/26 from 2024/25 outturn, and ensuring no off-contract expenditure. - Ensure a reduction in agency spend on Healthcare Support Worker, Admin & Clerical, and Estates & Ancillary staff to zero by 30th September 2025.

Trust's Strategic Equality Plan

As part of our specific duties under the Equality Act 2010 and Regulations in Wales, the Trust is required to develop and publish a Strategic Equality Plan and its strategic equality objectives every four years and our current plan is set for 2024-8. This year's refresh incorporates the Anti-racist Wales actions.

1. **Fairness and Respect**
   Increase workforce diversity and inclusion and eliminate Pay Gaps We would like the workforce to better reflect the diverse nature of the communities that we serve and also to ensure that there is no systemic pay disparity between people of different genders, races or disability.

   Key Milestones:
   - Develop a positive organisational culture, across all training and communication mechanisms. Q4 ~Year 1
   - Implement the Trust's Widening Access Plan. Q4 ~Year 1
   - Implement the second phase of the Wales Anti-racist Action Plan. Q4 ~Year 1
   - Implement the LGBTQ+ Action Plan. Q2 ~Year 1

2. **Engagement**
   Engage with the community In order to ensure that we are providing services that our patients and donors want and need, it is important that we understand them and ask them about what things they want from us and how we might be able to do to that in better ways.

   Key Milestones:
   - Increase the number of donors across specified target groups in line with the Welsh Blood Service 5 Year Strategy. Q4 ~Year 1
   - Use Equality Impact Assessment process to prepare cancer services for the move into new Velindre Cancer Centre. Q4 ~Year 1

3. **Accessibility**
   Communicate with people in ways that meet their requirements. We have a variety of ways that we stay in contact with the people of Wales; letters, phone calls, social media; it is important that we are doing this in way that people can easily understand and in their first, or preferred, language.

   Milestones:
   - Any legislative changes in British Sign Language are translated into service plans. Q4 ~Year 1

- Implement the Welsh language clinical consultation plans. Q4 ~Year 1
- Any regulatory changes regarding accessibility are translated into service plans. Q4 ~Year 1

4. **Data**

Ensure service delivery reflects individual requirements. We provide specialist cancer services to the population of south-east Wales at a time when people are particularly vulnerable. We are also indebted to our donors who volunteer to give blood or tissue for the benefit of others. We want all these individuals to be able to access what they require as simply as possible.

Milestones:

- Review outcomes from Equality Impact Assessment activity in 2024-5. Q1 ~Year 1
- Build treatments around individual need with the move to the new Velindre@ Nevill Hall Radiotherapy Unit in 2025 and preparing for the new Velindre Cancer Centre. Q3 ~Year 1
- Data is used to improve staff experience in relation to Equality, Diversity and Inclusion. Q1 ~Year 1

Outcomes, delivered in line with our Values:

Caring	***Respectful***	***Accountable***
The diversity of donors will increase, particularly in relation to ethnic origin and sexual orientation. This will lead to better blood and transplant products being available to people across Wales so that differential health outcomes relating to ethnic background can be minimised. DATA Patients will receive increasingly personalised care tailored to their clinical need	Staff will feel safe, supported and respected which will enable them to thrive at work. Improved psychological safety will be reflected in staff survey results in 2025. A positive organsiational culture will lead to better services and lower costs (reduced turnover and sickness)	Equality Impact Assessments are essential to understanding variation in delivery in terms of who can access, and how people access health and care services is key to ensuring equitable delivery.

Digital

Over several years, the Trust has undertaken a number of significant developments in Digital Services which have made a positive difference to the quality, safety and experience for our service users. Alongside this the Digital team has been developing its digital and data capabilities to support the future plans for the Trust. This has been articulated in the Trust's Digital Strategy, "Digital Excellence: Our Strategy 2023-2033". Our Digital plan supports the strategy and enables the service plans for the Velindre Cancer Service, the Welsh Blood Service, and the new Velindre Cancer Centre. The plans are well aligned with national policy including the "Digital and Data Strategy" and "A Healthier Wales" and reviewed periodically at Board level.

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Our Digital Strategy describes our response to the Trust purpose to *'Improve Lives'"*, and its vision to deliver *'Excellent Care, Inspirational Learning, Healthier People'* and aligns well with the Welsh Government Health and Care Digital Strategy.

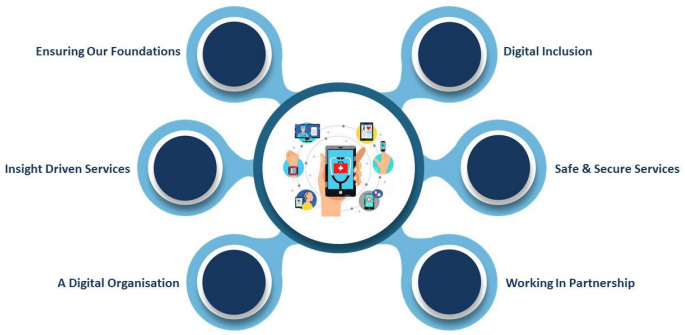


Figure 1 Digital Strategy Themes

Our Digital Vision

Our Digital Vision: To Ensure Patient, Donor and Staff Experience of Digital Services is the same as our Care… Outstanding.

Priorities for this Plan

Further to the enablement of the programmes the blood, cancer and new Velindre Cancer Centre digital programmes, other digital priorities include:

- Collaboration with the Electronic Health Record Club and National Business case to shape the future direction for Electronic Health Records in Wales. This will need to recognise the specialist nature of cancer services alongside an Electronic Health Records core all-Wales solution.
- Embedding digital leadership through the organisation through our Digital Inclusion plan and strengthen clinical safety representation in digital initiatives.
- Moving our Data and Insights plan forward and migration onto the National Data Repository and setting out the Trust position and governance with regards to Artificial Intelligence.
- Infrastructure and core services work on telephony/omni-channel solutions, the cyber action plan, continuing to remove legacy infrastructure and the continued migration of sites onto our new modernised network core.
- Implement actions plans from the Cyber Assessment Framework continued assessments to achieve the baseline profile and testing of Cyber capabilities.
- Strengthen our local Enterprise Architecture governance to contribute to and ensure compliance with the National Architecture and standards implementation.
- Upgrading digital systems in line with the recommendations from the Infected Blood Inquiry.

In order to affect a safe transition of digital services to new Velindre Cancer Centre we will be working through the transition plan to new Velindre Cancer Centre with a view to introducing a digital change freeze in 2026 which will need to be considered against future service plans.

Milestones:

1. **Ensuring our Foundations**

Trust

- Implementation of Call Centre telephony underpinning service plans – Q4 ~Year 1

Blood service

- Implementation of National LIMS 2.0 system – Q3 ~Year 1
- Migrate Prometheus donor matching from Digital Healthcare Wales – Q1 ~Year 1
- Live Connectivity (Connections) – Q2 ~Year 1

Cancer service

- Implementation of National Radiology Informatics System (RISP) – Q1 ~Year 1

- Deployment of Integrated Radiotherapy Solution Programme ~Year 3
- New SACT e-Prescribing contract and move to one national instance in contract – Q3 ~Year 1
- Phase 2 of key requirements for WPAS/WCP National systems ~Year 3
- Implementation of new Blood Establishment Computer System ~Year 3

2. Digital Inclusion

Trust

- Year 2 implementation of Trust Digital Inclusion Plan – Q4 ~Year 1
- Microsoft 365 colleague upskilling and adoption – Q4 ~Year 1

Cancer service

- New arrangements for Video Consultation platform – Q1 ~Year 1

3. Insight Driven

- Digitally enable Value Based Healthcare initiatives including implement new digital system for Patient Reported Outcome Measures (PROMS) for Value Based Healthcare – Q2 ~Year 1
- Quality measures Reporting – Q2 ~Year 1
- Forecasting methodology: Demand / Capacity – Q4 ~Year 1
- Review and rationalize Data and Insight Product Estate for improved user experience and insight – Q3 ~Year 1
- Data and Insight: explore the use of Artificial Intelligence to improve clinical coding – Q4 ~Year 1

4. Safe and Secure Systems

- Continue rollout of new Trust-Wide network for the new Velindre Cancer Centre, Talbot Green Infrastructure and trust Headquarters. ~Year 2
- Continue to implement strategic cyber security plan – Q4~Year 1
- Continue to remove legacy infrastructure and refresh backup and storage arrangements – Q4 ~Year 1
- Complete migration from Windows 10 to Windows 11 and create a common user/device experience – Q4 ~Year 1
- Pilot and scale Single Sign-On – Q2 ~Year 1

5. A Digital Organisation

Trust

- Scale Robotic Process Automation (RPA) and automation – Q4 ~Year 1
- Scale the Digital Training Platform (Learn365) and continue to develop digital skills programmes – Q4 ~Year 1
- implement Velindre Fundraising Donor Relationship Management and plan for WBS Donor Contact Centre ~Year 3

Blood service

- Go-live for new digital system for WHAIS – Q1 ~Year 1 and commence next phase – Q2 – Year 1
- implementation of new digital system for the Welsh Bone Marrow Donor Registry ~Year 3

Cancer service

- Implementation of electronic Prescribing General Medicines (eEPMA) ~Year 2
- Scoping/Discovery for digitalisation of Medical Records – Q1 ~Year 1

6. **Working in Partnership**

Blood service

- implementation of new digital system for NEQAS external quality assessment service – Q4 ~Year 1

Cancer service

- Digital services go-live Velindre@ Nevill Hall Radiotherapy Unit Q1 ~Year 1
- Progress new Velindre Cancer Centre Digital workstream ~Year 3

Outcomes, delivered in line with our Values:

Caring	***Respectful***	***Accountable***
Collaborative national working.	Robust governance and clinical safety for cyber and digital including Artificial Intelligence	An organisational wide digital and data strategy that is underpinned by a sustainable financial plan.

Estates, Health & Safety and Sustainability

Our strategic priorities for Estates for this Plan are:

- A safe and high quality estate which provides a great experience
- Healthy buildings and healthier people
- Minimising our impact
- Use our estate to deliver the maximum benefit and social value to the community.

In addition, our areas of focus for sustainability:

- Creating wider value: our organisational approach
- Sustainable care models
- Eliminating carbon
- Sustainable infrastructure
- Transition to a future of renewables
- Sustainable use of resources
- Connecting with nature
- Greening our travel and transport
- Adapting to climate change
- Our people as agents of change

The Estates, Health & Safety and Sustainability function are central to all the infrastructure development across the Trust that have been outlined in this Plan.

Additional **Milestones:**

- Establish effective sustainability governance structure and model for funding streams and management of savings, building on Site Improvement Plan approach – Q2 ~Year 1
- Integration of Well-being Objectives to long term goals – Q4 ~Year 1
- Development of Climate Adaption risks and comprehensive plan, including embedding the climate emergency clearly and effectively into decision-making– Q4 ~Year 1
- Implementation of effective, and based on best practice, Health and Safety Management System ("P" – Principle):

  Year 1
  - P1 - Leadership and Accountability
  - P2 - Competent People
  - P3 Compliance Assurance

  Year 2
  - P4 Risk and Opportunities
  - P5 Learning from Events
  - P6 Occupational Health
  - P7 Asset Management

  Year 3
  - P8 Contractor and Supplier management
  - P9 Communication
  - P10 Emergency Preparedness
  - P11 Measuring Performance
- Effective implementation of Computer Aided Facilities Management Software – Q2 ~Year 1
- Strategic agreement and implementation of plans for the Whitchurch Hospital site - Q3 ~Year 1
- Transition of Estates staffing model to meet the changing landscape of the Trust Estate. Focus on management of the Mutual Investment Model (MIM), implementation of an workforce model to meet the approach required in readiness for the new Velindre Cancer Centre – Q4 ~Year 2
- Strengthen partnerships and collaboration across public and private sectors, including with Specialist Estates Services – Q4 ~Year 1

Outcomes, delivered in line with our Values:

Caring	***Respectful***	***Accountable***
The NHS in Wales is responsible for ~2.6% of the total carbon emissions of Wales and fallen behind other sectors when it comes to reducing its environmental impact. The Trust will play an important role in reversing this trend.	Effectively supporting the ambitions of Stronger, Fairer, Greener Wale as part of a Foundational economy	Effective Health and Safety Management system in place which is in line with industry best practice.

Research and Development

Cancer

We are committed to its strategic vision of being "A beacon for research, development, and innovation." The Trust's Research and Development function plays a pivotal role in advancing healthcare through clinical trials, translational research, and multidisciplinary collaborations. As part of this Plan, the Trust aims to further strengthen its research capacity, aligning with the Welsh Government's priorities for evidence-based

healthcare improvements and innovation-driven service delivery. The overarching objective is to enhance patient outcomes, embed research within clinical practice, and ensure that every eligible patient has the opportunity to participate in a clinical trial.

Strategic Priorities in Research and Development
The Trust's cancer research priorities are structured around four key strategic themes:

1. Driving Forward the Cancer Research and Development Ambitions.
The Overarching Cancer Research and Development Ambitions 2021-2031 strategy outlines the Trust's commitment to leading and participating in high-impact cancer research. This includes:

- **Expanding Early and Late Phase Clinical Trials:** Developing the VUNHST research portfolio expanding to the Cardiff Cancer Research Hub (CCRH) to facilitate early- and late- phase complex trial delivery, and translational research in partnership with Cardiff & Vale University Health Board and Cardiff University.
- **Integrating Translational Research:** Bridging laboratory discoveries with clinical applications, ensuring that new treatments move swiftly from research to patient care.
- **Enhancing Radiotherapy Research:** Capitalising on the development of the new Velindre Cancer Centre (nVCC) to expand radiotherapy research capacity and capability, and embrace the opportunity offered by the radiotherapy research bunker at nVCC to deliver cutting edge radiotherapy research for cancer patients in Wales.
- **Increasing Patient Participation in Research:** Ensuring that an increasing proportion of Velindre cancer patients are offered opportunities to engage in research including clinical trials.
- **Establishing Clinical Academic Posts:** Strengthening collaborations with academia to create research-focused clinical and translational posts that support sustainable research growth.

2. Strengthening Clinical Trials and Research Infrastructure.
VUNHST is dedicated to maintaining and expanding its role as a leading research sponsor and trial site. The focus areas include:

- **Sponsorship:** Increasing the Trust's portfolio of sponsored studies by building on strong experience and well-established reputation as a leading sponsor of clinical research, demonstrated in a proven track record in successfully sponsoring multi-centre UK investigator led studies and co-sponsoring international research, with a commitment to excellence.
- **Clinical Research Treatment Unit (CRTU):** Increasing capacity to conduct Phase I-III clinical trials at VCC in collaboration with Cardiff's Experimental Cancer Medicine Centre (ECMC).
- **Expanding Research Workforce:** Recruiting additional research delivery staff, governance staff, and specialist support service staff to enhance trial delivery.
- **Developing Satellite Research Units**: Establishing research in the Velindre@ Nevill Hall Radiotherapy Unit, to ensure equitable access to radiotherapy trials for patients from across South-East Wales.
- **Enhancing Data Capabilities:** Leveraging artificial intelligence, digital trial management systems, and remote monitoring technologies to optimise research delivery.

3. Maximizing National and International Research Collaborations
Collaboration is central to the Trust's R&D strategy. The Trust's research service key initiatives include:

- **Participation in Wales and UK Research Networks:** Engaging with organisations such as Health and Care Research Wales (HCRW), Wales Cancer Research Centre (WCRC), and Experimental Cancer Medicine Centres (ECMC).
- **Commercial Research Partnerships:** Expanding commercial clinical trials through utilisation of VPAG funds and via collaborations with pharmaceutical companies, ensuring sustainability through reinvestment of commercial income.
- **Advancing Genomic and Precision Medicine Research:** In partnership with the All-Wales Medical Genomics Service, VUNHST aims to establish the UK's first routine 500-gene panel for metastatic cancer patients.

4. Embedding a Research Culture within the Organisation
To ensure sustainable research development, the Trust will:

- **Integrate Research into Clinical Pathways:** Ensure that research is an "Always Event," making trial participation a routine option for eligible patients.
- **Develop the Velindre Oncology Academy:** A research and education initiative to support the next generation of cancer researchers and clinical academics.
- **Strengthen Patient and Public Involvement (PPI):** Engage patients and communities in research design and priority-setting to ensure alignment with patient needs.
- **Enhance Research Training and Career Development:** Offer research-focused fellowships, mentorship programs, and CPD opportunities to build capacity across the Trust's workforce.

Milestones:

- Increase patient access by 30% from FY2024/25 by FY2027/28 ~Year 3
- Increase of 10 new trials per year. ~Year 2
- Increase of 3 new trials delivered via the Cardiff Cancer Research Hub per year. ~Year 2
- Increase of five trials involving radiotherapy per year ~Year 2
- Increase in research active posts across the Trust by 10% from FY2024/25 by FY2027/28, including five new clinical academic posts. ~Year 3
- Increase commercial income by 50% by 2028. ~Year 3
- Increase in five collaborations per year ~Year 2

Transfusion and Transplantation Research Welsh Blood Service Research, Development and Innovation strategy was approved in November 2024 and commits to seven missions and actions. Each mission area aims to sustain a number of ongoing innovative research project throughout the three years 2025 to 2028.

- Mission One: Centred on improving patient and donor care.
- Mission Two: Advancing Blood Components
- Mission Three: Advancing Transplant Research in Wales.
- Mission Four: We will use Innovation and Value-Based Healthcare to improve our services and performance.
- Mission Five: Using Collaboration to Sustain our RD&I
- Mission Six: Serve the people of Wales by supporting international initiatives.
- Mission Seven: Enhance the impact of RD&I and celebrate success.

Outcomes, delivered in line with our Values:

Caring	***Respectful***	***Accountable***
Ensuring that research improves patient experience and enhances quality of life.	Promoting collaborative research that considers diverse patient perspectives and community needs.	Maintaining transparency in research funding, governance, and impact assessment.

Innovation

Our Vision: To be an International Beacon for innovation in Cancer and Blood Services.

Our mission: To drive continuous improvement and breakthrough innovations in cancer and blood services by fostering a culture of innovation, creativity, collaboration, and excellence.

Strategic Objectives for innovation

1. **Enhance Patient Outcomes and Improve patient and donor Experience:** Develop and implement innovative treatments and care pathways that improve patient survival rates, quality of life, and overall experience for patients and donors.
2. **Improve Operational Efficiency:** Utilise innovation to streamline processes, reduce costs, and improve the efficiency of service delivery.
3. **Strengthen Collaboration:** Build strategic partnerships with academic institutions, industry, third sector, government /governmental support organisations and other healthcare organisations to accelerate innovation.
4. **Cultivate an Innovation Culture:** Encourage a culture of innovation among staff through continuous learning, incentives, and support for creative initiatives.

Our implementation themes provide us with the framework for our activities to support the delivery of our objectives.

1. **A collaborative innovation ecosystem:** Our vision includes building a collaborative innovation ecosystem where staff, healthcare providers, researchers, academia, industry, patients, donors and community partners work seamlessly together to drive innovation, address healthcare disparities, and create healthier communities. We are building an ecosystem that supports and strengthens the capability and capacity for the Trust to innovate. We will implement the ISO 56001 (International standard for Innovation to provide a framework for our innovation ecosystem to thrive. **The CCLI** aims to improve whole system cancer care through collaboratively accelerating cancer research, innovation education and involvement. Providing a virtual and physical space to encourage creativity, collaboration, and knowledge exchange with practical and positive impact on cancer care for all those involved. The Collaborative Centre will strengthen the innovation infrastructure and ecosystem for the Trust.
2. **A culture of innovation:** We are dedicated to fostering a culture where every member of our organisation is empowered, informed, and supported to innovate, experiment, and embrace change, making innovation a way of life rather than an isolated event.
3. **Clear communications and recognition:** We are committed to delivering clear communications to support the capability and capacity building for Innovation within the Trust. Recognising the efforts of our staff, patients, donors, community, funders partners and stakeholders; and reinforcing our Trust culture of innovation. This includes
4. **Patient and Donor Centred Excellence**: aspiring to redefine patient and donor centred care, placing patients and donors at the heart of every decision, ensuring their voices are heard, and tailoring healthcare experiences to their unique needs and preference.
5. **Leadership and role modelling:** As a University Designated Organisation – Senior Leadership are committed to sponsoring key initiatives and novel projects and ensuring that Innovation, Research, Development, Learning and Education opportunities are enabled and reflected in job roles and responsibilities and provide the support and resources needed to drive innovation.
6. **Advancing Technology Integration:** Our approach is to harness the power of cutting-edge technologies, including artificial intelligence, telemedicine, wearable devices and data analytics, to optimise treatment, experiences, inform diagnostics and preventative care, with the aim of making services more accessible and efficient.
7. **Data Driven Insights:** Leveraging data as a strategic asset, using it to inform our innovation activities and efforts.
8. **Health equity and Inclusion:** Our commitment extends to achieving health equity and inclusion for all with a focus on disparities in healthcare access and outcomes. Our innovations will strive to remove barriers to care and promote health equity.
9. **Empowerment and Autonomy:** Empowering employees by giving them autonomy to propose and implement innovative ideas within their areas of expertise.
10. **Training and Development:** Innovation training is key to building the capability and capacity of the innovation infrastructure for the Trust. It will equip staff with the knowledge, skills and mindset necessary to drive innovation, improve patient and donor care, and adapt our delivery approaches to the changing

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innovation landscape. It helps create a culture where innovation is not just encouraged but also effectively implemented for the benefit of our patients and donors.

Milestones:

- Establish Innovation Infrastructure – Q2 ~Year 1
- Launch Idea platform – Q1 ~Year 1
- Strengthen Infrastructure for Cultural enablement and Communication via training and Innovation champions – Q2 ~Year 1
- Effective project secretariat, reporting structures and benchmarking approach – Q2 ~Year 1
- Apply/Achieve for ISO 56001 certification; receive international award.~ Year 3

Outcomes, delivered in line with our Values:

Caring	***Respectful***	***Accountable***
Ensuring that innovation activities improve patient experience and enhances quality of life.	Promoting collaborative innovation that considers diverse patient /donor perspectives and community needs.	Strong leadership demonstrated, maintaining transparency in governance and reporting approaches for innovative ways of working and partnerships.

Value Based Healthcare

Our vision is to enable clinical and operational teams to deliver exceptional services, using linked datasets to identify and deliver continuous improvements that maximise the value, quality, safety, and efficiency of the service our donors and care our patients receive.

In 2023 the Trust received an allocation from the Welsh Government VBHC (Value Based Health and Care) fund to implement 2 programmes, Pre-op Anaemia and the Value Intelligence Centre. In addition to these, the Trust has ratified a Food Mission which is included within the programme.

Pre-op anaemia programme:
This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery. It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG). The evidenced benefits are:

- Prudent use of donated blood and reduced demand for blood
- Improved clinical outcomes post operatively, especially after major surgery
- Reduced length of stay post-surgery
- Ensuring equity of care and outcomes across Wales in pre-operative anaemia management
- Providing evidence for further roll out of the All-Wales Anaemia Pathway to benefit others.

Recurrent funding has been allocated to each Health Board to recruit clinical staff to support Blood Health Management, and for the programme team within Welsh Blood Service.

Milestone: In 2025 the programme will launch the Preoperative Anaemia Screening Major Surgery Dashboard, and continue to work to develop a data flow for transfusion and use of IV iron. This work aligns with the Infected Blood Inquiry. – Q3 ~2025

Value Intelligence Centre:

The Value Intelligence Centre works across the organisation to enable the optimisation of care through the application of Value Based Healthcare principles.

The team comprises of project management, data, finance and business analysts.
We will achieve our vision through the following enabling workstreams:

- Training, Engagement and Communication
- Technical Development:
- Data Maturity:
- Data Driven Sense Making and Action Planning
- Digital PROMs Platform
- Patient Outcomes

The additional information that patient reported outcomes brings to clinical practice represents a seismic shift in our ability to support shared decision making and patient centred care. The Value Intelligence Centre will work to ensure that the enabling structures are in place to support services with this transition.

Milestone - Over the next 3 years, clinical and operational teams will see a step change improvement in capability to evaluate patient reported outcomes alongside cost of treatment and be supported to change and refine practice as a result. ~Year 3

Food Mission:
The Trust's Food Mission sets a long-term ambition to provide our people with access to affordable, healthy food with an objective to source 70% of our food from Welsh, environmentally friendly or globally responsible providers by 2035. This will improve the wellbeing of patients, donors, staff, and their families. Further, it will support the delivery of our wider Value Based Healthcare, workforce and sustainability strategies, the Trust's Wellbeing Objectives, and our ambition to reach Net Zero by 2030.

Milestone: Actions to support this ambition include a menu redesign, swapping catering and hospitality items for enabling access to healthy food, developing knowledge and skills of staff on this subject, working with Procurement to achieve both value and values for money through shorter supply chains and helping to deliver the Social Partnerships and Public Procurement (Wales) Act 2023. ~Year 2

Caring	***Respectful***	***Accountable***
Raise awareness of Value Based Healthcare including education, motivation and incentivisation for staff to undertake Value Based Health Care projects	*Evidence of integration of early and secondary prevention in line with other priority areas highlighted in this guidance.*	*Implementation of Value & Sustainability Board recommendations, which includes local implementation of clinically endorsed and mandated product choice to maximise market share and deliver best value.*

Velindre University NHS Trust Charity

Velindre University NHS Trust Charity has been a beacon of hope and support for cancer patients in South and Mid Wales for over 28 years. Its mission has been to provide comprehensive care, support, and research funding to improve the lives of those affected by cancer. With a proven track record of success and a strong regional presence, we must now determine a route for expansion to not only advocate for cancer at a regional level, but potentially at a national level, while ensuring the Welsh Blood Service has a comparable route for representation in the charity sector.

Our vision: "Invest in promoting quality, care and excellence in services provided by Velindre University NHS Trust.

Our mission: “To support the Trust’s provision of world class research-led treatment, care and support for patients and families affected by cancer as well as other patients supported by the Trust and those who are involved in the donation of blood or stem cells.”

Our funds are used in two key ways in the delivery of this Plan. Most are used to support innovative research and clinical trials. These trials can aid the development of advanced treatments that enhance patient and donor care, and improve the quality and safety of blood components and products. Secondly, there is significant expenditure on patients and staff welfare by funding support services, therapies and equipment. These resources help to improve the quality of patient care and contribute to staff well-being.

Milestones:

1. Enhance Digital Fundraising Efforts
Objectives:
- Launch a new, user-friendly online donation platform ~Year 1.
- Develop and execute a digital marketing campaign to promote online giving ~Q4 Year 1
- Achieve £10,000 per month income against online donations by the end of ~Year 2.

2. Launch a Major Charity Expansion Plan to Incorporate Velindre Cancer Services and the Welsh Blood Service

Objectives:
- Within the first six months of agreement, develop a strategic plan to integrate Velindre Cancer Services and the Welsh Blood Service creating a Trust wide charity. ~Year 1
- Foster collaborative relationships with Velindre Cancer Services to enhance patient support and fundraising initiatives ~Q4 Year 1
- Work with the Welsh Blood Service to promote blood donation drives and increase donor participation by the end of ~Year 2.
- Achieve a noticeable increase in donations through joint initiatives with Velindre Cancer Services and the Welsh Blood Service ~Year 3.

3. Expand Donor Base
Objectives:
- Implement a donor acquisition plan targeting individuals, corporations, and foundations within year 1.
- Increase the number of active donors by 10% ~Year 2.
- Establish a donor retention program to maintain and grow donor relationships, aiming for a 15% increase in repeat donations ~Year 3.

4. Organise High-Impact Fundraising Events
Objectives:
- Plan and execute at least four major fundraising events annually, ~Year 1.
- Collaborate with local businesses and celebrities to boost event visibility and participation. ~Year 2.
- Raise a cumulative total of £1million from events ~Year 3.

5. Strengthen Corporate Partnerships
Objectives:
- Identify and approach potential corporate partners ~Year 1
- Secure at least five major corporate sponsorships ~Year 2.
- Develop long-term partnership agreements to ensure sustained support, aiming for a 25% increase in corporate donations ~Year 3.

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Transformation Roadmap [Graphic]

2025		
	June	Velindre@ Nevill Hall Radiotherapy Unit open Integrated Radiotherapy Solution Phase 2 complete Radiology Informatics System (RISP) go live
	July	New Velindre Cancer Centre earthworks complete
	October	Welsh Laboratory Information Management System (WLIMS) go live Welsh Histocompatibility and Immunogenetics Service (WHAIS) go live
	December	Talbot Green Infrastructure Business Case approval
2026		
	April	Talbot Green Infrastructure construction starts
	September	New Velindre Cancer Centre construction phase 1 complete and access for Trust starts
	October	Electronic Prescribing and Medicines Administration (ePMA) implementation
2027		
	April	Integrated Radiotherapy Solution (final) phase 3 complete
	June	New Velindre Cancer Centre open
	November	Blood Establishment Computer System (BECS) go live
2028		

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Overview of our Financial Plan – 2025/26 – 2027/28

This section sets out our Medium Term Financial Plan from 1st April 2025 to 31st March 2028. During this period, the Financial Strategy aims to enable the Trust to meet the anticipated growing demand for services whilst dealing with significant financial challenges due to a number of major strategic developments as part of the Trust's transformation programme. In addition, there are other significant cost and service pressures as well as the cost of implementing additional capacity to deal with rising demand, which will need to be funded by the Trust, Commissioners and Welsh Government in 2025/26.

As outlined in the Health Board Allocations 2025-26 document issued by Welsh Government, the Trust understands that a 1.77% uplift to Recurrent Discretionary Allocations will be provided in 2025-26. In line with Welsh Government policy, and further guidelines received from the NHS Executive Financial Planning and Delivery directorate, we recognise that the funding settlement is intended to support sustainability, unavoidable demand and core cost inflationary pressures. Further, the Trust recognises Welsh Government's expectation that an equivalent 1.77% allocation will be passed through to Provider organisations by Commissioners.

The Trust financial plan assumes that its Commissioners pass the 1.77% uplift to the Trust via its Long-Term Agreements (LTAs) which is clearly articulated in the allocation letter, which together with a 2.8% savings target, is a fundamental assumption in enabling the Trust to develop a balanced financial plan in 2025/26. However, the ability to deliver a balanced budget during 2025-26 is currently subject to the Trust receiving the Same Day Emergency Care (SDEC) funding on a recurrent basis.

The Trust is expecting to deliver a balanced financial position over the three year period, however there are challenges and risks in achieving this.

The financial plan for 2025/26 consists of three distinct parts:

Core Plan: Balanced - (At Risk)

Balanced Brought Forward Position:

- The Trust brought forward a balanced position into 2024/25, and despite challenges has managed to maintain this position bringing a balanced position into 2025/26.
- The Trust received significant challenge during 2024/25 from some of its commissioners in relation to the pass through of discretionary income from Welsh Government which resulted in the Trust receiving £0.737m less LTA income than anticipated during the period with £0.254m being on a recurrent basis. This was managed by the Trust through a combination of increased savings target and reducing or mitigating cost pressures and reducing investment decisions.
- The Trust Finance Team have been in regular dialogue with our Commissioners regarding the Trust income assumptions and have agreed LTA funding principles with all Commissioners. However, in order to reach agreement with Hywel Dda on LTA principles and financial value the Trust has had to agree a compromise position with a non-recurrent reduction in NICE / HCS income of c£0.483m as agreed in 2024-25 to reflect resources consumed rather than historic shares. The Trust continues to face a significant recurrent income risk with Hywel Dda beyond 2025-26 of c£0.843m who have given notice that the NICE/HCD £0.483m and historic shares activity baseline funding of c£360k will be removed recurrently in 2026-27.
- During 2024-25 LTA activity performance is expected to underachieve the income growth target set by c£0.300m which will result in marginal income not matching the level of service investment that was made

to support capacity within VCS. Whilst LTA activity performance has improved in recent months it will remain a financial risk during 2025-26.

- Welsh Government provided recurrent funding towards the increase in energy costs during 2024-25 which eliminated the underlying cost pressure.
- The Trust has received notification that the SDEC funding will cease at the end of 2024-25 which could lead to the Trust reporting a financially unbalanced position for 2025-26 which will need to be recovered on a recurrent basis from the discretionary uplift funding during 2026-27. The Trust is however in dialogue with Welsh Government Officials regarding continued funding of £0.867m to cover the cost of the SDEC IO Toxicity Clinics and Ambulatory care services which has always been considered recurrent funding by the trust in its Financial Plan, given that the costs are recurrent and the service which has been running for a number of years clearly required substantive staffing when first established. The Trust has provided Welsh Government Officials with a cost – benefit analysis as requested which demonstrates the impact these services have had on reducing Accident and Emergency admissions and inpatient length of stay in Health Board hospitals.

Growth Pressures:

- The 1.77% core discretionary uplift (sustainability) funding will be required to fund the significant underlying cost pressures, investment in capacity beyond marginal cost, the revenue investment decisions in relation to the Trust's major infrastructure and equipment projects.
- Divisional cost pressures above those recognised in the Financial Plan at this stage will either need to be mitigated, funded from existing budgets in service divisions or require additional savings above the £2.3m (2.8%) target already identified.

Savings Plans:

- The following table summarises the level of savings the Trust is planning to deliver during 2025-26 which will be required to support the level of investment decisions and cost pressures within the system.

Savings Plan	2025-26 £000
CIP Planned Savings	1,560
Income Generation	720
Total Savings / Income Generation	**2,280**
CIP % (of Core LTA values)	**2.8%**

Financial Plan

The plan aims to provide services with sufficient capacity to meet demand, whilst targeting improved levels of efficiency and productivity alongside sustained delivery against national targets and / or professional performance standards. In terms of efficiency the Trust has set a 2.8% savings target of £2.3m in 2025-26.

In addition to this internal savings target and the associated savings schemes the Trust is leading on a number of all Wales service developments that are currently leading to, or will lead to, capacity release, cost avoidance and cost reduction in Health Boards.

Whilst the Trust is submitting a three year balanced financial plan there is significant financial risk and challenges to deliver this plan particularly in the first year due to the uncertainties around the income it will receive to cover the committed capacity investment in Velindre Cancer Services, and whether or not the Trust will receive recurrent funding to support SDEC services.

The proposed financial plan has been developed using the latest assumptions regarding the Trust's expected income from Commissioners and Welsh Government, the likely cost pressures facing the Trust, both pay and non-pay inflation, and realistic, but challenging view of the cost saving potential of our services.

These assumptions have been discussed and agreed with Commissioners and Trust Board through the engagement process.

The formal agreement of the Trust income planning assumptions will be summarised within respective Commissioner Long Term Agreements for 2025-26 with planning principles agreed on the 28th February 2025 with a view to formally sign all agreements by June 2025. A summary financial plan reflecting the marginal revenue and cost impact for period 2025-26 to 2027-28 is presented in the following table:

	2025/26		2026/27		2027/28	
Summary of Financial Plan 2025-28	**In Year Effect £000**	**FYE of Recurring £000**	**In Year Effect £000**	**FYE of Recurring £000**	**In Year Effect £000**	**FYE of Recurring £000**
Underlying Core Position b/f	0	0	(867)	(867)	0	0
Unallocated reserves b/f	0	0	0	0	0	0
b/fwd. underlying deficit	**0**	**0**	**(867)**	**(867)**	**0**	**0**
Revenue						
Anticipated Commissioner Income:						
LTA Core Uplift (1.77% 25/26 assumed 1.5% for 26/27 & 27/28)	1,065	1,548	1,340	1,340	1,361	1,361
VCS & WBS LTA Income Growth for NICE / Blood Products	11,996	11,996	12,628	12,628	13,355	13,355
VCS LTA Service Growth Investment	1,392	1,392	50	50	6,907	4,377
VCS LTA Marginal Income for Service Capacity Investment	1,307	1,307	1,200	1,200	1,200	1,200
Anticipated WG Income:						
New VCS MIM ASP Payments and Infrastructure Support					34,691	34,691
WG AME & Non Cash (Includes Accelerated Depreciation, Impairment Charge and IFRS 16)	17,142	0	13,421	0	16,986	0
WG SDEC Funding withdrawn	(867)	(867)				
Total Revenue	**32,035**	**15,376**	**28,639**	**15,218**	**74,499**	**54,983**
In year Changes to Operational Cost Base						
VCS LTA Service Growth Investment for IRS, AO, RSU, nVCC	(1,392)	(1,392)	(50)	(50)	(42,476)	(39,666)
VCS NICE Drug Growth	(7,785)	(7,785)	(7,785)	(7,785)	(7,785)	(7,785)
WBS Blood Derived Products Growth	(4,212)	(4,212)	(4,843)	(4,843)	(5,570)	(5,570)
VCS LTA Marginal Income for Service Capacity Investment	(1,307)	(1,307)	(1,200)	(1,200)	(1,200)	(1,200)
National / General Cost Pressures	(188)	(188)	(171)	(171)	(171)	(171)
Divisional Cost & Service Pressures	(3,095)	(2,545)	(2,302)	(1,602)	(2,312)	(1,891)
WG AME & Non Cash (Includes Accelerated Depreciation, Impairment Charge and IFRS 16)	(17,142)	0	(13,421)		(16,986)	
Total In Year Changes to Cost Base	**(35,120)**	**(17,428)**	**(29,772)**	**(15,651)**	**(76,499)**	**(56,283)**

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Net Opening Balance before Savings	**(3,085)**	**(2,052)**	**(2,000)**	**(1,300)**	**(2,000)**	**(1,299)**
Savings Plan 2.8% (2025/26)	2,280	1,185	2,000	1,300	2,000	1,300
Net Opening Balance	**(805)**	**(867)**	**0**	**0**	**0**	**0**

Income Assumptions

Income Assumptions and Extent of Alignment with Commissioner and Welsh Government Plans:

The following are the income growth assumptions the Trust has made to meet the unavoidable inflationary, demand and growth pressures forecast during 2025-26:

- Commissioners will uplift LTA values by 1.77% which amounts to £1.548m core uplift in 2025-26 less £0.483m loss in income non-recurrently from Hywel Dda. For planning purpose. The Trust is assuming a 1.5% uplift to LTA values for 2026-27 and 2027/28. The Trust expectation is the uplift is 1.77% and will be passed on by the commissioners as clearly set out in the Health Board Allocation Letter.
- Commissioners will pass through as additional income to the LTA the 2024-25 Agenda for Change Medical and Senior Manager (VSM) staff costs as per the Welsh Government Pay award matrix.
- The 2025-26 Pay Inflation is not currently agreed but is expected to be funded directly by Welsh Government over the three years of this Plan based on actual staff in post (any shortfall such as staff increments and use of bank staff will need be met by discretionary uplift, additional savings or absorbed by Divisions).
- **In line with Welsh Government guidance any planning assumption for the 2025-26 pay award is excluded from the financial plan, but the assumption is Welsh Government will continue to fund in addition to the 1.77% uplift.**
- Funding for the Real Living Wage (the impact of the policy on Social Care) will be dealt with as a non-recurrent allocation, addressed in year.
- The cost increase in employer's pension contributions from 14.3% to 20.6% will continue to be paid by Welsh Government. (**Per Welsh Government guidance excluded from the plan**)
- Allocations for accelerated depreciation, AME depreciation for donated assets, relevant IFRS 16, and DEL and AME impairments will be issued as direct funding from Welsh Government. This will also apply to any increases in depreciation related to approved schemes with confirmed strategic support.
- Activity demand modelling forecasts £1.300m additional LTA marginal cost income above the 2024-25 projected outturn.
- The Trust will receive pass through income from commissioners to cover the cost of NICE / High-Cost drugs the Velindre Cancer Service uses in delivering cancer care. The forecast annual cost growth has been estimated using historic trends and the latest horizon scanning, this amounts to a £7.800m increase in 2025-26.
- The Trust will receive pass through income from Health Boards through their Service Level Agreements (SLAs) to cover the cost of wholesale blood derived products the Welsh Blood Service supplies to them. The forecast annual cost growth for 2025-26 has been calculated based on an estimated 15% volume growth and general price inflation totalling £4.200m.
- In 2022-23 the Trust secured funding from Welsh Government from the Value Based Healthcare fund. Funding will continue be held by Welsh Government and invoiced based on actual costs.
- Welsh Government and / or Joint Commissioning Committee will fund the WBS Plasma for Medicines (Fractionation) business case.
- Welsh Government and / or Joint Commissioning Committee will fund the BECS blood management system business case.

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- WBS has been managing a number of financial risks within the service that support supply chain sufficiency, demand and patient safety. In addition, since the publication of the Infected Blood Inquiry in May 2024, the service will be required to improve patient safety for transfusion wherever possible.

  The Trust submitted five Welsh Blood Service business cases relating to key service areas for consideration that help either maintain or improve the safety of the supply chain for the transfused patients in Wales. These cases include:

  1. £0.196m for additional capacity 24/7 for the Red Cell Immunohaematology laboratory
  2. £0.070m for implementation of Haemoglobin S (HbS) testing to comply with national guidance
  3. £0.675m for investment in component development research laboratory capacity to ensure validation and development work required to meet regulations e.g. requirement to replace blood packs which currently contain plasticizer Di (2 ethylhexyl) phthalate (DEHP) due to safety concerns
  4. £0.194m for introduction of new Buccal swab testing and testing pathway for recruitment of stem cell donors to expand Welsh Bone Marrow Donor Registry panel
  5. £0.323 for additional blood collection capacity to ensure the sufficiency of supply of blood products in Wales can be delivered

  Joint Commissioning Committee has not approved additional funding for any of the business cases for WBS. This places a significant increased financial risk on the Trust as these cases are necessary to maintain and improve quality and safety, so the Trust will inevitably be forced to make some investment at financial risk.
- Welsh Government will support the significant investment required in the Welsh Blood Service and wider NHS Wales to deliver the actions required to meet the recommendations from the Infected Blood Inquiry Report, ensuring quality and safety within the Welsh Blood System.
- The Trust has received notification that the SDEC service development funding of £0.867m available during 2024-25 will cease at the end of the financial year. On application the Trust was led to believe that his funding was recurrent. Unless funding is secured recurrently this becomes a significant issue for the Trust during 2025-26 and beyond in terms of achieving financial balance. It is assumed that the Trust will receive additional income from commissioners to cover any new service developments or additional capacity they agree to commission. Should funding not be agreed, developments and infrastructure will not be implemented, and any costs already committed to will need to be mitigated or removed. Funding for the key service infrastructure, quality improvement, activity growth and cost pressures included in the table below have previously been shared and agreed with Commissioners:

	2025/26				Incremental Income		
VCS Service Growth Investment	**LHB (£000)**	**WHSCC (£000)**	**WG (£000)**	**TOTAL (£000)**	**IMTP Total 2025/26 £000**	**IMTP Total 2026/27 £000**	**IMTP Total 2027/28 £000**
Acute Oncology Services	0			0	0	0	0
Integrated Radiotherapy Solution	621			621	621	(50)	18
Velindre@ Nevill Hall Radiotherapy Unit	671			671	671	0	0
nVCC Revenue Budget Recurrent				0	0	0	50,927
nVCC Revenue Budget Non-Recurrent				0			2,412
SACT (MIFs)	100			100	100	100	100
Total Approved Service Improvement & Growth	**1,392**	**0**	**0**	**1,392**	**1,392**	**50**	**53,457**

- The current financial plan assumes no additional internal investments in major programmes and projects beyond resources agreed within approved business cases. Any additional funding requirements will either need to be met through a reallocation of existing resources, additional savings above the £2.0m target or additional commissioner funding following consideration of a business case.

Pay Related Cost Assumptions:

- Expectation that Pay Inflation funding received will cover the cost growth based on actual staff in post. (Any shortfall such as the cost of increments and the use of bank staff will need be met by discretionary uplift, additional savings or absorbed by service Divisions).
- The Trust financial plan assumes a £1.2m vacancy factor target through natural staff turnover, which will need to be achieved on an ongoing basis in order to balance the overall financial position.
- In line with the guidance the 2025-26 pay inflation and employer's pension contributions from 14.3% to 20.6% have been excluded from the financial plan.

Non-Pay Related Cost Assumptions:

- The national / general cost pressures have currently been estimated at £0.222m for 2025-26. General Non-Pay inflation is forecast to be 2.6% (£0.120m).
- Non-pay Inflationary uplifts on Welsh NHS SLAs of 1.77% (£0.061m) have been assumed for 2025-26 on the basis of a 1.77% core funding uplift to LTA values is passed through to the Trust.

National / General Cost Pressures:

National / General Cost Pressures	Recurrent/ Non-Recurrent	2025/26 £K	2026/27 £K	2027/28 £K
NHS SLA Increase 1.77% 25/26, (1.5% 26/27 & 27/28)	Rec	61	51	51
Non-Pay Inflation (2.6% 24/25 - 2.5% 25/26 & 26/27)	Rec	120	120	120
Digital (DHCW SLA)	Rec	7	TBC	TBC
Total National Cost Pressures		**188**	**171**	**171**

Local Core Service Growth and Cost Pressures:

- The Trust has undertaken a review of its local core service growth and cost pressures, which has resulted in a number being mitigated, removed or costs reduced.
- The cost pressures in the table below are included in the financial plan as needed to meet demand, quality & safety statutory requirements and essential Trust wide infrastructure so unavoidable for 2025-26.

Local Cost Pressures	Recurrent/ Non-Recurrent	2025/26 £K
VCS		
VCS Service Investment to maintain capacity above marginal income	Rec	675
EPMA - National Development	Rec	260

C&V Pathology SLA	Rec	70
Increased Radiology Reporting Fees	Rec	147
Growth in Radiation Services (advice, activity, consumables)	Rec	120
HCSW Regrades	Rec	35
MRI Safety Expect (Medical Physics)	Rec	36
Radiopharmaceutical Nuclear Medicine	Rec	170
WBS		
WBS Service investment to support Deliver Model	Rec	160
WBMDR	Rec / Non Rec	600
WBS Licenses (Vertigo, Esign and Qpulse)	Rec	46
Corporate / Trust		
W&OD Attraction and Resourcing lead	Rec	50
External Contracts (Audit Fees, Trust wide Systems)	Rec	73
Scan for Safety	Rec	28
VCS Estate running costs	Non Rec	300
Inflationary External Contracts	Rec	22
MCA Practice Educator	Rec	23
Trust Pay Increments (Unfunded 2024-25 Pay Award)	Rec	280
Total Local Cost Pressures		**3,095**

- The current financial plan assumes that cost & growth pressures that have been identified as unavoidable for 2025-26 will be funded in part by the 1.77% LTA core uplift (sustainability & capacity) and in part from savings delivery.
- Other local pressures of c£0.900m are expected to be mitigated or managed at Divisional level.

The national cost pressures are funded in part by the 1.77% LTA core uplift (sustainability & capacity) funding and in part from savings delivery:

Other Assumptions:

- Prioritised service developments will be submitted to commissioners as business cases for funding consideration.
- Plan assumes no additional investment in major programme / project resources beyond those agreed in capital business cases.
- The plan assumes Divisions will mitigate or manage other local cost pressures not recognised in the financial plan.
- Expectation is other new cost pressures that may materialise over the period are either avoided/mitigated as far as possible. Where costs are unavoidable additional savings will be required to fund them.
- Investment in organisational staff capacity and capability to deliver major change Programmes is required to progress regional work to deliver improved cancer services, establish clinical leadership and to meet statutory duties around quality & safety and duty of candor.
- Without funding support for major change capacity and capability the Trust is considering what decisions are required with regards to reallocation of existing resources or delivery of additional savings and

efficiencies, but this is proving difficult given competing priorities and will only enable a small element of the staff capacity and capability to be implemented with consequential impact on delivery of major change.

Planned Savings

The following table summarises the level of savings the Trust is planning to deliver in 2025-26.

Savings Plan	2025-26 £000
CIP Planned Savings	1,560
Income Generation	720
Total Savings / Income Generation	**2,280**
CIP % (of Core LTA values)	**2.8%**

The Trust has currently Identified schemes against full savings target of £2.000m, (£1.680m RAG Green, £0.600m RAG Amber & 0.000m RAG Red).

	Recurrent	Non Recurrent	TOTAL
Saving RAG Rating	£k	£k	£k
Green RAG Rated Schemes	675	1,005	1,680
Amber RAG Rated Schemes	510	90	600
Red RAG Rated Schemes	0	0	0
Total	**1185**	**1,095**	**2,280**

Savings Plan by Division	Target £K	Identified (Green) £k	Savings Target Gap £k
Welsh Blood Service	705	555	(150)
Velindre Cancer Centre	1,043	593	(450)
Corporate Services	302	302	0
RD&I	230	230	0
Total	**2,280**	**1,680**	**(600)**

- Work is ongoing within the Divisions to urgently finalise the savings plans and address those schemes that are RAG rated amber. Each Senior Management member has been assigned a target to achieve, ensuring ownership and clear routes for escalation.

Contracting Model & National Funds Flow Framework:

LTA Contract Rebasing for Velindre Cancer Services:

- The Trust was unable to complete the proposed LTA Contract Rebasing exercise during 2024/25.

  Hywel Dda HB did not agree to the Collective Commissioner proposed re-base (from 2004/05 activity & cost) of the Velindre Cancer service LTAs using 2023/24 activity and cost with an allocation adjustment

between commissioners to neutralise the cost impact in the year of implementation. Hywel Dda wrote to Velindre at the beginning of 2024/25 IMTP process stating they intended to only pay its LTA on actual usage, but with no agreement to this change in payment basis agreed with other Commissioners.

Currently there is no agreed way forward for the rebasing to progress as Health Boards cannot reach agreement on the principles and there does not appear to be any realistic prospect of agreement.

- During 2024-25 the Health Boards agreed the transfer of commissioning for non-Specialised Cancer Services from the Joint Commissioning Committee to Health Boards with an associated adjustment of baseline activity and cost.

Financial Risks and Opportunities:

There are several financial risks that could impact on the successful delivery of the plan. The Trust recognises these and is taking appropriate actions as set out below, to ensure risks are appropriately managed and mitigated against. All areas of delivery are risk assessed and any identified risks are included within the Trust Assurance Framework and Trust wide Risk Register.

Key Financial Risks	Worst Case £'000	Best Case £'000	Description / Risk Mitigation
Non Recurrent Funding supplementing core services	(1,200)	0	The Trust has been reliant on non-recurrent contributions from charitable funds and wider external parties/ partners to supplement core services. There is not a sustainable model and remains a risk to the core revenue position going forward
Commissioners not supporting Service Investment / Growth in VCS	TBC	TBC	Several service growth investments have been presented to the Trust commissioners, with early indication that only the SACT Treatment Capacity Expansion will be considered for funding support. 2025/26 marginal income growth held to support service investment.
JCC Not supporting Service investment / Growth in WBS	(1,456)	0	The Trust has received confirmation from JCC that they will not fund any of the WBS Business cases which were submitted to JCC as part of the IMTP process. Founding now sought via Welsh Government following recommendations from the IBI report.
Marginal Income Risk	(500)	0	A new financial risk emerged during 2024-25 whereby LTA marginal income from cancer activity growth is not expected to match the level of investment into services.
Non-delivery of amber / red saving schemes	(600)	0	Divisions to review and finalise savings plans for 2024-25
Management of operational Pressures	(500)	0	Operational cost pressures to be mitigated at divisional level
Total Risks	**(4,256)**	**0**	
Key Financial Opportunities	**Worst Case £'000**	**Best Case £'000**	**Opportunity application and action**

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SDEC Funding	0	867	On application the Trust was informed that the funding provided for SDEC would be recurrent, however the Trust has now received notification that the funding will cease at the end of 2024-25
Further vacancy turnover savings above the vacancy factor held in divisions	0	400	Used to provide non-rec savings against savings schemes that are amber
Emergency Reserve	0	500	Reserve held for emergency expenditure but could be released to support position if no unforeseen costs materialise.
Bank interest	0	500	N/R benefit from the recent rise in interest rates above the £0.500m declared in the savings plan. Predicted outlook for 2025/26 is that interest rates will start decreasing now that inflation has been controlled
Total Opportunities	**0**	**2,267**	
Net Financial Risk	**(4,256)**	**2,267**	

Value & Sustainability

- The Trust is committed to delivering the minimum 2% savings in the next financial year. Further, we will continue to integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline.

- The Trust will continue with the Finance and Investment Enhanced Monitoring arrangements as enhanced measures.

  The purpose of the Finance and Investment Enhanced Monitoring agenda item is to strengthen the control environment by ensuring accountability at an Executive level in relation to:

  1. Savings delivery
  2. Cost control
  3. Choices and Options which could contribute towards wider system financial pressures
  4. Impacts of spending decisions considering quality, safety, experience and value

  This process will also help to address the strategic risk theme of Financial Sustainability and Long-Term Value for the Trust.

  It will provide an additional level of assurance before reporting to external monitoring bodies including:

  - Monthly Value and Sustainability Board
  - Welsh Government / NHS Exec Quarterly Reviews

- The Trust is reviewing its productivity & efficiency using measures to compare to its peer organisations in England – The Clatterbridge Cancer Centre, The Christie, Royal Marsden, and Leeds Cancer Care to identify areas of improvement.

- The Trust is committed to reducing its reliance on the use of agency staff and the premium costs associated. A significant reduction was seen over the course of 2024-25 with an aim to eradicate all use of agency by the end of quarter 2 2025-26, subject to market conditions enabling recruitment of substantive staff.

- Divisions will continue to review non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.

- For 2025/26 onwards the Trust will continue to explore ways to deliver value through the organisation and relieve financial pressures across the Welsh NHS system.

Capital Plans for the Trust

The focus of the Capital Investment Programme is to maintain a high-quality environment in which to collect, transport, process and supply blood, treat cancer patients and provide modern treatment equipment.

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

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

All Wales Approved and Unapproved Capital Schemes	2025-26 £m	2026-27 £m	2027/28 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes					
TCS nVCC	22.835	39.954	6.056	0.000	68.845
Integrated Radiotherapy Solution (IRS)	1.020	16.820	0.943	0.000	18.783
Velindre@ Nevill Hall Radiotherapy Unit	1.200	0.000	0.000	0.000	1.200
RISP (DPIF)	0.471	0.000	0.000	0.000	0.471
Total Approved Capital Schemes	**25.526**	**56.774**	**6.999**	**0.000**	**89.299**
All Wales Unapproved Schemes					
Whitchurch Hospital Site	1.134	0.945	1.741	0.000	3.820
WBS TGI Infrastructure	2.457	5.762	17.292	41.600	67.111
WBS BECS Blood Management System	TBC	TBC	TBC	TBC	0.000
WBS Plasma for Fractionation	0.910	0.002	0.001	0.000	0.913
WBS Fleet Replacement	0.364	1.124	1.465	0.000	2.953
WBS Asset Replacement	0.532	0.215	0.000	TBC	0.747
Digital WHAIS	0.092	0.000	0.000	0.000	0.092
LIMS 2.0	TBC	TBC	TBC	TBC	0.000
EPMA (DPIF)	0.086	0.025	0.000	0.000	0.111
Digital CRM Multi Case Functions (WBMDR, AOS etc	0.500	0.000	0.000	0.000	0.500
Digital IT Infrastructure	0.500	0.500	0.500	0.500	2.000
Other Digital Service Developments	TBC	TBC	TBC	TBC	0.000
Other Service Developments (New)	TBC	TBC	TBC	TBC	TBC

Total Unapproved Capital Schemes	**6.575**	**8.573**	**20.999**	**42.100**	**78.247**
Total All Wales Capital Plans	**32.101**	**65.347**	**27.998**	**42.100**	**167.546**

Trust Discretionary Capital Funding:

The Trust discretionary allocation of £2.000m for 2025-26 is an increase of £0.089m from the £1.911 allocated during 2024-25.

Depreciation & Impairment Funding:

The Trust will require additional Welsh Government funding to support the accelerated depreciation in relation to the existing cancer centre building and equipment.

The total cost for the accelerated depreciation is expected to be £34.464m with £10.593m having been funded during 2024-25. This will leave a required funding balance of £23.871m over the three years of the IMTP 2025-26 to 2027-28. These costs are set out in the table below and were approved as part of the nVCC FBC:

VCC Accelerated Depreciation	2024-25 £m	2025-26 £m	2026-27 £m	2027-28 £m	Total £m
Buildings and Equipment	10.593	10.533	10.468	2.870	34.464
Total	**10.593**	**10.533**	**10.468**	**2.870**	**34.464**

The Trust will require further Welsh Government impairment funding in 2025-26 of c£3.3m in relation to the capital costs incurred on the highway improvement works which is in addition to the ASDA Enabling Works access road for the new Velindre Cancer Centre which was impaired during 2024-25. This is currently an asset under construction and will be reflected as such in the Trust Balance Sheet in 2024-25. However, once construction is completed in 2025-26 the asset value will need to be fully impaired as the Trust does not have legal ownership of the asset, but a right to use the asset by way of a license.

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Section 3 - Delivering Our Strategy

This Plan from 2025-8 will take us to the mid-point of achieving our ambitions in Destination 2033. There are strategic risks related to this which form our Trust Assurance Framework and will be actively managed alongside the management of the delivery of activities and outcomes of the Plan:

Strategic Goal	***Strategic Risk***
Outstanding for **quality, safety and experience.**	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.
An internationally renowned provider of **exceptional clinical services** that always meet, and routinely exceed, expectations.	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, optimised workforce supply and shape, and lack of consistent quality, outcome and mortality metrics.
A beacon for **research, development and innovation** in our stated areas of priority.	There is a strategic risk of: 1. Not effectively delivering against the Velindre Cancer Service 10 year Cancer Research Ambition and the Welsh Blood Service Research Strategy and 2. The ability to fully embed innovation activities in line with the national Innovation Framework.
An established **University Trust** which provides highly valued knowledge and experience for all.	There is a strategic risk of failing to optimise the full potential of a University designation.
A **sustainable** organisation that plays its part in creating a better future for people across the globe	There is a strategic risk of not effectively embedding our role as a sustainable organisation, outside of main infrastructure and specific centrally led activity.
Core strategic Enabler	***Strategic Risk***
Culture	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes
Digital	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security
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.
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.
Transformation Delivery	There is a strategic risk that given this planning window represents such a significant transformation agenda that this change will not be delivered in a way that meets our strategic objectives.

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In summary:

1. Our 2025/2028 Integrated Medium Term Plan delivers on our vision of **"Excellent Care; Inspirational Learning; Healthier People"** through our values of **"Caring; Respectful; Accountable**."

2. This is to **deliver all core services consistently and reliably**, in line with commissioned and quality patient and donor facing standards and national best practice.

3. To achieve this the Plan is informed by current and predicted **demand, experience, safety and quality outcomes**.

4. The Plan demonstrates delivery on principles of **value in health and efficiency,** a **multi professional workforce** and a **digitally enabled** transformation.

5. This planning window will see **significant infrastructure investment**, including a new Cancer Centre, new Radiotherapy equipment and facilities for our Blood Service.

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Integrated Medium Term Plan 2025-8

Cross-Reference to all Planning Guidelines

Trust Board – 27th March 2025

Contents

- Presentation
- General Welsh Government Planning Guidance
- Cabinet Secretary Letter to Chairs
- Cabinet Secretary Key Delivery Expectations
- Cabinet Secretary Enabling Actions
- Additional Guidance in Director General Letter to CEOs
- Allocation Letters from Cabinet Secretary to Chairs
- Technical Welsh Government Guidance
- A Healthier Wales

Presentation

To Note – Final proof to be distributed to Trust Board before meeting

- The word document will be used to create a professional product, using the same designers who did HTW Annual Report and our brief has been to use similar style.
- It will have the same electronic tabbing to make it great to use electronically and can be downloaded as pdf too.
- We are using our recently enhanced Trust image bank so the report will show our own patients, staff, donors and premises.
- Where the word document has ~year1/2/3 etc – this will be a symbol to allow clear labelling.





General Welsh Government Planning Guidance

- ✓ Need to include five key messages
- In addition to publishing Board approved plans, each organisation is asked to develop a short video summarising what the plan will deliver, which can be shared with stakeholders on websites and social media channels
  - This will be in the summer and is in plan with our communications and engagement team
- ✓ Include summary of progress from previous IMTP

Cabinet Secretary Letter to Chairs

Requirement to include	Cross-reference to Plan
Areas which have been consistently raised through FM's conversations and engagement with public and staff since summer 2024: Timely access to care Population health and prevention Building community capacity Mental heath access Women's health	• Context section • Timely access to care outcomes in core services sections • Specific new sections on: population health and prevention; and women's health
Enabling actions - mandating on basis of "adopt or justify" - Each has an evidence base to demonstrate improved efficiency and/ or outcomes, without driving additional cost.	• Included all able to contribute to – see slides 11-15
To support delivery and performance across the NHS, the Ministerial Advisory Group on Performance and Productivity will provide findings by end March – work collaboratively in responding to those recommendations.	• Reference to commitment to support in context section
Expect to hear how organisations are developing their leadership and culture to ensure the safety, health and well-being of their workforce to enable them to deliver, optimise their team effectiveness and improve their services.	• Culture and leadership in Workforce section

Cabinet Secretary Key Delivery Expectations
1. Timely Access to Care

Ministerial Expectations for 2025-6	Cross-reference to Plan
Reduce the number of ambulance patient handovers over 1 hour – national target - zero	Not in scope
Reduce the number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge compared to the same month the previous year, building towards the national target of zero	Not in scope
No patients waiting more than 104 weeks for referral to treatment	Not in scope
12-month improvement trend in the percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route), building toward a national target of 80% by 31 March 2026.	Outcome measure for cancer services
Number of patients waiting more than 8 weeks for a specified diagnostic – target zero	Not in scope

Cabinet Secretary Key Delivery Expectations
2. Population Health and Prevention

Ministerial Expectations for 2025-6	Cross-reference to Plan
Increase in % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Not in scope, although our Trust contribution to this agenda included
Achievement of vaccinations targets in the performance framework	Not in scope, although our Trust contribution to this agenda included

Cabinet Secretary Key Delivery Expectations
3. Building Community Capacity

Ministerial Expectations for 2025-6	Cross-reference to Plan
Deliver a 12-month reduction trend in the number of people who are delayed in hospital as measured by the Delayed Pathways of Care dashboard	Outcome measure for cancer services
100% of GP practices achieving all National Access Standards for In- hours GMS	Not in scope
Increase in number of people accessing Pharmacist Independent Prescribing Service for acute minor conditions and routine contraception services where the patient reports they would have otherwise visited their GP	Not in scope
Increase in % of adult/child population accessing NHS Dental care over a 24 (adult) /12 (child) month period	Not in scope
Increase in capacity at the weekend of community nursing and specialist palliative care nursing to at least the required levels previously set for 2024/25 and greater where possible	Not in scope
Increase in capacity of Enhanced Community Care to at least the required levels previously set for 2024/25 and greater where possible	Not in scope

Cabinet Secretary Key Delivery Expectations
4. Mental Health Access

Ministerial Expectations for 2025-6	Cross-reference to Plan
80% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	Not in scope
80% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	Not in scope

Cabinet Secretary Key Delivery Expectations
5. Women's Health

Ministerial Expectations for 2025-6	Cross-reference to Plan
Establishment of one Women's Health Hub in each health board area by March 2026 (aligned to the Women's Health Plan)	Not in scope, although our Trust contribution to this agenda included

Cabinet Secretary Enabling Actions

1. Operational Productivity and Efficiency – **Urgent and Emergency Care**

Objective: Improve timely access to care, reducing the length of wait in key areas of the urgent and emergency care stream through addressing variation	**Cross-reference to Plan**
Implementation of the Community Based Falls Response - 6 Goals Programme	Not in scope
Implementation of the remote clinical assessment services framework - 6 Goals Programme	Implementation of relevant parts of 6 Goals Programme Included as outcome measures for cancer services
Implementation of acute frailty model at the Front Door - 6 Goals Programme	Implementation of relevant parts of 6 Goals Programme Included as outcome measures for cancer services
Implementation of the Welsh Health Circular - Ambulance Handover Guidance - 6 Goals Programme	Not in scope
Implement the Optimum Hospital Flow Framework - 6 Goals Programme	Implementation of relevant parts of 6 Goals Programme Included as outcome measures for cancer services
Maintaining the actions within the 50 Day challenge that can be delivered consistently with minimal additional resource, within organisations and as a priority within regional partnership arrangements. Ensure consistent delivery of effective integrated discharge planning, utilising the National Discharge Guidance issued by the 6 Goals Programme.	Implementation of relevant parts of 6 Goals Programme Included as outcome measures for cancer services

Cabinet Secretary Enabling Actions

2. Operational Productivity and Efficiency – **Planned Care**

Objective: Improving timely access to care, reducing unwarranted variation in clinical productivity	**Cross-reference to Plan**
Implement national guidelines with thresholds by Clinical Implementation Network (CIN) and procedure. This includes delivery of effective outpatients through See on Symptom (SOS) and Patient Initiated Follow-up (PIFU) by default. Individual CINs will establish PIFU / SOS targets by specialty & sub-specialty on an ongoing basis by March 2025	Planned care section in cancer services plan
All new Cataract referrals should be direct listed to treatment stage of the pathway following an admin triage by the end of Q2	Not in scope
Ensure monitoring of DNA/CNA rates is in place for every Outpatient clinic. When DNA/CNA as a combined rate is greater than 5%, overbooking additional patients should be implemented and monitored.	Outcome measure for cancer services
Implementation of CIN follow up criteria both prospectively and retrospectively to established Follow-up waiting lists.	Not in scope
On 90% of days planned care inpatient/daycase/theatre recovery capacity should be protected from unscheduled care pressures and outlying of patients by the end of Q1.	Not in scope
Ensure effective utilisation of theatre capacity through: reducing late starts to less than 20%; reducing early finishes to less than 10%; and increasing session utilisation to the GiRFT standard of 85% by March 2026.	Outcome measure for cancer services
Improvement in the implementation and delivery of High Volume Low Complexity Theatre lists, with an initial focus on: Anthroplasty 90% compliance with GiRFT standard of 4 primary joints/day, 2 by end of quarter 2; cataract 90% of lists to have 7 Cataracts per list by end of Q2; 90% of the time achieve at least 6 HVLC general surgery procedures on an all day list made up of hernia or gallbladders by end of Q2.	Not in scope
Deliver improvements in day surgery rates, with an expectation to achieving a BACDS daycase rate of 70% from April 2025, moving to 80% by the end of June 2025	Not in scope
Consistent clerical and clinical validation should be in place on an ongoing basis and reported quarterly for impact.	Outcome measure for cancer services

Cabinet Secretary Enabling Actions

3. Workforce Productivity

Objective: Maximise workforce productivity and efficiency, strengthening value and effective deployment of the workforce.	**Cross-reference to Plan**
Fully implement the actions outlined in the Variable Pay & Agency Control Framework Welsh Health Circular	Outcome measure in workforce section
Deliver a further continued and sustained reduction in agency expenditure, with a target 30% reduction in 2025/26 from 2024/25 outturn, and ensuring no off-contract expenditure.	Outcome measure in workforce section
Ensure a reduction in agency spend on Healthcare Support Worker, Admin & Clerical, and Estates & Ancillary staff to zero by 30th September 2025.	Outcome measure in workforce section
Ensure effective implementation of job planning policy, to include ensuring that > 90% of all Consultants have an agreed job plan in place at all times by 30 September 2025.	Outcome measure in workforce section
Ensure a reduction in sickness absence in 2025/26 in comparison to 2024/25, through maximising adherence to the requirements of agreed attendance at work policies and adhering to the all-Wales Occupational Health minimum service levels.	Outcome measure in workforce section

Cabinet Secretary Enabling Actions

4. Maximise Value for Money

Objective: Continue to optimise value for money and contribution to overall efficiency through key non-pay areas, optimising both efficiency and effectiveness	**Cross-reference to Plan**
Medicines Management - ensure full implementation of the high value medicines Value & Sustainability Board programme, which includes delivering opportunities against each of the four programme areas (maximise use of biosimilars, switch to generics, preferential use of medicines in primary care, restrict low value prescriptions)	Outcome measure for cancer services
CHC - ensure implementation of Value & Sustainability Board recommendations which include continued actions to improve clinical and financial effectiveness associated with packages of care. This includes implemented a standard digital solution to support effective intelligence capture on a national basis	Not in scope
Estate - ensure ongoing actions to strengthen estate utilisation including the appropriate repurposing and disposal of under-utilised estate	Estates section
Non-Pay - ensure implementation of Value & Sustainability Board recommendations, which includes local implementation of clinically endorsed and mandated product choice to maximise market share and deliver best value.	Value Based Healthcare section

Cabinet Secretary Enabling Actions

5. Improving Value, Optimising Outcomes and Minimising Variation

Objective: Support improvements in outcomes, effectiveness, and value, through optimising how resources are utilised, and focus on improving outcomes	**Cross-reference to Plan**
Ensuring full implementation of the nationally optimised pathways in the cancer recovery programme	Outcome measure for cancer services
Ensuring full compliance with straight to test guidance	Not in scope
Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Diabetes	Not in scope
Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Bone Health	Not in scope
Ensure progress with the implementation of Value & Sustainability Board High Value High Impact pathway - Arthroplasty (Hip & Knee)	Not in scope
Ensure implementation of national digital priorities, specifically the implementation of the digital maternity system, and NHS Wales app.	Digital plan
Support the implementation and roll-out of the NHS Wales app for maximum impact and benefit to include the uptake of its use for repeat prescriptions.	Digital plan
Eradicate unsupported systems and devices, and ensure a clear cyber response plan for the organisation.	Digital plan
Progress implementation of the national approach to Interventions not normally undertaken (INNU) - Deliver the 8 priority procedures determined for implementation as part of Phase 1.	Not in scope
Ensure delivery of effective referral management processes. This includes consistent implementation of Health Pathways (Pathway Alliance Programme) across all Health Boards with the rapid adoption of the 282 pathways within the programme.	Outcome measure for cancer services

Additional Guidance in Director General Letter to CEOs

Requirement to include	Cross-reference to Plan
Anti racism action plans should continue to address employment and service delivery	Equality section
Duty of Quality – and must take into account the 12 health and Care Quality Standards when making decisions and planning services	Quality section
Legislative that will need to be considered: WBFG (Wales) Act 2015; Social Partnership and Public Procurement (Wales) Act 2023;	Context section
Expect to see tangible commitments to regional delivery in plans	New regional planning section
Implementation of Welsh Language framework “More than just words 2022-27”	Workforce section

Allocation Letters from Cabinet Secretary to Chairs

Requirement to include	Cross-reference to Plan
Expecting a significant step-up in the achievement of key priority delivery expectations and enabling actions. There should be less tolerance of inefficiency and unwarranted variation	Captured across service plans and also in Financial Sustainability strategic risk
Expecting savings in non-core areas and overheads to prioritise front-line services	Financial section
In addition to delivering effective savings plans, expect actions to control overall workforce expenditure	Financial section
Minimum savings delivery 2025/6 of 2%	Financial section
Concerned on challenges in reaching agreement across organisations on commissioning and at the slow progress on regional working.	New regional planning section

Technical Welsh Government Guidance

Digital

Requirement to include	Cross-reference to Plan
Have in place an organisational wide digital and data strategy that is underpinned by a sustainable financial plan	Digital section
Ensure governance and clinical safety for digital and MedTech including AI is robust and risks fully assessed considered	
Implement the Cyber Assessment Framework (CAF) profiles	
Alignment to development and implementation of national systems and architecture	
Implementation of core digital standards and Notices	
Improve clinical coding to ensure clinical safety and meet national coding targets. Clear plans and actions to adopt innovative approaches to improving patient care and processes using AI and Automation technology	

Innovation

Requirement to include	Cross-reference to Plan
Accountability at Board level and tracking of innovation activities in line with framework of 'define, understand and define' to 'spread and scale'	Innovation section
Increasing the focus of innovation for people working in the organisation	
Working with an All Wales approach for an up-to-date IP Policy	

Research and Development

Requirement to include	Cross-reference to Plan
NHS Framework for R&D: Research matters – what excellence looks like in NHS wales' – published July 2023 – sets expected standards across 10 pillars	R&D section

Technical Welsh Government Guidance

Value Based Healthcare

Requirement to include	Cross-reference to Plan
Raise awareness of VHC including education, motivation and incentivisation for staff to undertake VBHC projects	Value Based Healthcare section
Measurement and tracking of resources in the best way in order to improve patients outcomes, patient experience and ensure value and patient centred care.	Financial, Value Based Healthcare and Service sections
Evidence of integration of early and secondary prevention in line with other priority areas highlighted in this guidance.	Not in scope

Workforce and Wellbeing

Requirement to include	Cross-reference to Plan
NHS workforce planning must be driven by an understanding of the service redesign needed to meet these ambitions	Workforce and Culture section
Must demonstrate how using robust workforce data	
Need to demonstrate how they are listening to and responding to staff voices to improve staff experience, which in turn, impacts patient experience and retention	
The annual staff survey is a key data source that feeds a better understanding of structural issues at the heart of staff experience and wellbeing	
Must support the ambitions of Stronger, Fairer, Greener Wales: A Plan for Employability and Skills and enable the NHS to act as a key employer in the foundational economy across Wales	Estates, Health & Safety and Sustainability section

A Healthier Wales

Refreshed actions published in November 2024

Preventative

Requirement to include	Plan
Promote a collective responsibility to maintain good health for individuals, communities and the health and social care system with a focus on preventing the onset of poor health and disease and on identifying and intervening early where disease occurs	Population Health and Prevention section
Through Primary, Communityand Social Care services, help people stay well at or closer to home, through an integrated approach to improving the nation's health and wellness. With a focus on rehabilitation, reablement and recovery, provide active support to keep people healthy and maintain independence	Not in scope
Prevent and detect disease and illness earlier to improve individual and population health outcomes through targeted health screening, delivery of the National Immunisation Framework for Wales and delivering against the World Health Organisation targets for disease elimination	Not in scope
Build and strengthen the health protection system to prevent, prepare and respond to existing and future health protection threats, including pandemics, on an 'all hazards' basis	Population Health and Prevention section

Person Centred

Requirement to include	Plan
Ensure that all citizens can receive timely health and care services equitably, regardless of the language or communication format they need	Strategic Equality Plan section
Establish and deliver against clear visions and plans for women's health and children's health from pre-birth to end of life	Women's Health section
Continue to implement an integrated community care system for Wales that delivers seamless place-based care planned and delivered around the needs of individuals and groups of people	Not in scope
Create an age friendly Wales that supports people of all ages to live, age and die well	Across service provision and Quality sections

Sustainable

Requirement to include	Plan
Embed action on the climate emergency in decision-making and plans across the health and social care system	Estates, Health & Safety and Sustainability section
Through the national direction of the Value & Sustainability Board embed a value-based health care approach across the system to focus on how we use our resources wisely to get the best possible evidenced based outcomes for patients	Value Based Healthcare section
Embed A Healthier Wales into a National Plan, which can then be translated for the NHS through the planning framework cascading into planning at the national, regional and local level	Will be in scope when National Plan progresses
Recover, reset and transform planned care services by focusing on clearing the backlog of those waiting for treatment, resetting the service with a focus on a value-led and efficient service model and driving transformation by embedding sustainable services	Cancer Services – Planned Care outcomes
Ensure that NHS Wales provides the very best care for patients at all times through the performance, oversight and escalation framework	Not specifically in plan – Trust operates within framework
Ensure partnership arrangements at national, regional and local levels drive system change, efficiency and sustainability through collaboration and a 'one Welsh public service' approach	National context for Blood Service and Regional cancer service planning

A Healthier Wales

Refreshed actions published in November 2024

Equitable

Requirement to include	Plan
Reduce health inequalities by ensuring equality of access to the health and social care system to achieve equity of outcomes	Strategic Equality Plan section
Ensure Health and Social Care in Wales achieves its vision to provide an equitable whole system person centred approach, delivering more equal health and wellbeing outcomes for the population of Wales	Strategic Equality Plan section

High Quality and Safe

Requirement to include	Plan
Standardise and reduce variation in pathways, service models and processes, through implementing standardised models and maximising the use of technology on a once for Wales basis	Digital, Value Based Healthcare and Service sections
Drive the containment, control and mitigation of Antimicrobial Resistance (AMR) in Wales, the UK, and beyond	Infection, Prevention and Control core Quality metrics for Trust albeit not specifically in this Plan
Maximise the use of the NHS Executive to drive improvements in the quality and safety of care	Way of working with NHS Executive
Towards a National Care and Support Service for Wales	Not in scope

Digital and Data

Requirement to include	Plan
Deploy with industry partners, proven clinical systems, electronic care records and medical technologies to deliver greater standardisation of care pathways, improved productivity and support clinicians and professionals in decision making and enable wider population health planning	Digital, Service and Population Health and Prevention sections
Through a strengthened digital and data profession boost significantly the digital and data maturity required to meet international best practice and standards in cyber, infrastructure, user design, data sharing and recording, workforce development, electronic health and wellbeing records, agile procurement and clinical safety	Digital plan section
Establish a clear and agreed-upon National Enterprise Architecture built around core standards and with clear understanding of how data, applications and technology underpins national health and care transformation and policy priorities	Digital plan section
Ensure the complete deployment of key national digital capabilities, such as diagnostic and specialist systems, the Wales NHS App and electronic prescribing to support patients and public in accessing their own data and managing their care, while ensuring that no one is left behind by digital exclusion	Digital and Service sections
Put the use of data, insight and analytics, used safely and securely, at the core of the health and care system to deliver improved health and wellbeing outcomes	Digital and Value Based Healthcare sections

A Healthier Wales

Refreshed actions published in November 2024

Workforce

Requirement to include	Plan
Deliver an inclusive, flexible, multi-professional workforce able to work across sectors and traditional boundaries by ensuring the Workforce Strategy is implemented and underpinned by excellent workforce data and planning to attract, recruit and retain talented people to train, work and live in Wales	Workforce and Culture plan
Embed compassionate leadership and building a positive culture across the NHS and social care system in Wales to become exemplar employers for health, wellbeing, diversity and inclusion at work with the intent to share this approach across the wider economy	Workforce and Culture plan
Deliver effective and efficient deployment of the workforce to make the most of our investment in the skills of the workforce and technology to deliver safe patient outcomes	Workforce and Culture and Value Based Healthcare sections

Research, Development & Innovation

Requirement to include	Plan
Strengthen research capacity and capability, and raise awareness of research across the health and social care sectors by developing targeted improvement plans and strategic funding partnerships, and promoting the effective use of research to inform policy and service improvement	R.D & I sections
Develop and deliver a comprehensive vision for life sciences and innovation that serves as a catalyst for enhancing the health and wealth of the Welsh population and its economy	R.D & I sections
Use modern and emerging technologies, innovations and biosciences, including genomics and personalised treatments, to deliver greater value and sustainability across all national improvement and transformation programmes and initiatives	R.D & I sections

Co-operation and Partnership

Requirement to include	Plan
Ensure the people of Wales havea strong voice to inform the ongoing development of an effective, joined up health and social care system	Engagement section
Ensure individuals and their carers are enabled to work as key partners in co-producing and owning their own health and care plans	Engagement section

Integration

Requirement to include	Plan
Develop and scale up models of integrated community based services in line with population health and wellbeing needs to achieve a consistent model of Integrated Community Care across Wales	Not in scope
Build on regional and local partnership arrangements to ensure closer alignment in the planning, commissioning and delivery of health and care services to maximise assets and resources	Regional planning section

TRUST BOARD	
STRATEGIC PLANNING UPDATE	
DATE OF MEETING	27 March 2025
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	LAUREN FEAR – DIRECTOR OF TRANSFORMATON (INTERIM)
PRESENTED BY	LAUREN FEAR – DIRECTOR OF TRANSFORMATON (INTERIM)
APPROVED BY	LAUREN FEAR – DIRECTOR OF TRANSFORMATON (INTERIM)
EXECUTIVE SUMMARY	This paper provides a regular update on key strategic planning matters to the Trust Board.
RECOMMENDATION / ACTIONS	The Trust Board is asked to note the update.
APPENDICES	
1	Regional Cancer Programme Update

1. SITUATION

This is the fourth strategic planning update, with previous papers outlining the development and progress across a number of matters, including the Integrated Medium Term Plan.

This update covers two key topics:

- Regional Cancer Programme
- Integrated Medium Term Plan Strategic Planning next steps

2. BACKGROUND

Regional Cancer Programme

As previous papers have outlined, there has been positive progress in the development of the South East Wales regional cancer programme since autumn 2024. The programme was invited to provide an update in the Regional Portfolio Oversight Board on 25th March. The update is attached for Trust Board's information in appendix 1.

Integrated Medium Term Plan Strategic Planning next steps

Also in this agenda, the Integrated Medium Term Plan outlines a number of strategic planning matters in which staff from across the Trust will be involved in and have various leadership roles for over coming months. These matters will be captured in the overall approach to Integrated Medium Term Plan tracking of milestones and outcomes – and will also be updated in this paper on a bi-monthly basis.

This includes, with the key milestones:

- **Women's Health**
    - For both blood and cancer services, adopt a multi-disciplinary approach to scope the way in which the Trust can add most value to improving outcomes for women and feed this into the development of Women's Hubs. – Quarter 1 2025/6

- **Population Health and Prevention**
    - Continuing with the multi-disciplinary approach established for the Women's Health plan in Quarter 1, agree our Population Health and Prevention strategy and implementation plan in Quarter 2 2025/6.

- **Benchmarking and Excellence**
    - We have identified a number of work packages, including for instance, our approach to peer benchmarking and international centres of excellence accreditations. This work will be led by a community of practice and will be established in Quarter 1 2025/6

- **Joint Academic Health Science Programme**
    - The full delivery plans will be developed under this Programme and incorporated into the Trust's key milestones going forwards. – Quarter 2 2025/6.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
QUALITY IMPACT ASSESSMENT	Not required - not a strategic decision
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required
TRUST WELL-BEING GOAL(S) IMPLICATIONS / IMPACT	
The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated. Please indicate whether any of the matters outlined in this report impact the Trust's Wellbeing goals: YES - Select Relevant Goals below	
If yes select the relevant goals: • A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒	

• A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. ☒ • A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health ☒ • A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances ☒ • A Wales of more Cohesive Communities - Attractive, viable, safe and well-connected communities. ☒ • A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation. ☒ • A Globally Responsible Wales – Consideration of whether an action may make a positive contribution to global well-being ☒	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Not required - please outline why this is not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

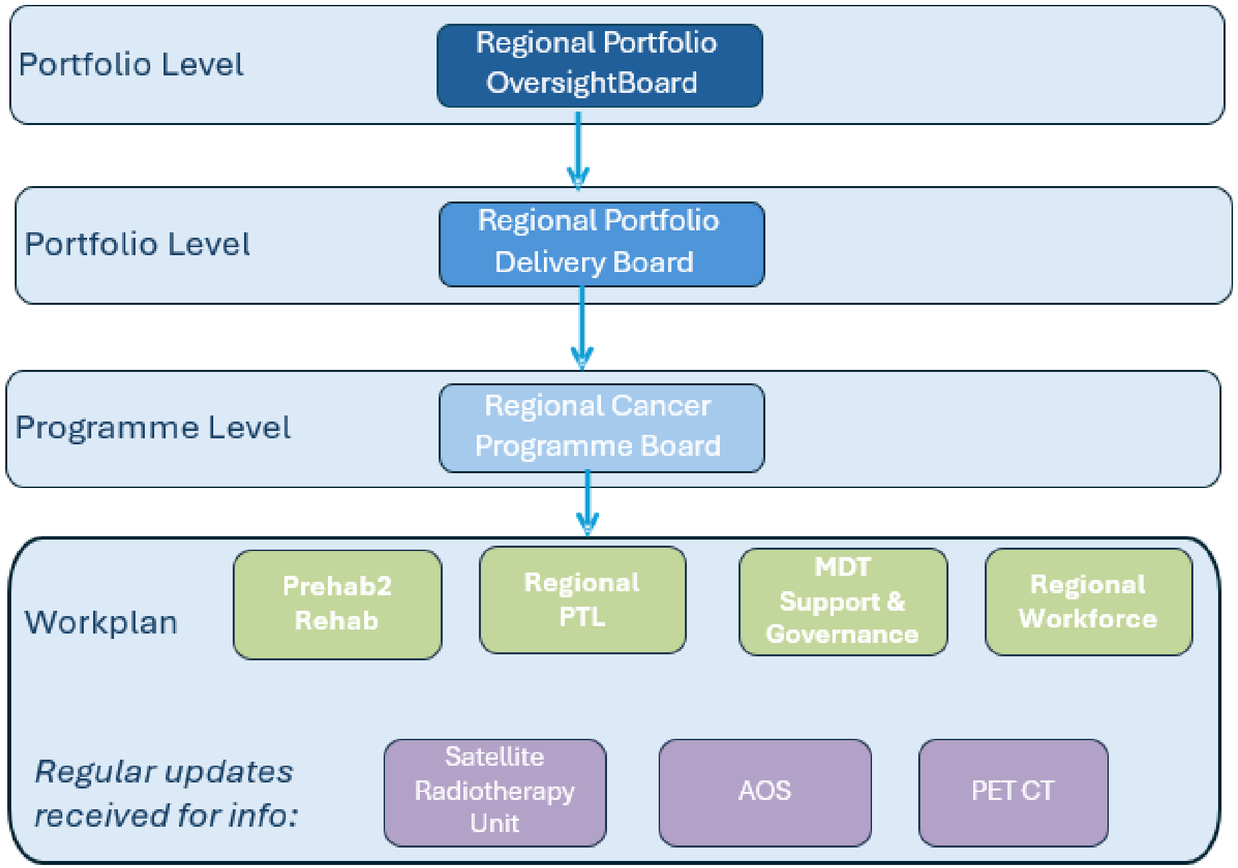
SE Wales Regional Cancer Programme Update

25th March 2025

Background

- Cancer was added as the fifth regional programme into the South East Wales regional planning structures
- Membership from all South East Wales Health Boards – Aneurin Bevan University Health Board CEO (Chair), Directors of Planning, Chief Operating Officers, Directors of Nursing, Medical Directors and Cancer Clinical Leads. Also from Cancer Network.
- The Cancer Programme Board has met three times since its formal inception (Sept ‘24, Nov ’24 and Feb ‘25), following an initial scoping workshop.

Governance arrangements



Progress to Date – *establishing the programme*

- **Reviewed all regional cancer strategies –** summarising key areas, common themes and mapping to national priorities in the Cancer Quality Statement and Wales Cancer Improvement Plan in order to inform further regional strategic planning.

- **Baseline review of regional cross-organisational work** relating to cancer services – to inform the regional work programme where collective leadership can add value to addressing any cross-organisation issues.

- **Agreed Regional Cancer Programme priorities –** agree initial priorities across a range of the following categories: enablers, immediate priority actions, and horizon scanning.

Progress to Date – *agreed priorities*

- **Specifically agreed priorities where there is additional value in co-ordinating regionally**

- **Project Briefs developed for the following agreed priorities –**
    1. Regional Cancer PTL (Patient Tracking List)
    2. Regional MDT (Multi Disciplinary Team) Support & Governance
    3. Regional Workforce Development

- **Project Briefs in development for –**
    1. Prehabiliation to Rehabilitation
    2. Haemato-oncology

Next Steps

1. **Regional PTL –** demonstration of the regional data solution developed to Regional Programme Board
2. **Regional MDT Support & Governance –** review outputs of MDT baseline survey undertaken by Clinical Fellow and identify specific areas for improvement in region (potentially MDT training material development and pilot of an AI solution)
3. **Regional Workforce Development –** establish a Regional Oncology Workforce Task & Finish Group linking with HEIW and Velindre Oncology Academy
4. **Prehab to Rehab –** finalise Project Brief, to include gathering baseline of prehab provision across region and gaps analysis to achieve equitable access
5. **Haemato-oncology –** agree Project Brief with regional engagement
6. **Resource** requirements for all work being worked through by leads, with emphasis on how we leverage and pivot existing roles and sessions to deliver in way we want to on regional basis.
7. **Next meeting – 10th April 2025**

TRUST BOARD	
CHAIR'S URGENT ACTION MATTER REPORT	
DATE OF MEETING	27 March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	**TO RATIFY**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	This report details Chair's Urgent Actions taken between the **24/01/2025 – 20/03/2025.** There was one (1) urgent item of business for the Trust Board that was considered via Chairs Urgent Action during this period: 1. Renewal of Contract for Human Leukocyte Antigen (HLA) Typing by Next Generation Sequencing (NGS) No objections to approval were received in respect of the items of business considered. However, a number of concerns were raised and are detailed in the report.
RECOMMENDATION / ACTIONS	To **RATIFY** the Chairs Urgent Action taken between the **24/01/2025 – 20/03/2025.**

GOVERNANCE ROUTE	
Trust Board Members – Via Email	**19/02/2025**: Renewal of Contract for Human Leukocyte Antigen (HLA) Typing by Next Generation Sequencing (NGS)

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Trust Board **APPROVED** each item of business considered via Chair's 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 Chair's Urgent Action between the **24/01/2025 – 20/03/2025.**

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 Interim Director of Corporate Governance, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Interim Director of Corporate Governance 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 Chair's Urgent Action since the last formal meeting of the Trust Board at the end of January 2025:

3.1 Renewal of Contract for Human Leukocyte Antigen (HLA) Typing by Next Generation Sequencing (NGS)

The Trust Board were sent an email and Chair's Urgent Action Report on the **19th February 2025** in relation to the **Renewal of Contract for Human Leukocyte Antigen (HLA) Typing by Next Generation Sequencing (NGS)** that required urgent approval.

This matter followed on from queries raised about the Commitment of Expenditure at the November 2024 Trust Board where the dates of the contract were queried. The cover paper with this request addresses those queries raised.

The wording of the Action was as follows:

The Trust Board is requested to:

- **AUTHORISE** the Chief Executive to **APPROVE** the award of the contracts summarised within this report and supporting appendix.
- **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements.

Recommendation Approved by:

- Donna Mead, Chair
- David Donegan, CEO
- Stephen Harries, Vice Chair
- Andrew Westwell, Independent Member

During the approval process there was concern raised by the CEO in relation to the delays and the retrospective nature of the request for approval. Clarity was provided by the Vice Chair that provided the context and content of the previous Trust Board discussions and the actions required to resolve the issues raised for final Trust Board approval.

In response to the concerns raised relating to the apparent custom of reactive contract management that necessitates the need for Urgent Chair's Action, the CEO requested that a contract management review be undertaken by the Chief Operating Officer, Executive Director of Finance and Welsh Blood Service Divisional Director to ensure a corrective look forward approach to managing contracts.

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)	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 ☒
	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:	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
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	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal impact was captured within the documentation considered by the Board.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

AMENDMENTS TO THE MODEL STANDING ORDERS AND RESERVATION AND DELEGATION OF POWERS FOR NHS TRUSTS

DATE OF MEETING	27 March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to advise the Trust Board of the amendments to the Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards, NHS Trusts and Special Health Authorities following the making of the Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024. The Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024 came into force on the 20 January 2025. These Regulations amended the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, The

	Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009, The National Health Service Trusts (Membership and Procedure) Regulations 1990 and The Health Education and Improvement Wales Regulations 2017. The Trust's Model Standing Orders, Reservation and Delegation of Powers have been updated to reflect the amendments.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the adoption of the revised Trust Model Standing Orders, Reservation and Delegation of Powers.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Audit Committee	25/03/2025

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

At the time of publication, the Audit Committee has not yet **ENDORSED** the adoption of the revised Trust Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts for submission to the Trust Board for Approval.

The Interim Director of Corporate Governance will provide a further update to the Trust Board regarding the status of the Audit Committee **ENDORSEMENT** at the meeting.

7 LEVELS OF ASSURANCE - N/A

APPENDICES

APPENDIX 1	Revised Trust Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts

1. SITUATION / BACKGROUND

1.1 Velindre University National Health Service Trust is a statutory body that came into existence on 1st December 1993 under the Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838), as amended, "the Establishment Order".

1.2 Velindre University NHS Trust has a duty under Regulation 19(2) of the National Health Service Trusts (Membership and Procedure) Regulations 1990 to make Standing Orders for the regulation of their proceedings and business. It is important to note that the Trust is able to vary or suspend its own Standing Orders, providing that it is able to satisfy that it complies with the relevant regulations.

1.3 The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales. All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

2. ASSESSMENT

2.1 The Local Health Boards, NHS Trusts and Special Health Authorities (Constitution, Membership and Procedures) (Miscellaneous Amendments) (Wales) Regulations 2024 came into force on the 20 January 2025.

2.2 These Regulations amended the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009, The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009, The National Health Service Trusts (Membership and Procedure) Regulations 1990 and The Health Education and Improvement Wales Regulations 2017. As a result, the Model Standing Orders and Reservation and Delegation Of Powers for NHS Trusts require amendment.

3. SUMMARY OF MATTERS FOR CONSIDERATION

3.1 **Eligibility Requirements**

No amendments required.

3.2 **Appointment of Officer Members**

No amendments required

3.3 **Appointment of the Trade Union Member to Local Health Boards**

Not applicable

3.4 **Publication of Board agendas and papers**

Section B – Meetings: Notifying and equipping Board members

Amend the highlighted text within the following paragraph. The term "clear days" refers to a period of time calculated by excluding both the starting day and the ending day. For example, if a notice is given on a Monday and the meeting is scheduled for the following Monday, there are six clear days in between. This is calendar days so the weekend is included.

The proposed changes are as follows, from:

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 7 calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

To:

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 5 clear days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

Section B – Meetings: Notifying the public and others

Amend the highlighted text within the following paragraph, from:

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On the Trust's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the Trust's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the Trust shall set out when and how the Agenda and the papers supporting

the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

To:

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, ~~and the public part of the agenda,~~ shall be displayed bilingually (in English and Welsh):

- On the Trust's website, ~~together with the papers supporting the public part of the Agenda~~; as well as
- Through other methods of communication as set out in the Trust's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the Trust shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Board.

3.5 The Trust Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts (**Appendix 1**) have been updated and the changes highlighted in red text.

3.4 The Trust Board is asked to **APPROVE** the adoption of the revised Trust Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 – Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	*There are no socio-economic impacts linked directly to the activity outlined in this report.*
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	*There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.*
FINANCIAL IMPLICATIONS / IMPACT	*There is no direct impact on resources as a result of the activity outlined in this report.*
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	*There is no direct equality impact in respect of this report.*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is essential that the Trust complies with its standing orders.

5. RISKS

The Trust's governance structure aims to identify issues early to prevent escalations and the Committee integrates into the overall Board arrangements.

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No**

Model Standing Orders

Reservation and Delegation of Powers

Velindre University NHS Trust

Foreword

These Model Standing Orders are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. National Health Service Trusts ("NHS Trusts") in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs Trusts must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

They are designed to translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024) as amended] into day to day operating practice, and, together with the adoption of a Schedule of decisions reserved to the Board of directors; a Scheme of decisions to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework GC03 Standards of Behaviour Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Trust's Director of Corporate Governance will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the Trust.

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

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Section A – Introduction

Statutory framework

i) Velindre University National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838),** as amended, "the Establishment Order".]

ii) The principal place of business of the Trust is –
Velindre University NHS Trust Headquarters, 2 Charnwood Court, Parc Nantgarw, Cardiff, CF15 7QZ

iii) All business shall be conducted in the name of Velindre University National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee.

iv) NHS Trusts are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

v) **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024)**, as amended ("the Membership Regulations") set out the membership and procedural arrangements of the Trust.

vi) Sections 18 and 19 of and Schedule 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give directions about how they exercise those functions. NHS Trusts must act in accordance with those directions. The NHS Trust's main statutory functions are set out in their Establishment Order, but additional functions may also be contained in other legislation, such as the NHS (Wales) Act 2006.

vii) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
- The creation of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

NHS Trusts will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

viii) The Well-being of Future Generations (Wales) Act 2015 also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

ix) In exercising their powers NHS Trusts must be clear about the statutory basis for exercising such powers.

x) In addition to directions the Welsh Ministers may from time to time issue guidance which NHS Trusts must take into account when exercising any function.

xi) **The National Health Service Joint Commissioning Committee (Wales) Directions 2024 (WG24-06)** provide that the seven Health Boards in Wales will establish a joint committee to exercise the functions of planning, securing and commissioning:

(a) specialised services for –
  (i) cancer and blood disorders,
  (ii) cardiac conditions,
  (iii) mental health and vulnerable groups,

(iv) neurosciences, and
(v) women and children,

(b) services where there is agreement between the Local Health Boards that they should be arranged on a regional and national basis,
(c) emergency medical services,
(d) non-emergency patient transport services,
(e) emergency medical retrieval and transfer services,
(f) NHS 111 services,
(g) sexual assault referral centres, and
(h) other services as directed by the Welsh Ministers.

Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Welsh Ministers have made the **National Health Service Wales Joint Commissioning Committee (Wales) Regulations 2024 (2024 No. 135 (W29))**, which make provision for the constitution and membership of the Joint Commissioning Committee, including its procedures and administrative arrangements.

xii) **The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012) (as amended) require the Trust to establish a Shared Services Committee and prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

xiii) **The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014.**

xiv) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trust and, for the purposes of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

xv) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xvi) The Welsh Language (Wales) Measure 2011 makes provision with regard to the development of standards of conduct relating to the Welsh Language. These standards replace the requirement for a Welsh Language Scheme previously provided for Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of NHS Trusts. The Trust will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xvii) Paragraph 18 of Schedule 3 to the NHS (Wales) Act 2006 provides for NHS Trusts to enter into arrangements for the carrying out, on such terms as considered appropriate, of any of its functions jointly with any Strategic Health Authority, Local Health Board or other NHS Trust, or any other body or individual.

xviii) NHS Trusts are also bound by any other statutes and legal provisions which govern the way they do business. The powers of NHS Trusts established under statute shall be exercised by NHS Trusts meeting in public session, except as otherwise provided by these SOs.

NHS framework

xix) In addition to the statutory requirements set out above, NHS Trusts must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

xx) Adoption of the principles will better equip NHS Trusts to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xxi) The overarching NHS governance and accountability framework incorporates these SOs; the Scheme of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of

Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

xxii) The Welsh Ministers, reflecting their constitutional obligations, and legal duties under the **Well-being of Future Generations (Wales) Act 2015 (2015/2)**, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

The Trust is considered a public body under the Act.

xxiii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of NHS Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

NHS Trust framework

xxiv) Schedule 2 provides details of the key documents that, together with these SOs, make up the NHS Trust's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxv) NHS Trusts will from time to time agree and approve policy statements which apply to the Trust's Board of directors and/or all or specific groups of staff employed by Velindre National Health Service Trust and others. The decisions to approve these policies will be recorded and, where appropriate, will also be considered to be an integral part of the Trust's SOs and SFIs. *Details of the Trust's key policy statements are also included in Schedule 2.*

xxvi) NHS Trusts shall ensure that an official is designated to undertake the role of the Director of Corporate Governance (the role of which is set out in paragraph xxxvi) below).

xxvii) For the purposes of these SOs, the Trust Board of directors shall collectively to be known as “the Board” or “Board members”; the executive and non-executive directors shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SO 1.1.2 refers.

Applying Standing Orders

xxviii) The SOs of NHS Trusts (together with SFIs and the Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy), will, as far as they are applicable, also apply to meetings of any formal Committees established by the Trust, including any sub-Committees and Advisory Groups. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs.*

xxix) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Corporate Governance, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non-compliance to the Director of Corporate Governance as soon as they are aware of any circumstance that has not previously been reported.

xxx) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual’s dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxxi) Although these SOs are subject to regular, annual review by the NHS Trust, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Director of Corporate Governance shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 19] of the Membership Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;
- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and

- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxii) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the Trust shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Director of Corporate Governance and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

xxxiii) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Director of Corporate Governance

xxxiv) The role of the Director of Corporate Governance is crucial to the ongoing development and maintenance of a strong governance framework within NHS Trusts, and is a key source of advice and support to the NHS Trust Chair and other Board members. Independent of the Board, the Director of Corporate Governance acts as the guardian of good governance within NHS Trusts. The Director of Corporate Governance is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of NHS Trust business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the NHS Trust compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

As advisor to the Board, the Director of Corporate Governance's role does not affect the specific responsibilities of Board members for governing the organisation. The Director of Corporate Governance is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal

responsibilities.

Further details on the role of the Director of Corporate Goverance within Velindre University NHS Trust, including details on how to contact them, is available from the Trust by contacting the Trust on 02920 196161 or visiting the Trust's public internet site.

Section B – Standing Orders

1. THE TRUST

1.0.1 The Trust's principal role is to:

(a) to own and manage Velindre Hospital, Velindre Road, Whitchurch, Cardiff CF4 7XL and associated hospitals and premises, and there to provide and manage hospital accommodation and services;

(b) to own and manage Welsh Blood Service Headquarters, Ely Valley Road, Talbot Green, Pontyclun CF72 9WB and associated premises, and there to provide and manage services relating to the collection, screening and processing of blood and its constituents and to the preparation and supply of blood, plasma and other blood products;

(c) services relating to prescribing and dispensing;

(d) to manage and provide Shared Services to the health service in Wales;

(e) to own or lease the premises associated with the provision of the services in paragraph (d), and

(f) to manage and administer the Wales Infected Blood Support Scheme in accordance with directions issued by the Welsh Ministers.

1.0.2 The Trust was established by, and its functions are contained in, the **Velindre National Health Service Trust (Establishment) Order 1993** (S.I. 1993/2838), as amended. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

1.0.3 To fulfil this role, the Trust will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Trust

1.1.1 The membership of the Trust shall comprise the Chair, Vice-Chair, 6 non-executive directors and 6 executive directors.]

1.1.2 For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively. The

Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. All such members shall have full voting rights.

1.1.3 The Minister for Health and Social Services shall appoint the Chair and non-officer members of the Trust.

1.1.4 The Trust will appoint a Committee whose members will be the Chair and non-executive directors of the Trust whose function will be to appoint the Chief Executive as a director of the Trust.

1.1.5 The Trust will appoint a Committee whose members will be the chair, the non-executive directors and the Chief Executive whose function will be to appoint the executive directors other than the Chief Executive.

Executive Directors

1.1.6 A total of 6, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance, a medical or dental practitioner (to be known as the Medical Director), a registered nurse or registered midwife (to be known as the Nurse Director) and 2 others. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.]

Non-executive directors [to be known as Independent Members]

1.1.7 A total of 6 (excluding the Chair and Vice-Chair) appointed by the Minister for Health and Social Services, which will include:

- A person appointed from Cardiff University.

1.1.8 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Membership Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice-Chair
- Non-Executive Directors

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the Trust is shared between more than one person because of their being appointed jointly to a post:

(i) Either or both persons may attend and take part in Board meetings;
(ii) If both are present at a meeting they shall cast one vote if they agree;
(iii) In the case of disagreement, no vote shall be cast; and
(iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.]

1.3.2 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.3 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in the Membership Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.4 The Trust will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the Trust, its Board and responsibilities of individual members

Role

1.4.1 The principal role of the Trust is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through

effective challenge and scrutiny of the Trust's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 NHS Trusts shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the Trust within the communities it serves.

1.4.6 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.7 The Chair shall work in close harmony with the Chief Executive and, supported by the Director of Corporate Governance, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.8 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason and will do so until either the existing chair resumes their duties, or a new chair is appointed.

1.4.9 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They are the

appointed Accountable Officer for the Trust and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.10 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the Trust, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF TRUST FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

(i) Schedule of matters reserved to the Board;
(ii) Scheme of delegation to committees and others; and
(iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 The Trust retains full responsibility for any functions delegated to others to carry out on its behalf. Where Trusts and Local Health Boards have a joint duty, the Trust remains fully responsible for its part, and shall agree the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner organisations.

2.1 Chair's action on urgent matters

2.1.1 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 the Chief Executive, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other

Independent Members. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

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

2.2 Delegation of Board functions

2.2.1 The Trust shall delegate its Shared Services functions (that is, the provision and management of Shared Services to the health services in Wales) to the Shared Services Partnership Committee which they are required to establish and confer such functions on in accordance with the Shared Services Regulations.

Subject to Standing Order 2.2.2 the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2 (i), to Committees and others, setting any conditions and restrictions it considers necessary and in accordance with any directions or regulations given by the Welsh Ministers. These functions may be carried out:

(i) By a Committee, sub-Committee or officer of the Trust (or of another Trust); or
(ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
(iii) With one or more bodies including local authorities through a sub-Committee.]

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees or sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may

periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 NHS Trust Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term "Committee"

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- sub-Committee

unless otherwise stated.

3.2 Sub-Committees

3.2.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees, they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.3 Committees established by the Trust

3.3.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds *[as appropriate]*;

- Remuneration and Terms of Service; and
- Mental Health Act requirements *[as appropriate]*.

3.3.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity;
- Maximise cohesion and integration across all aspects of governance and assurance.

3.3.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board**,** its Committees and any Advisory Groups);
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.3.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.3.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the Trust.

3.3.6 Executive Directors or other Trust officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated Trust officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.4 Other Committees

3.4.1 The Board may also establish other Committees to help the Trust in the conduct of its business.

3.5 Confidentiality

3.5.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.6 Reporting activity to the Board

3.6.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs, Trusts and Special Health Authorities setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The Trust may and where directed by the Welsh Ministers must, appoint Advisory Groups to the Trust to provide advice to the Board in the exercise of its functions.

5.0.2 *Details of the Trust's Advisory Groups, their membership and terms of reference are set out in Schedule 4.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Advisory Groups established by the Trust

5.1.1 The Trust has established the following Advisory Groups:

- Local Partnership Forum

5.2 Terms of reference and operating arrangements

5.2.1 The Board must formally approve terms of reference and operating arrangements in respect of any Advisory Group it has established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the Board, its Committees and Advisory Groups) as well as other relevant local and national groups;
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.2.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements for the Trust's Advisory Groups are set out in Schedule 4.

5.2.3 The Board may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.3 Support to Advisory Groups

5.3.1 The Trust's Director of Corporate Governance, on behalf of the Chair, will ensure that Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the Trust Board and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see 5.7 and Schedule 4);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.4 Confidentiality

5.4.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.5 Advice and feedback

5.5.1 The Trust may specifically request advice and feedback from the Advisory Group(s) on any aspect of its business and they may also offer advice and feedback even if not specifically requested by the Trust. The Group(s) may provide advice to the Board:

- In written advice;
- In any other form specified by the Board

5.6 Reporting activity

5.6.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.6.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.6.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.7 The Local Partnership Forum (LPF)

Role

5.7.1 The LPF's role is to provide a formal mechanism where the Trust, as employer, and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

5.7.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.8 Relationship with the Board and others

5.8.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.8.2 The Board may determine that designated Board members or Trust staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or Trust staff, subject to the agreement of the Trust Chair.

5.8.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

5.8.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.8.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 4 for detailed Terms of Reference and Operating Arrangements.

6. WORKING IN PARTNERSHIP

6.0.1 The Trust shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the Trust through:

- The Trust's own structures and operating arrangements, e.g., Advisory Groups; and

- The involvement (at very local and community wide levels) in partnerships and community groups – such as Public Service Boards – of Board members and Trust officers with delegated authority to represent the Trust and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 The Citizen Voice Body for Health and Social Care, Wales (known as Llais)

6.1.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales)**

Act 2020 (2020 asc 1) (the 2020 Act) places a range of duties on Trusts in relation to the engagement and involvement of Llais in its operations.

6.1.2 The 2020 Act places a statutory duty on the Trust to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.1.3 The 2020 Act also places a statutory duty on the Trust to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The Trust must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant)

The Code of Practice on Access to Premises and Engagement with Individuals can be found at

https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

6.1.4 In discharging these duties, and given the all-Wales nature of the Trust's functions, the Board shall work constructively with the Board of Llais to ensure that regional offices of Llais are involved, as appropriate, in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- Engaging, formally consulting and working jointly with Llais on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023 .

The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

6.1.5 The Board shall ensure Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.6 The Board may determine that a designated Llais representative (s) shall be invited to attend Board meetings.

6.1.7 The Board shall ensure arrangements are in place for regular meetings between Trust officers and representatives of Llais.

6.1.8 The Board's Chair shall put in place arrangements to meet with the Chair or Deputy Chair and/or representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The Trust's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The Trust, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested and required) and in electronic formats;
- Requesting that attendees notify the Trust of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the Trust's citizens and other stakeholders, including any views expressed formally to the Trust, e.g., through Llais.

7.2 Annual Plan of Board Business

7.2.1 The Director of Corporate Governance, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include

proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the Trust to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisation's website.

Annual General Meeting (AGM)

7.2.5 The Trust must hold an AGM in public no later than the 31 July each year. [Note : this will be no later than 30 September in 2023 to take account of the timetable for audit and laying of the Accounts by Audit Wales.] At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the Trust's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the Trust are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts and may also include presentation of other reports of interest to citizens and others.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Director of Corporate Governance, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the Trust. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Director of Corporate Governance, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12-day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 5 clear days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Director of Corporate Governance, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must

consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting shall be displayed bilingually (in English and Welsh):

- On the Trust's website, as well as
- Through other methods of communication as set out in the Trust's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the Trust shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc. The agenda and papers will be made available to the public at least 5 clear days before each meeting of the Board.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The Trust shall encourage attendance at its formal Board meetings by the public and members of the press as well as Trust officers or representatives from organisations who have an interest in Trust business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> *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).

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Director of Corporate Governance, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Trust, (whether directly or through the activities of bodies such as Llais and the Trust's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the Trust will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and

relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Director of Corporate Governance. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least one-third of all Board members, at least one of whom is an Executive Director and one is an Independent Member, must be present to allow any formal business to take place at a Board meeting.]

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Director of Corporate Governance will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined

that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e.., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned, and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

7.5.24 In determining every question at a meeting, the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the Trust's citizens and stakeholders. Such views will usually be presented to the Board through the Chair*(s)* of the Trust's Advisory Group*(s)* and the Llais representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the Trust's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulations 2018, and the Trust's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members together with members of any Committee or Advisory Group established by or on behalf of the Board and Trust officials must respect the confidentiality of all matters considered by the Trust in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework GC03 Standards of Behaviour Policy or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the Trust that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Trust, including Board members, Trust officers and others, as appropriate. The framework adopted by the Board is the Trust's Standards of Behaviour Policy (GC03) and will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy and their statutory duties under the Membership Regulations. Board members must notify the Chair and Director of Corporate Governance of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Director of Corporate Governance will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Director of Corporate Governance. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Director of Corporate Governance will ensure that a Register of Interests is

established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Director of Corporate Governance, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Director of Corporate Governance will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Director of Corporate Governance must take reasonable steps to ensure that the citizens served by the Trust are made aware of and have access to view the Trust's Register of Interests. This may include publication on the Trust's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the Trust's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Director of Corporate Governance, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the Trust and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Director of Corporate Governance before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

(i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example

where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

(ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;

(iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;

(iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Director of Corporate Governance when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

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[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

8.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a Trust Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Director of Corporate Governance.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Director of Corporate Governance, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of Trust officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy approved by the Board prohibits Board members and Trust officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or Trust officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Trust Board member or officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Director of Corporate Governance as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems

[2] The term gift refers also to any reward or benefit.

than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Trust;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Trust; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition, gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Director of Corporate Governance, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to Trust officers working within their Directorates.

8.7.2 Every Board member and Trust officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Director of Corporate Governance, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and Trust officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the Trust;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Director of Corporate Governance will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Trust to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the

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[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

adequacy of the Trust's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

9.02. Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1 Register of Sealing

9.1.1 The Director of Corporate Governance shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the Trust, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the Trust shall be kept securely by the Director of Corporate Governance.

10. GAINING ASSURANCE ON THE CONDUCT OF TRUST BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Trust business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in

accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the Trust.

10.0.4 Arrangements for seeking and providing assurance is respect of any other services provided on behalf of or in association with the Trust shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Board Development Programme, as part of an overall Organisation Development framework; and
- the Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the Trust's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the Trust implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee or other appropriate bodies.

10.3.4 The Trust shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and

- Responds to the views and representations made by those who represent the interests of citizens and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their partners.

11.0.3 The Board shall also facilitate effective scrutiny of the Trust's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the Trust, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 The Director of Corporate Governance shall arrange for an appropriate impact assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.

12.0.2 These SOs shall be reviewed annually by the Audit Committee [or equivalent], which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	30th January 2025

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Olayinka Sokoya Executive Support Assistant
PRESENTED BY	Stephen Harries, Vice - Chair and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic, Planning & Digital

REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee held on 5th of December 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	**Digital Strategy Update** This paper provides updates against the strategy and highlights as follows: • The Digital Strategy was subject to review in Aug '24 and minor updates to the strategy are recommended (including increasing the prominence of Artificial Intelligence). Overall, the strategy remains relevant and aligned. • The Digital Programme Board is now well established to deliver the strategy. • Good progress has been made against the six themes of the Digital Strategy and examples are highlighted as follows: • The National Architecture – delivered by Digital Health Care Wales (DHCW) - has unmet need for a cancer information system and limited visibility of the patient pathway tracking. These are being followed up with DHCW. • There needs for a continuous focus on Digital essentials, including infrastructure and data, to support the Trust's strategic ambitions. • Further investment is needed to deliver the Digital Strategy – the Trust's KPI for digital investment is 4% of overall spend with the current level of investment at 2.6%. As we move more services to the cloud the split between capital/revenue will also need to be addressed. • Workforce planning for digital roles needs to move towards the government capability model around Digital, Data and Technology roles (DDaT) as we introduce new modern service design and product management approaches into our digital operating model. • Challenges remain with the delivery of the National digital programmes and in particular for the Trust (Cancer Informatics Programme, Radiology Information System Programme, Laboratory Information System and Electronic Prescribing). The paper was **ENDORSED** for Board approval, subject to the minor amendments discussed by the Committee

Integrated Medium Term Plan 2025 – 2028 Framework

The IMTP planning guidance update was presented to the Committee.

A robust discussion which was predicated principally on the structure, strategic, context, and the need to make the document meaningful for patients, donors, and staff.

The Committee made the following observations:

- To Define the clinical standards required for each core service area and ensure alignment with national standards and regulatory requirements.
- Integrate staff feedback, EDI actions, and culture work into the IMTP plan, ensuring it reflects the values and priorities of the organization

Feedback was provided on the categorization of core services and the integration of staff feedback and EDI actions.

The update was **NOTED** by the Committee.

The purpose of this report is to provide an update against the agreed actions relating to the development of a Tier 1 Portfolio Dashboard.

Major Programme Reporting

The report outlines progress within the following areas in the period since the last update which covers:

- Stakeholder engagement and meetings
- Progress this month:
- Programme Restructuring (Velindre Futures and WBS Futures)
- Scope of Tier 1 Portfolio Report
- Proposed structure of Tier 1 Portfolio Report
- Update of existing dashboard
- Portfolio Timeline (GANTT chart)

The report provided an overview of the change portfolio and highlighted the need for consistent reporting and prioritization.

The Committee **NOTED** the Major Programme Reporting

Digital Programme Highlight Report

This paper had been prepared to provide the Executive Management Board with details of the key updates from the Digital Programme Board held on the 23rd October 2024 and the content of the report is as follows:

- A DH&CR Phase 1 Executive Summary was prepared for EMB, providing assurance to EMB that the aims and objectives from the PID for Phase 1 have all been met and that the MVP has been delivered, as agreed. The suite of Phase 1 closure document was presented to SLT on 8th August 2024. However, the DH&CR Phase 1 Closure report was not approved by EMB.

- A further review of the Executive Summary and Benefits Realisation document was requested to be undertaken by the new Chief Operating Officer (COO). To include further detail on how benefits have been and will continue to be achieved. This activity is now taking place before the documents can continue to progress through the internal governance route, prior to being submitted into the National CIP.

- RISP - The status of the project is AMBER, due to Philips revised plan which has not been finalized. Workflow Demonstration sessions have been well attended, with positive feedback from the Service teams. A second batch of RISP Workflow Specific Demonstrations have been planned in collaboration with Philips and Soliton, covering various topics such as vetting, critical results, statistics, and system administration. Deployment of interfaces to the SIT environment, local workflow analysis, and technical builds at each Health Board/Trust. Resource planning work is being undertaken, for an understanding of Radiology requests.

The Committee **NOTED** the Digital Programme Highlight Report

ASSURE	The Strategic Development Committee **NOTED** the status and on-going development of the Trust Assurance Framework The Strategic Development Committee **NOTED** the Arrangements for Public Switched Telephone Network (PSTN) switch off.
INFORM	
APPENDICES	**NOT APPLICABLE**

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE	
DATE OF MEETING	27 March 2025.
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Olayinka Sokoya, Executive Support Assistant
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 17th October 2024.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to Trust Board.
ADVISE	**TCS Programme Finance Report** The overall forecast outturn for the Programme as at 30th September 2024 is an overspend of £7.956m for the financial year 2024-25 against a budget of £0.666m.

	The main financial risk to the TCS Programme at present is the lack of funding for the capital projects, which is being mitigated by the submission of the nVCC Full Business Case and Enabling Works Full Business Case Addendum to Welsh Government on 3rd September 2024. It is expected that funding should be released upon the approval of both Full Business Cases. The Sub-Committee **NOTED** the TCS Programme Finance Report.
ASSURE	**Programme Director's Report (including all project updates in scope)** The Sub-Committee received the report for the period covering 1st September – 30th September 2024 which provided an update on the interdependencies between the nVCC Project and other Velindre transformation projects that may impact upon delivery of the nVCC within time, cost, and quality tolerances. This refined interdependency focus also meets the PwC Review Report recommendation. The Sub-Committee noted the change and rationale for the Delivery Confidence Assessment (DCA) for the TCS Programme that has been assessment against the DCA criteria and deemed to be Amber-Red in this reporting period, which is a change from Amber in the previous month. The following comments were made in relation to further improvements to the Programme Director and Interdependencies Report: • More specific dates within the Summary of Dependencies & Associated Risks section. • Further information on the risks and issues. • More accurate dates throughout the report i.e. not including October 2024. The dates need to be more specific. The Sub-Committee discussed in detail the TrAMS Project. It was confirmed the workforce and pathways to enable TrAMS to deliver to plan is on track for the VUNHST TrAMS Project. For the National TrAMS Project, the go live date has not been delayed although there is a delay with the Trust receiving the Business Case. The expectation of the TrAMS go live date has not changed. The Sub-Committee noted that the Workforce and OD Team are developing the workforce section within the Programme Director and Interdependencies Report to include further information regarding the project workforce activity and an update will be provided at the next Sub-

	Committee meeting including the workforce pinch points for each project. The Sub-Committee requested an update on the Outreach Project at the November Sub-Committee. The Sub-Committee **NOTED** the Programme Director and Interdependencies Report. **new Velindre Cancer Centre (nVCC) Highlight Report** The Sub-Committee received the nVCC Highlight Report and noted that the Project status for the month of September was Amber. The nVCC Project achieved 12 milestones but missed six milestones within the September period. The missed milestones related to Welsh Government approval of the final cases of the nVCC Full Business Case, which is still in progress. The completion of the RDD work on Mechanical Engineering and Medical Gases was delayed awaiting information from Acorn and the confirmation of funding for equipment procurement. The commencement of the Digital Services recruitment is dependent on Full Business Case approval. The nVCC Project held their first Liaison Committee on 7th October and was reported to be successful. The Sub-Committee **NOTED** the content of the nVCC Highlight Report.
INFORM	**Communication and Engagement Update Report** Further clarification is required in relation to the Communication Programme to ascertain whether there is a separate communications programme managed by the Consortium. A short slide deck is to be provided at the next Sub-Committee meeting that outlines the activities between the Trust and Acorn that summarises the key arrangements and responsibilities. The Sub-Committee **NOTED** the Communication and Engagement Update Report.
APPENDICES	None.

3. RECOMMENDATION

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

TRUST BOARD

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

DATE OF MEETING	30 January 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Olayinka Sokoya Executive Support Assistant
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Executive Director of Transformation.
REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 19th December 2024.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to Trust Board.
ADVISE	There were no items to advise to Trust Board.

ASSURE	**nVCC Project Highlight Report**
	
	The nVCC Project Highlight Report provides a high-level status update on the Project.
	
	The following key highlights were noted as follows:
	• Recruitment of Digital posts has now commenced and it not now a missed milestone.
	• Missed milestones related to the following aspects:
	  ○ Waiting to settle the commercial agreement regarding the changes arising from 1:50 design process with Acorn and the agreement on the change process. It is anticipated that the savings set aside from the chutes will be used to cover off any change implications.
	  ○ Equipping issue relating to small commonly available items to be wall mounted by Acorn. Awaiting information from Acorn to progress.
	• New Construction Programme received from Project Co that has been brought up to date with their progress on site. Everyone is now working off that new programme.
	
	• The Reviewable Design Data (RDD) has been received and work will progress with the Team reviewing the data post-Christmas break. However, there are RDD submissions that appear to be non-compliant that are being discussed with Acorn to ensure they understand what is required regarding the technical submissions in terms of compliance.
	
	It was confirmed that there is pressure on the consultants because they are doing their job more than once. There have been multiple reviews of some areas, in particular, the mechanical and engineering piece for Holly and Kirkwood that has caused some pressures. However, there are no provisions in the contract for the Trust to be able to make a claim against the impact of non-compliance and this has potential implications for the Trust.
	
	• Launch of the major equipment procurement has commenced and will need to conclude by September 2025. This is a key activity that includes items such as the large imaging kit and pharmacy robot and will inform Acorn of the equipment being purchased in order for the design to be completed. Some risk regarding the commissioning has been passed to Acorn and this means that the Trust will need to ensure it keeps to the timeline.

The TCS Programme Scrutiny Sub-Committee **NOTED** the nVCC Project Highlight Report and the project status for the month of November is **Amber.**

Programme Directors Report (including all project updates in scope)

The report provides a monthly assessment of the TCS Programme's performance against a range of criteria in relation to its live projects for the period to 30th November 2024. The following areas are highlighted for information:

- The Delivery Confidence Assessment (DCA) remains as Amber Red for this reporting period as the SRU and TrAMS are at Red status, which is the same as the previous month.

- The default RAG status for Outreach is Red because there is currently no rating. There was a presentation the previous month however, to be more accurate this should be reflected in the Velindre Futures governance as a 'no rating' instead however, this does not provide the required assurance either yet, but will more accurately reflect the delivery of Velindre Futures governance.

- A number of the actions have not been written in a smart way with clear dates for delivery. This will be addressed when the minimum data sets for project reporting are agreed.

- The DCA is an improving position and receiving the nVCC Full Business Case approval has been a key driver. However, the Satellite Radiotherapy Unit (SRU) and national TrAMS are still areas of concern. However, once the delivery date is certain for the SRU then this could potentially move to Amber status.
- Ways of working have improved with the move to working closely with the PMOs with the flow of reporting and the tighter management of the interdependencies has resulted in an improving position overall.

- An update on the SRU which is Red Status on the risk register was provided, however, a lot of work has been done despite the initial delay, which was 12 weeks. The critical path areas, which included the resolving of the water issues, CT SIM, M&E works and RPA shield. Following the issues with the flooding and

	asbestos which have been resolved, the commissioning has commenced, and it is expected that the first patient will be scanned around 9th/10th June 2025 and the Radiotherapy treatment would commence around 20th June 2025. Where possible the contractor is running things in parallel to make up the lost time. • The Clatterbridge has also agreed to be a Critical Friend and will be review progress at various points, using their experience, and currently reviewing the Trust's SRU Implementation Plan to advise on whether there are any elements that have been missed. The TCS Programme Scrutiny Sub-Committee received for ASSURANCE, assessed at Level 3, the content of the Programme Director and Interdependencies Report and **NOTED** the Amber Red Status of Delivery Confidence Assessment (DCA)
INFORM	**nVCC Programme Finance Report** The purpose of the report is to provide a financial update for the Transforming Cancer Services (TCS) Programme and its associated projects for the financial year 2024-25, outlining spend against budget as at 30th November 2024 and the current year-end forecast. Funding approvals letter had been received from Welsh Government on 18th November 2024, which confirmed the nVCC Project has £69.7m capital and £2.4m in revenue. The Enabling Works Project has £8.9m capital. Both capital amounts included a QRA amount that will be held by Welsh Government that can be called upon as and when risks materialise. The third element of Welsh Government funding that is expected this year is in relation to the Whitchurch Hospital site, which is now under the ownership of the Trust. The Trust is finalising the figures with Welsh Government and would expect that to be in the region of £350k to support the development of the disposal strategy, some minor works and clearance works on site. It was confirmed that work is ongoing to finalise financial plans with Workstream Leads, which will be based on the latest forecast and reflect

agreed budgets. This will be included in the December 2024 financial report that will be presented to the Committee in January 2025.

The year-to-date spend as 30th November 2024 for the TCS Programme is £4.6m Capital with a forecast outturn of £7.1m. Revenue is £749k with a forecast outturn of £749k. The forecast at year end for the TCS Programme is a break even position.

The TCS Programme Scrutiny Sub-Committee **NOTED** the financial position for the nVCC Programme and associated projects as at 30th November 2024.

Communication and Engagement Report

The Communication and Engagement Report was presented to the TCS Programme Scrutiny Sub-Committee. The following points were brought to the Committees attention:

It was highlighted as follows:

- There is a piece of work Kate Hammond has undertaken as part of the wider Cardiff Council Initiative and the nVCC Community Benefits, in particular, the Open your Eyes Week. Two virtual education sessions were hosted in partnership with Acorn for school pupils across Cardiff to help with the myth busting around construction roles and the importance of collaborative working.

- A communication piece has been produced that highlights the successful sessions and will be shared outside of the Committee.
- The learning from the Summer events is being used to explore what can be undertaken in the wider communities.
- Kate Hammond has been in contact with other Engagement colleagues in Health Boards to explore opportunities to take a Roadshow to other healthcare settings to create more awareness among patients, carers, and families.

The TCS Programme Scrutiny Sub-Committee **NOTED** the Communication and Engagement Report.

nVCC Project Board Terms of Reference

The Project Board Terms of Reference were delivered to the TCS

	Programme Scrutiny Sub-Committee. The Terms of Reference were endorsed at Extraordinary Project Board on 16th July 2024. It was confirmed the SRO will chair the nVCC Project Board once appointed. Currently the nVCC Project Board is chaired by Matt Bunce, Executive Director of Finance. It was requested to include a caveat that if it was decided it was not appropriate for the meeting to be chaired by the SRO, but that it should be chaired by another senior officer, the Terms of Reference would be amended as required. From September onwards the nVCC Project Board will include external parties including NWSSP, Welsh Government and Acorn. The TCS Programme Scrutiny Sub-Committee **ENDORSED** the nVCC Terms of Reference in principle.
APPENDICES	None.

3. RECOMMENDATION

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

TRUST BOARD	
HIGHLIGHT REPORT FROM THE CHAIR OF THE TRANSFORMING CANCER SERVICES (TCS) PROGRAMME SCRUTINY SUB-COMMITTEE	
DATE OF MEETING	27 March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Olayinka Sokoya Executive Support Assistant
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Director of Transformation.
REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 23rd January 2025.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to Trust Board.
ADVISE	There were no items identified to advise the Trust Board.
ASSURE	**nVCC Project Highlight Report** The Sub-Committee received the nVCC Project Highlight Report setting out progress during the reporting period. The following key highlights were noted: • Recruitment is behind schedule. However progress is being made to catch up in relation to recruitment activities during the month and workstreams have adopted new strategies considering recent experiences in the market. • A revised programme for RDD was issued by Acorn in late December 2024 however, due to the concerns around the RDD, a session was held with Acorn to work through the RDD technical and mechanical packages. There are some residual issues to pick up and there is an agreed process going forward for reviewing the RDD and ongoing discussions for the Independent Tester to be part of the RDD review process. • As the RDD Programme is still behind schedule, a further revised programme is expected to be issued on 24th January 2025 and there is a commitment from Acorn to ensure there is an acceptable design by the given timescales and this will assist in the de-escalation of the project risk. • Good progress is being made with the procuring of the Category 2C major medical equipment. Workshops with the suppliers went well and all are up to speed with what is required to meet the contractual requirement to provide information to Acorn. • Planning for the commissioning migration activities is underway with departmental meetings and work with the VCS Leadership Team to define and scope the roles and responsibilities of the Commissioning Board that oversees the commission migration activities and it is anticipated to be completed by the end of the month. • A planning application to extend the use of the Temporary Construction Access Road (southern entrance) for a further year has been submitted and is being considered by the Planners. • Construction work is progressing with the lower levels of the building and drainage.

	• Work continues to implement the recommendations of the Governance and Capability review. A proposed way forward in terms of a blended structure within the project resourcing plan is being developed.
	• Formal authorisation of the change relating to concrete mix is being worked through in order to confirm acceptance of it with the contractor.
	• A design solution for the Lolfa is being developed by the contractor that retains the exposed timber.
	• The five Amber Project risks related to matters discussed during the meeting relating to:
	  ○ Resourcing – capacity and capabilities of the Project Team.
	  ○ Relationships – predominantly arising from the delays and issues with the RDD Programme, which is being resolved.
	  ○ RDD Programme – as above.
	  ○ Retained Project Aagreement (PA) Obligations – TCAR extended planning application.
	  ○ Planning Compliance – ongoing monitoring and advising the contract of any breaches.
	• Missed milestones related to the following aspects:
	  ○ RDD Programme.
	  ○ Issuing of contract for construction of HV Intake room due in December is awaiting final internal approvals.
	  ○ Completion of recruitment to all key posts.
	  ○ Commencement of inventory of Cancer Centre equipment is awaiting staff appointment.
	  ○ Engagement milestone missed relates to communication work regarding the inventory work (see above).
	  ○ The formal quarterly sharing of PA notices with Acorn due in December 2024 was completed in January 2025, to ensure that all notices from the year 2024 were included.
	• Future reporting of missed milestones will include whether the responsibility is with the Authority and / or Contractor and also include a Critical Path Analysis that details the effect of the missed milestones on the Project completion.
	• A session to capture lessons learnt from the Enabling Works Project and how those lessons learnt can be planned into and utilised in relation to the capabilities of the Team to map and improve the business processes that are being developed.

	The TCS Programme Scrutiny Sub-Committee **NOTED** the nVCC Project Highlight Report and the Amber Project status for the month of December 2024. **nVCC Programme Finance Report** The Sub-Committee received the nVCC Programme Finance Report and noted that for the period as at 31st December 2024, the year-to-date spend for the TCS Programme is circa £4.9m Capital and £474k Revenue, with a forecast expenditure for the current financial year of circa £7.1m Capital and £749k Revenue. Following the approval of the nVCC FBC and the EW FBC Addendum, further funding was received in November 2024 of £69.719m Capital and circa £2.4m Revenue for the nVCC activities between 2024 and 2028. Circa £8.9m Capital was received for the Enabling works relating to works between 2024 and 2027. For the Enabling Works, the Trust is profiling the expenditure for each of those years with Welsh Government and for the Trust's Financial Plan, which is anticipated that this will be finalised by the end of February 2025. Additional funding of £0.082m was received from the Welsh Government in November 2024 in respect of nVCC Project Resources Funding 2024-2028 to cover the recurrent pay award for 2024-25. There are no anticipated financial risks and the year-end forecast is break even. The TCS Programme Scrutiny Sub-Committee **NOTED** the financial position for the nVCC Programme and associated projects as at 31st December 2024 and the current year-end forecast. **Programme Director and Interdependency Management Report** The Sub-Committee received the Programme Director and Interdependency Management Report for the period 1st to 31st December 2024 and the Delivery Confidence Assessment of an Amber-Red status for this reporting period. The Sub-Committee discussed the outstanding action regarding the overall effectiveness of the reporting in providing the assurance needed around the project interdependencies related to the nVCC Project and considered the proposed change in the management and the reporting of those interdependencies between the nVCC Project, Velindre Futures Programme and the Whitchurch Land relationships, with particular reference to the workforce requirements for the nVCC Project. Given the pressures on the workforce which are impacting on

	a number of projects, it was agreed that the workforce analysis would be presented more frequently than quarterly and that a full analysis will be presented to the Sub-Committee in February 2025. Concerns were raised in relation to the national TrAMS Programme which has remained in Amber - Red status for some time with little progress. The Sub-Committee requested that the report on TrAMS scheduled to be presented at the February meeting includes a Contingency Plan should the national TrAMS Programme not be delivered on time. It was clarified that the 8.4-week delay and the build completion being moved to 1st May 2025 highlighted in Section 3 Matters of Note referred to the Satellite Radiotherapy Unit (SRU). The TCS Programme Scrutiny Sub-Committee **NOTED** the Programme Director and Interdependency Management Report and the work being taken forward to further review the report in the context of enhancing the model, approach and structure of how the interdependencies between the nVCC Project, Velindre Futures Programme and the Whitchurch Land relationships are managed.
INFORM	**Communication and Engagement Update Report** A very successful site visit took place with local Councillors, Senedd Member and MP to the nVCC construction site. The visit was led by SACYR and involved a brief tour of the site and a presentation on the Community Benefits followed by a discussion about plans and activities that could be undertaken together in the future. The Sub-Committee was informed that the Trust Chair has written to the Cabinet Secretary with an invitation to visit the Trust also the nVCC construction site. The TCS Programme Scrutiny Sub-Committee **NOTED** the Communications and Engagement Update and the work being undertaken the publicise the new hospital. **Sub-Committee Public Meeting Frequency** The Sub-Committee was informed that following discussion with the Independent Members and Executive Team, going forward the frequency of the Public meeting of the TCS Programme Scrutiny Sub-Committee will be changed to every two months, so that the Sub-Committee will be meeting publicly six times a year. It was clarified for reassurance to the public that although the Public meeting was moving to a two-monthly cycle, a 'Private' meeting will still be held each month

	to scrutinise matters of an appropriate nature i.e. contractual and / or commercial in confidence. The Sub-Committee was also informed that a review of the title of the Sub-Committee is also being considered to better reflect the role of the Sub-Committee and the review of the Terms of Reference for the Sub-Committee will be proposing the new Sub-Committee title.
APPENDICES	None.

3. RECOMMENDATION

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

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TRANSFORMING CANCER SERVICES (TCS) PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	20th February 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Christine Sion, Business Support Officer
PRESENTED BY	Hilary Jones, Independent Member and Interim Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Director of Transformation.
REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 20th February 2025

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to Trust Board.
ADVISE	There were no items identified to advise the Trust Board.
ASSURE	**nVCC Project Highlight Report** The Sub-Committee received the nVCC Project Highlight Report, providing an update on progress during the reporting period. The following key highlights were noted: • Digitisation of Health Records Plan – Work is progressing to scope the transition to a fully digital, paperless organisation. The initial scoping work will assess current records, review existing processes, and explore planned digital solutions, including ePMA. A proposal for this work has been submitted and is being actioned. • Health and Safety Data – The report included health and safety statistics for the construction site. Questions were raised about contextualising the data, particularly regarding the 390 safety observations and two lost time incidents. It was clarified that safety observations are proactively reported by site personnel and are considered a positive measure of engagement with health and safety processes. • RDD Progress and Decision-Making – Assurance was sought on the involvement of external advisors in the Reviewable Design Data (RDD) process. It was confirmed that while external advisors provide structured guidance, VUNHST retains full ownership of decisions. All written documentation is reviewed and signed off internally, ensuring clarity and accountability. • Target Dates for Risk Management – The Sub-Committee reiterated the need for target dates to be assigned to risks in the nVCC Highlight Report to provide greater assurance on active risk management. It was confirmed that this improvement will be implemented in the next reporting cycle. • Lolfa Design Solution – The contractor is working on a design solution that retains the exposed timber while complying with fire safety regulations. No update on progress has been received, and discussions are ongoing to determine an acceptable resolution. • Project Readiness – It was highlighted that by April 2025, the project must have a fully capable team in place, with all reporting and contracts finalised. The construction programme over the

next six weeks will be closely monitored to ensure there are no delays that could impact delivery.

- Risk Reporting – A discrepancy was identified in the risk section of the report, where risks were stated as unrelated despite potential interdependencies. This will be reviewed, and a second highlight report may be issued if required to ensure risks are accurately reflected.

The TCS Programme Scrutiny Sub-Committee **NOTED** the **nVCC Project Highlight Report** and the **Amber Project status** for the reporting period.

nVCC Programme Finance Report

The TCS Scrutiny Committee **received** the financial position for the TCS Programme and Associated Projects for 2024-25 as at 28th February 2025, and noted that the year-to-date spend for the TCS Programme is £6.339m Capital and £0.643m Revenue, with a forecast expenditure for the current financial year of £7.266m Capital and £0.799m Revenue

The summary of the financial position for January 2025 is as follows:

- The capital year-to-date is £5.5 million, with a forecast of £7.2 million.
- The current forecast includes a turnover spend of £368,000, which is pending the approval of a QRA funding by the Welsh Government. This funding will be included in the updated Capital Expenditure Limit (CEL) for the Trust.
- Revenue year-to-date is £600,000, with a forecast of £700,000, and forecasting a break-even is anticipated.
- No financial risks were reported.

Additionally, the Committee noted the limited expenditure of £200k on Project 5: SACT and Outreach. It was clarified that the project has not received dedicated project funding and is instead being supported through existing Velindre Cancer Services (VCS) resources. While the reported expenditure appears minimal, ongoing work is being carried out but is not fully captured within the current financial reporting structure. Governance and reporting processes are being refined to ensure progress and dependencies are more accurately reflected. Moving forward, a revised report will provide greater clarity, and efforts

	are underway to consolidate all relevant information in alignment with the Committee's terms of reference. The TCS Programme Scrutiny Sub-Committee **NOTED** the financial position for the TCS Programme and Associated Projects for 2024-25 as at January 2025. **Programme Director and Interdependency Management Report** The Sub-Committee received the Programme Director and Interdependency Management Report for the period 1st to 31st January 2025 and the Delivery Confidence Assessment of an Amber-Red status for this reporting period, although overall programme performance is improving. The number of red risks has reduced from four to two, reflecting progress in risk mitigation. The Sub-Committee discussed key programme developments, including the Satellite Radiotherapy Unit (SRU), which remains in a critical implementation phase. It was noted that the revised go-live date is early June 2025. While several risks related to PSBA and the CT simulator were noted, these are considered manageable given the project's pace. A comprehensive review of the Critical Path is underway to ensure go-live plans are robust. A potential de-escalation of the Delivery Confidence Assessment will be considered next month, dependent on risk trends. The Interdependencies Report remains a priority, with efforts ongoing to strengthen the structure across three levels: national, programme-to-programme, and internal workstreams within the nVCC project. The PwC review is informing this work, and upcoming workshops will further enhance alignment. The Sub-Committee also received updates on workforce requirements, with improvements in data accuracy through collaboration with key stakeholders. Recruitment for SRU remains on track, though a critical vacancy for a physiotherapist has been highlighted. A RAG rating system will be implemented in future reports to track the recruitment timeline and ensure early visibility of potential risks. Concerns continue to be raised regarding the national TrAMS Programme, particularly its potential impact on nVCC. The Sub-Committee emphasised the need for greater oversight and clarity on whether the TrAMS model aligns with the anticipated requirements for nVCC. Given the lack of progress at the national level, it was agreed that TrAMS will be flagged as a red risk in interdependency reporting,

	and work will continue independently within Velindre Cancer Service to ensure an internal model is fit for purpose. The TCS Programme Scrutiny Sub-Committee **NOTED** the Programme Director and Interdependency Management Report and the ongoing work to further refine interdependencies, workforce planning, and governance structures.
INFORM	**Communication and Engagement Update Report** The Sub-Committee received an update on the latest communications and engagement activities supporting the nVCC project. Key initiatives included ongoing promotion of the project and planning for upcoming staff engagement activities. A scale model of the new hospital is now available for public viewing in the Patient Information area of the cancer centre, offering staff, patients, and visitors an opportunity to visualise the completed facility. Work is also underway to develop high-quality visuals to be displayed both on-site and digitally, enhancing awareness and engagement while ensuring a welcoming and informative environment. The Sub-Committee was informed that a regional programme update will be presented next month, with growing interest in ongoing work at Whitchurch hospital grounds. The TCS Programme Scrutiny Sub-Committee **NOTED** the Communications and Engagement Update and the work being undertaken the publicise the new hospital. **Review of Sub-Committee Terms of Reference** The Sub-Committee was informed that a review of the Terms of Reference (ToR) is underway to ensure clarity on governance arrangements and the committee's role within the TCS Programme. This follows discussions on strengthening oversight of project interdependencies and ensuring alignment across the programme. It was clarified that the proposed changes relate only to the name of the Sub-Committee and do not alter its functions or responsibilities. The committee will continue to oversee project interdependencies, while VCS Futures will be overseen by the Strategic Development Committee. The revised ToR will ensure that the committee's remit remains clear and consistent with its existing role.

APPENDICES	None.

TRUST BOARD	
PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	27 March 2025
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, Quality, Safety & Performance Committee Chair and Independent Member
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
REPORT PURPOSE	FOR DISCUSSION
APPENDICES	
Appendix 1	Quarter 3 Quality & Safety Report

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 13th March 2025.

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. Following its annual review in March 2024, the Committee continues to mature, actively seeking opportunities for continuous improvement, together with the ongoing development of reporting formats, additional assurance mechanisms and discussions to facilitate ongoing streamlining and triangulation of information.

3. HIGHLIGHTS FROM THE MEETING HELD ON 13TH MARCH 2025

3.1 Triangulated themes

The following triangulated themes were identified:

- **Quality and Service Improvement**: There was a focus on demonstrating improvements through data and intelligence, aligning with patient, donor, and staff feedback. This theme was evident in the Quality and Safety Report, NHS Staff Survey, Workforce and Finance Report, and PMF.
- **Financial Risk**: The financial risk linked to the Long Term Agreement (LTA) and the position with Hywel Dda was highlighted as a significant concern.
- **Governance Arrangements**: The need for clarity in governance arrangements, particularly related to the TrAMs and Shared Services, was discussed extensively.

These themes were discussed across various sections of the meeting, reflecting the ongoing efforts to improve quality, manage financial risks, and ensure robust governance structures.

3.2 Further Information

Board members who are not members of the Committee and would like further detail of the Quality, Safety and Performance (QSP) Committee are able to access the agenda and papers for the January 2025 QSP Committee meeting at:

https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-2025/quality-safety-performance-committee-13032025/

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 to alert/escalate to Trust Board.
ADVISE	**Trust Quality & Safety Report** The Committee received the Trust quarter 3 Quality & Safety report and the Integrated Quality & Safety highlight report from the meeting held on 17th February 2025. The Quality and Safety report is attached in ***Appendix 1***. The following key points were highlighted: • Duty of Candour was not triggered during the quarter however six duty of candour incidents were identified during January 2025. Not all had occurred during January. There were no themes from within those incidents. Some repeated themes with previous incidents were identified and the cancer service senior team are reviewing these currently to ensure that actions being undertaken to address themes are being effective. • Putting Things Right Compliance reduced to 75% (lower than usual although still at national target) due to complex concerns and team resilience issues. Actions have been taken to further enhance resilience moving forward. • Work remains underway within Velindre Cancer Service to ensure that letters are sent to GPs within 30 days of an appointment.

The Committee **agreed** the proposed **assurance level of 4**.

Finance Report for the Period Ended 31st January 2025 (M10)
The Committee received the finance report, highlighting the following key points:

- **Long Term Agreements (LTA)**: There was a reduction of £800,000 in income due to negotiations on LTAs for the current financial year. There was a discussion about the challenges in rebasing contracts and the lack of agreement from commissioners.
- **Savings**: The report indicated that savings are largely on track, but there is a £100,000 pressure due to non-delivery of recurrent savings targets. This will impact next year's plan.
- **Financial KPIs**: The Trust is expected to meet all three key performance indicators: revenue balance, staying within capital resource limits, and meeting the public sector payment policy.
- **Next Year's Plan**: There are risks for next year's plan due to lack of additional funding for business cases from Commissioners.

Transforming Access to Medicine / Clinical Pharmacy Technical Services Update

The Committee received an update from NHS Wales Shared Services Partnership (NWSSP) in respect of Pharmacy Technical Services and the Transforming Access to Medicines (TrAMs) project.

Ongoing projects within the service were highlighted, such as the national influenza programme and new product development. The Committee were advised that a detailed annual review of the service, including performance metrics, will be presented at the next meeting.

The Committee highlighted the programme board's approval for tendering to proceed in advance of the business case approval and expressed concern around the tight timelines in respect of the Board meeting cycle. The need for realistic timelines and ensuring that the tendering process aligns with the approval of business cases by the respective boards was highlighted.

Significant discussion took place in respect of TrAMs governance aligned with the Trust as hosting organisation rather than a commissioner (user). The need to strengthen and clarify the governance arrangements was identified. It was agreed that a meeting with key stakeholders would be arranged. In addition, a review of the board processes for approval will be undertaken to ensure clarity and alignment with the governance arrangements.

Sarcoma Service

	The Committee received a report providing an update in respect of the Sarcoma service. The following was highlighted: • The sarcoma service is currently stable, with no incidents reported since the previous report. • Themes arising from the previously reported incidents have been used to strengthen the service support infrastructure, particularly outpatient support. • Efforts are ongoing to enhance workforce resilience, including extending the existing consultant's contract, involving another consultant from a different specialty and discussions with potential new consultants. • A pathway navigator has been introduced to help track patients and ensure oversight. • The cancer patient tracking list and harm review process are being integrated to improve patient tracking and breach analysis. • The long-term solution involves moving to a super-regional approach for sarcoma services due to the highly specialised nature and recruitment challenges. • A register of fragile services is being developed to ensure consistent quality standards and approaches. • The service is linked to regional planning and the Joint Commissioning Committee for oversight and support. The applied **assurance level of 3** was **agreed** by the Committee.
ASSURE	**Findings from the Medicines and Healthcare products Regulatory Agency (MHRA) inspection of Welsh Blood Service, December 2024** The Committee received and discussed the report received following the WBS MHRA inspection carried out in December 2024. There were no 'critical' findings, one 'major' finding relating to deficiencies in the controls to ensure the integrity of data, and six '*others'.* The improvement plan has been developed and many actions have already been completed. Final sign off was awaited from the MHRA and the final report will be provided to Committee members when available. The Committee were advised that the report was very positive and one of the best inspections the Welsh Blood Service has received to date. This positive outcome was largely attributed to the team's open and transparent approach during the inspection, which was well-received by the inspectors. **Bullying, Harassment and Discrimination Actions** The Committee received the action plan, an iteration of the draft action plan which will support the Strategic Equality Plan for the next twelve

	months. The action plan focuses on fewer actions in order to ensure thorough implementation. In order to monitor progress against the action plan it was agreed that the Committee would receive a Culture and Inclusion paper at alternating Committee meetings to report on all of the elements of work and progress against those elements. The proposed **assurance level of 3** was **agreed** by the Committee. **Staff Survey Report** The Committee received the 2024 Staff Survey report and noted the following key points: • The overall response rate increased year on year, and there was positive movement on each of the ten themes. The staff engagement index also rose. • A staff survey group has been assembled, with terms of reference developed. The group will focus on both Trust-level and divisional-level actions. • The Executive Management Board identified three themes to form the foundation of the action plan at both Trust and divisional levels. • Trust-level actions will include enabling change at divisional levels, with a focus on training and support. The Committee **agreed** the **assurance level of 2.** **Performance Management Framework (PMF) Report and Supporting Analysis** The Committee discussed the PMF report, which was summarised as follows: • **Development Work**: The PMF development work has been reviewed, and an internal audit report provided reasonable assurance on the progress of the nine work packages. The audit suggested tightening up on specific deliverables and outcomes. • **Manual Handling Training**: There was an escalation regarding patient manual handling training. Actions have been taken to address the backlog, with weekly updates to be provided to ensure progress. • **Go Paperless Initiative**: The "Go Paperless" initiative went live on March 10th, which is expected to enhance utilisation and productivity. • **Cancer Patient Tracking List (PTL) and Harm Review**: The cancer PTL and harm review process are being integrated to improve patient tracking and reduce breaches. • **Radiotherapy Breach Data**: The extension of the life of two linear accelerators (LAs) was discussed to manage capacity and demand. • **Workforce and Well-being**: Focus on improving PADR compliance and ensuring actions lead to desired targets.

- **Digital Services**: Sustained improvement in the service desk and focus on cyber compliance. Issues with the radiology program were noted, with further updates to be provided.
- **Estates and Infrastructure**: Planned maintenance backlog at WBS is being managed, with a focus on completing backlog maintenance by the end of the financial year.
- **Health and Safety**: Two RIDDOR incidents were reported, with actions taken to address training and reporting issues.

Levels of assurance for each area were **agreed** as follows:

- Velindre Cancer Service - **level 3**
- Welsh Blood Service - **level 3**
- Workforce & Wellbeing - **level 4**
- Digital Services - **level 4**
- Estates, Infrastructure & Sustainability - **level 3**
- Health & Safety - **level 4**
- Financial Services - **level 4**

Trust Risk Register
The Committee discussed the Trust Risk Register, noting that there are 14 risks currently on the register. Two new risks were added during the period, and three risks had their scores reduced:

- New risks: The new risks are related to the review of blood tests at the cancer centre and black ice.
- Reduced risks: The reduced risks are linked to Chemocare, sarcoma service, and the Welsh Blood Service fleet.
- The Committee received a verbal update on the electricity supply risk for the Welsh Blood Service, noting that a major fix is planned for the forthcoming weekend, which would reduce the risk.
- In terms of the static risks on the risk register, clarity was sought as to why certain high-rated risks (e.g., 3270, 3332, 3448) remained static despite mitigations, and concern raised that this may indicate that the mitigations might not be effective. The absence of clear timeframes for achieving target risk levels was also noted, which made it difficult to assess whether the risks were within a tolerable range or if further action was needed. The Committee were advised that the Executive Management Board (EMB) had discussed the issue of static risks and was currently interrogating the details on DATIX to better understand the situation.

The Committee **agreed** to maintain a **Level 2 assurance** for the Trust risk register, with plans to improve this through ongoing work and reviews.

Trust Assurance Framework
The Committee received the Trust Assurance Framework (TAF), noting that the strategic leads are now offering a narrative. This is a new development aimed at providing the necessary information for

	assurance purposes. The goal is to evolve this approach to align with the IMTP for the next year. Concern was raised regarding the use of the three lines of defence in the Trust Assurance Framework, with inconsistencies in its application noted. it was suggested that the framework should include more comprehensive elements such as stakeholder engagement and patient voice, which are currently underrepresented. The importance of reviewing the levels of assurance and ensuring that the framework accurately reflects potential gaps in assurance was emphasised. The **level of assurance** was determined to remain at **Level 2** due to ongoing work on the GAR (Governance and Risk) programme and the review of policy and procedures governing risk management. The goal is to move towards a higher level of assurance by the next Committee, with clarity on dates and actions that will improve the assurance level. **Integrated Medium Term Plan - Progress against 2024 -2025 Quarter 3 Actions** The Integrated Medium Term Plan (IMTP) progress up until Quarter 3 was reviewed. The completion rate of actions is not as high as expected due to the way milestones are articulated. However, the IMTP will be updated to better reflect ongoing pieces of work and their completion status and the articulation of milestones for the next year's IMTP will be improved based on the learning from this review.
INFORM	**Welsh Blood Service Development Service Story** The Committee received a video from the Welsh Blood Service, which focused on the recent introduction of West Nile Virus testing and the positive impact that this has had on donors. The service development initiative was introduced between May and November last year due to feedback from disappointed donors who has been turned away from sessions following travel to high risk areas. The introduction of the test has seen a saving of over 2000 units in the supply chain for screening purposes, along with improvements in session time and performance. Furthermore, the initiative is anticipated to save around 3000 units through the summer season. The initiative was self-funded by the service and is an example of supporting equality, safety improvements, and enhanced donor experience. **Trust Policies for Approval** The Committee **APPROVED** the following Trust policies that had been reviewed in line with national guidance changes:

	• IPC01 - Viral Gastro-Enteritis (including Norovirus) policy • IPC04 - Decontamination policy • IPC07 - Policy for the Prevention & Control of Meticillin Resistant Staphylococcus Aureus (MRSA) • IPC15 - Control & Management of Multi-Drug Resistant Bacteria (MDRO) policy • IPC18 - Tuberculosis Management • Model Policy for Consent to Examination and Treatment
APPENDICES	None.

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 13th March 2025.

TRUST BOARD	
CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT	
DATE OF MEETING	27 March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Niké Hooper-Collins, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance
REPORT PURPOSE	FOR NOTING

ACRONYMS	
ISA	International Standard on Auditing
PSA	Prostate Specific Antigen

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 23rd January 2025.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Charitable Funds Committee (CFC) held on the 23rd January 2025:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**CHARITABLE FUNDS ANNUAL REPORT AND ACCOUNTS** **Velindre Charitable Funds Audit Plan 2024** Audit Wales presented the Audit Plan, summarising the main issues and risks identified during the audit planning prior to commencing the fieldwork. The findings from the audit are detailed in the Annual Financial Accounts Audit – ISA 260 Report, as a separate item for consideration however, it was confirmed that all identified risks have been satisfactorily addressed. The Charitable Fund Committee **NOTED** the Audit Wales Velindre Charitable Funds Audit Plan 2024. **Annual Financial Accounts Audit - ISA 260 Report** Audit Wales presented the ISA 260 Report summarising the results of the financial audit of the Charity annual accounts; the recommendations arising from the audit and the management response of those recommendations. The annual accounts will be receiving a clear opinion for 2024 and the opinion is also included in the Charity Annual Report for 2024. The Auditor General will be signing off the accounts on 29th January 2025 in preparation for the Trust to submit to the Charity Commission by the end of January 2025. The Charitable Fund Committee: • **APPROVED** the Audit Wales Annual Financial Accounts Audit - ISA 260 Report. • **AUTHORISED** the Chair and Executive Director of Finance to sign the Letter of Representation. **Velindre University NHS Trust Charitable Funds Trustee Annual Report and Annual Accounts 2023-2024** The Charity Director presented the Charitable Funds Annual Report for 2023-2024, which was a celebration in acknowledgement of the supporters of the Charity, the achievements, expenditure and the look forward as the Charity moves into the digital era, the strengthening of community engagement and embracing inclusivity.

The Charitable Funds Committee welcomed the Annual Report and Accounts for 2023-2024 and **NOTED** the new format and the plans for how it will be developed going forward.

The Charitable Funds Committee **APPROVED** the Annual Report and Accounts for 2023-2024, subject to the typographical amendments and final scrutiny by Audit Wales prior to final sign off by the Chair and Executive Director of Finance.

BUSINESS CASE AND EXPENDITURE PROPOSALS
Prior to considering each of the four Business Cases submitted in more detail, the Chair of the Charitable Funds Committee made a general observation that all four business cases, which amount to circa £700k, state that as an exit strategy will be incorporated into core funding when the Charity funding ceases. This will have a future impact on whether these services have to cease or whether the Trust will have to commit from core funding to continue to provide these services.

The Executive Director of Finance clarified that the expectation going forward is for those who prepare each business case should make every effort to consider the exit strategy and include the detail in their business case. It is the responsibility for business case authors to present their business cases to health board commissioners for advice in relation to whether their cases will be prioritised for exchequer public funding instead of the reliance of charity funding. As part of the exit strategy the business case should include an assessment of the likely risk at the end of the Charity funding period based on the advice obtained from the health board commissioners.

- **Complementary Therapies Business Case**
  The Charitable Funds Committee were in support of the business case in principle however, **AGREED** to defer until the March meeting on the basis that there needs to be further discussions alongside it to see how to futureproof the service delivery model and under the condition that an EQIA is provided.

- **My Medical Record - PSA Self-Management Business Case**
  The Charitable Funds Committee:
  - **AGREED** that this was an important addition to the Trust's service which could have a positive impact on both patient experience and outpatient flow.
  - **REQUESTED** that the service lead negotiates with the health board to discuss the possibility of including Velindre Oncology patients

	into their PSA tracking service or to fund the Trust going forward. ○ Depending on the outcome of the health board negotiations, will **APPROVE** funding for: ▪ Either a period of time whilst arrangements are made to transfer the service to the health boards; ▪ Or the full three year period should health boards decline the request. Subject to the outcome of the health board negotiation, the funding approval to be undertaken Out of Committee if necessary. • **Patient Education Charitable Funds Business Case** The Charitable Funds Committee **AGREED** to defer the patient education proposal to the March meeting, requesting further detail to address the outstanding matters highlighted from the previous meeting. • **Head of Patient Engagement Management Business Case** The Charitable Funds Committee: ○ **APPROVED** the proposal, subject to financial adjustments and updates on achieved objectives.
ASSURE	There were no items for assurance to the Trust Board.
INFORM	There were no items to inform the Trust Board.

3. RECOMMENDATION

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

TRUST BOARD

TRUST SEAL REPORT: 30 JANUARY 2025 – 20 MARCH 2025

DATE OF MEETING	27 March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	FOR NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Non Gwilym, Director of Corporate Governance (interim)
APPROVED BY	Non Gwilym, Director of Corporate Governance (interim)
EXECUTIVE SUMMARY	The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(30th January 2025 to 20th March 2025)**.
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	
7 LEVELS OF ASSURANCE – N/A	
APPENDICES	
Appendix 1 – Seal Register	

1. SITUATION/ BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(30th January 2025 to 20th March 2025).**

1.2 Board Members are asked to view the content of the report. Further information or queries should be directed to the Interim Director of Corporate Governance.

2.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis: Please refer to the Seal Register at **Appendix 1**.

3 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.

4 RISKS

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

Appendix 1 – Seal Register

Date	Document Details	Signed
13th February 2025	Construction contract for the provision of construction services in relation to: nVCC enabling works – HV Intake Building between Velindre University NHS Trust (the Client) and E.T. & S. Construction Ltd (the Contractor).	Professor Donna Mead OBE, Chair, and David Donegan, CEO

TRUST BOARD

TRUST WIDE POLICIES APPROVED UPDATE

DATE OF MEETING	27 March 2025
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR NOTING
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Trust Board regarding the status of the Trust wide policies and to advise of those that have been approved during the period **February 2025 to March 2025.**
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the policies that have been approved during the period **February 2025 to March 2025.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
APPENDIX 1:	
• Velindre Cancer Service Senior Leadership Team	05/12/2024
• Welsh Blood Service Senior Leadership Team	12/12/2024
• Integrated Quality and Safety Group	17/02/2025
• Executive Management Board	25/02/2025
• Quality, Safety and Performance Committee	13/03/2025

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

- **Appendix 1** – QS17 Model Policy for Consent to Examination and Treatment:

  Was **ENDORSED** by the Velindre Cancer Service Senior Leadership Team; Welsh

Blood Service Senior Leadership Team; Integrated Quality and Safety Group; Executive Management Board and Quality, Safety and Performance Committee.	
APPENDICES 2 - 6:	
• Extraordinary Trust Infection Prevention and Control Management Group (IPCMG)	15/02/2025
• Executive Management Board	25/02/2025
• Quality, Safety and Performance Committee	13/03/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The following policies were **ENDORSED** by the Extraordinary Trust Infection Prevention and Control Management Group (IPCMG); Executive Management Board and Quality, Safety and Performance Committee. • **Appendix 2** – IPC 04: Decontamination of Equipment Policy • **Appendix 3** – IPC 07: Meticillin Resistant Staphylococcus Aureus (MRSA) Policy • **Appendix 4** – IPC 18: Tuberculosis Management Policy • **Appendix 5** – IPC 01: Viral Gastroenteritis Policy • **Appendix 6** – IPC 15: Control & Management of Multi Drug Resistant Bacteria Policy	
APPENDICES 7:	
• Executive Management Board	25/02/2025
• Research, Development and Innovation Sub-Committee	12/03/2025
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS • **Appendix 7** – RD01: Intellectual Property Policy Was **ENDORSED** by the Executive Management Board and Research, Development and Innovation Sub-Committee.	

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
Appendix 1	QS17: Model Policy for Consent to Examination and Treatment
Appendix 2	IPC 04: Decontamination of Equipment Policy
Appendix 3	IPC 07: Meticillin Resistant Staphylococcus Aureus (MRSA) Policy
Appendix 4	IPC 18: Tuberculosis Management Policy
Appendix 5	IPC 01: Viral Gastroenteritis Policy
Appendix 6	IPC 15: Control & Management of Multi Drug Resistant Bacteria Policy
Appendix 7	RD01: Intellectual Property Policy

1. SITUATION/BACKGROUND

1.1 In accordance with the "Policy and Procedure for the Management of Trust wide Policies and other Written Control Documents", the Trust Board will receive all approved policy documents for information under the Consent Agenda.

1.2 The purpose of this report is for the Trust Board to note the policies that have been through the Trust governance process and approved during the period **October 2024 to November 2024.**

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Since the last Trust Board, the Quality, Safety and Performance Committee **APPROVED** the policy below, which has been uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

Appendix	Policy Title	Policy Lead / Function	Approving Body	Effective Date
1	QS17 Model Policy for Consent to Examination and Treatment:	Executive Medical Director	Quality, Safety & Performance Committee	13/03/2025
2	IPC 04: Decontamination of Equipment Policy	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	13/03/2025
3	IPC 07: Meticillin Resistant Staphylococcus Aureus (MRSA) Policy	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	13/03/2025
4	IPC 18: Tuberculosis Management Policy	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	13/03/2025
5	IPC 01: Viral Gastroenteritis Policy	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	13/03/2025
6	IPC 15: Control & Management of Multi Drug Resistant Bacteria Policy	Executive Director of Nursing, AHP & Health Science	Quality, Safety & Performance Committee	13/03/2025
7	RD01: Intellectual Property Policy	Executive Medical Director	Research, Development & Innovation Sub-Committee	12/03/2025

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*	04 – Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	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	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-Wales Consent to Treatment Group

Grŵp Cydsynio i Driniaeth Cymru Gyfan

VELINDRE UNIVERSITY NHS TRUST

Ref: QS17

Model policy for consent to examination and treatment

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Glossary

AC	**Approved clinician (Supplementary guidance only)**
ADRT	**Advance Decision to Refuse Treatment**
BMA	**BMA – British Medical Association**
BNF	**British National Formulary (Supplementary guidance only)**
CAD	**Court Appointed Deputy**
CANH	**Clinically Assisted Nutrition and Hydration**
CoP	**Court of Protection**
CTO	**Community Treatment Order (Supplementary guidance only)**
DBD	**Donation after brainstem death**
DCD	**Donation after circulatory death**
DNA	**Deoxy-ribo Nucleic Acid**
DNACPR	**Do Not Attempt Cardiopulmonary Resuscitation**
ECT	**Electroconvulsive Therapy**
EPO	**Emergency Protection Order**
GMC	**General Medical Council**
HFEA 1990	**Human Fertilisation and Embryology Act 1990**
HFEA	**Human Fertilisation and Embryology Authority**
HIW	**Healthcare Inspectorate Wales (Supplementary guidance only)**
HRA	**Human Rights Act 1998**
HTA 2004	**Human Tissue Act 2004**
HTA	**Human Tissue Authority**
HTA 2013	**Human Transplantation (Wales) Act 2013**
IMCA	**Independent Mental Capacity Advocate**

IMHA	**Independent Mental Health Advocate (Supplementary guidance only)**
ICSI	**Intracytoplasmic sperm injection**
IVF	***In vitro* fertilisation**
LPA	**Lasting Power of Attorney**
MCA	**Mental Capacity Act 2005**
MHA	**Mental Health Act 1983**
MCS	**Minimally Conscious State**
Montgomery	**Montgomery v Lanarkshire NHS Health Board**
OPG	**Office of the Public Guardian**
PPO	**Police Protection Order**
PDOC	**Prolonged Disorder of Consciousness**
PVS	**Persistent Vegetative State**
SCT	**Supervised Community Treatment (Supplementary guidance only)**
SOAD	**Second Opinion Doctor (Supplementary guidance only)**
WHC	**Welsh Health Circular**

Foreword

The Supreme Court ruling in Montgomery v Lanarkshire Health Board [2015] fundamentally changed the legal framework for consent to examination and treatment in the UK, focusing the consent process on the specific needs of the individual patient.

Existing best practice guidance from the General Medical Council (GMC) and other regulatory bodies, already highlighted the importance of individual autonomy and the active involvement of an informed patient in a shared decision-making process. The Montgomery judgement closed the gap between the legal and regulatory frameworks. The practical implications for clinical practice are clear, but so too is the legal framework.

The core part of this Policy provides general guidance on consent to examination and treatment in line with current legal and regulatory frameworks in Wales and England. Guidance is also incorporated for decision-making when patients temporarily or permanently lack capacity. Supplementary guidance is provided for specific scenarios which may be encountered in Obstetrics and Gynaecology or Mental Health settings.

We recognise that this is a lengthy policy document, but wanted to provide a detailed point of reference for healthcare professionals covering different situations they may encounter in their clinical practice. This policy also refers to the recently updated ‘Guide to Consent for Examination or Treatment’, produced by the Welsh Assembly Government, which provides a detailed overview of the current legal framework.

Executive summary

What is consent?

- Consent is a patient's ongoing agreement to treatment or care
- It is a process – not a one-off event
- For consent to be valid –
    - the patient must have the mental capacity to make the relevant decision about their treatment or care
    - consent must be given voluntarily
    - they must be properly informed about the proposed intervention
- Compliance, where a patient is not able to make an informed decision, is not "consent"

What information should be provided?

Patients must be provided with all the information they require, in a format and language they can understand, so that they can make an informed decision about what treatment, if any, they want to receive. The following should be discussed with the patient:

- All reasonable treatment options
- All of the intended benefits and material risks.
- Any requirement to take and retain tissue samples, photographs etc.
- The presence of any trainees or students
- The use of any experimental techniques

- Any requests for further information or clarification should be met

- Outside an emergency setting, patients should be given adequate time to consider all of the relevant information

What is a material risk?

The test of materiality is whether, in the circumstances of the particular case:

- a reasonable person in the patient's position would be likely to attach significance to the risk; or
- the clinician is, or should be, reasonably aware that the particular patient would be likely to attach significance to it

What are the exceptions to the duty to disclose all relevant information?

- Where the patient has made it clear that they do not want to know the risks involved; or

- Where treatment is required urgently, but the patient is unconscious or unable to make the decision for any reason (treatment is provided on the grounds of necessity); or

- Where advising the patient of the risks would be seriously detrimental to their health (this 'therapeutic exception' is limited and should not be abused)

When do healthcare professionals need to obtain consent?

- Before any kind of treatment or care is provided, if the patient has capacity to consent

Who is the right person to seek consent?

- The healthcare professional providing the intervention

- Seeking consent can be delegated to an appropriately trained colleague

- If you have been asked to obtain consent but don't feel competent to do so, you must refuse

How does a patient give consent?

- Consent is given through an ongoing dialogue between the patient and healthcare professional

- Consent will normally be given verbally or in writing, but consent may also be implied in certain circumstances

- The consent form is a record of the patient's decision, along with the record of any related discussions in a patient's medical or nursing notes

- A signature on a consent form does not prove that valid consent has been obtained

- This consent policy explains when you should obtain written consent

Can children (aged under 16 years) give consent for themselves?

- Children under 16 years who are *Gillick* competent can give consent

- Where a child is not *Gillick* competent, someone with parental responsibility must give consent on their behalf, unless the situation is an emergency and they cannot be contacted

- If a competent child consents to treatment, a parent **cannot** over-ride that consent

- If a competent child refuses necessary treatment, legal advice should be sought

- Not all parents have parental responsibility for their children (e.g. unmarried fathers do not automatically have such responsibility)

- If you doubt whether a patient has parental responsibility for a child, you must check

What about patients (aged 16 years and over) who lack capacity to give consent?

- Patients (aged 16 years and over) are presumed to have mental capacity unless demonstrated otherwise. A patient lacks capacity to make a specific decision if:

    - They have an impairment or disturbance that affects the way their mind or brain works; and

    - That impairment or disturbance causes them to be unable to make a specific decision at the time it needs to be made

- An assessment of a patient's capacity must be based upon their ability to make a specific decision at the time it needs to be made. A patient with an "impairment or disturbance" is unable to make a decision if they cannot do one or more of the following:

    - **Understand** the information relevant to the decision

    - **Retain** the information long enough to make a decision

    - **Use or weigh up** the information as part of a decision-making process

- **Communicate the decision** – this could be by talking or using sign language and includes simple muscle movements such as blinking or squeezing a hand

A patient is not to be treated as unable to make a decision unless all practicable steps to help the patient do so have been taken without success. A patient can only be said to be unable to communicate when all forms of communication have been explored.

- A person who has authority under a Health and Welfare Lasting Power of Attorney (LPA) or a Court Appointed Deputy (CAD) with appropriate authority can give consent when the patient lacks capacity

- In the absence of a person with authority under a Health and Welfare LPA or CAD, or a valid and applicable advance decision to refuse treatment, you must determine the patient's best interests in accordance with Mental Capacity Act 2005 (MCA)

- 'Best interests' includes past and present wishes, feelings, beliefs and values of the patient lacking capacity and any other factors which they would take into account if they were able to do so

- You must, where practical and reasonable, consult people who care for, or have an interest in the welfare of the patient, about the patient's wishes and beliefs

- Where there is nobody with whom you can consult, apart from paid staff, an Independent Mental Capacity Advocate (IMCA) must be instructed where decisions are needed about serious medical treatment (including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders). The only exception to this duty occurs when an urgent decision is required e.g. to save the patient's life. IMCAs will not make a decision for the patient, but healthcare professionals have a legal duty to consider their views.

What about refusal of treatment?

- Adults with capacity are entitled to refuse treatment or withdraw consent for any reason, at any time, no matter how unwise this may seem. The exception is where the treatment is for mental disorder and the patient is detained under the Mental Health Act 1983 (MHA)

- A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to the health of the fetus. If a woman in labour refuses treatment seek urgent legal advice

- If an *un-sedated* patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately and the event recorded in the notes

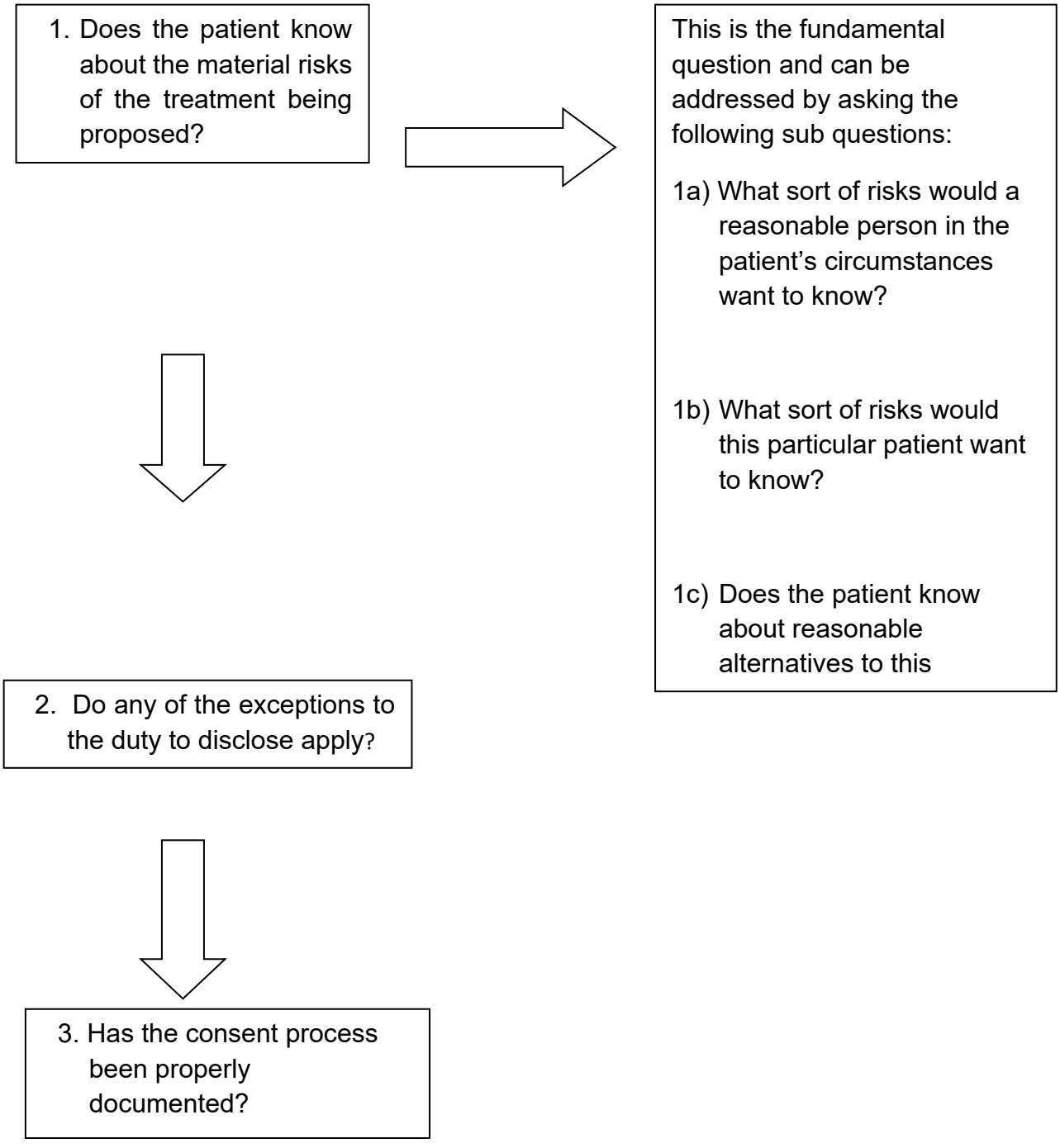
- If a patient lacks capacity but has clearly indicated in the past, while competent, that they would refuse treatment in specified circumstances (an advance decision), and those circumstances arise, you must abide by that decision if it is **valid** and **applicable**

- Advance decisions (made by patients with capacity aged 18 years or over) about life-sustaining treatment **must be** made in writing and contain a statement that the advance decision is to apply even if their life is at risk. The document must be signed by the patient (or by someone appointed by them), in the presence of a witness, who must also sign the document.

Informed Consent Flowchart

If a patient has capacity, they are entitled to decide which, if any, of the available treatments to undergo and their consent must be obtained before treatment.

In order to obtain and document informed consent the three questions below, together with the sub-questions, should be addressed:



CORE POLICY

1. Introduction

About this policy

1. Velindre University NHS Trust recognises that people have a fundamental legal and ethical right to determine what happens to their own bodies and this is reflected in this policy. Valid consent to treatment is absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is not only a legal obligation but also a matter of common courtesy between healthcare staff and patients. Both the Velindre University NHS Trust and healthcare staff may be liable to legal action if valid consent is not obtained.

2. Doctors, Nurses and Allied Health Professionals must at all times follow professional standards as set out in GMC, NMC, HCPC and other regulatory guidance. The Welsh Government's (WG) updated Welsh Health Circular: WHC 2023/021 - Consent for Examination or Treatment refers to the WG's Guide which sets out the legal framework for consent and can be found on the following link - Guide to Consent for Examination or Treatment - Revised guidance). The Supreme Court ruling in Montgomery v Lanarkshire NHS Health Board, has fundamentally changed the legal framework for consent to examination and treatment, enshrining the concepts of **informed consent** and **material risk** in UK law (discussed later in chapter 3), bringing the law on consent in line with existing regulatory guidance. Healthcare staff in this Velindre University NHS Trust should comply with the standards and procedures in this policy, which should be applied in conjunction with the principles set out in the Guide.

3. While this policy is primarily concerned with healthcare and refers to healthcare staff in all NHS settings, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

4. A patient may either be an adult or a child. Reference in this policy to an adult means a patient of 18 years or above and a child is a patient who is under the age of 16. Reference in this policy to a young person means a child aged 16 or 17 years.

5. In Section 17, the terms 'woman' and 'women' will be used to refer to those accessing obstetric and gynaecology services, however we recognise and respect that these services will be accessed by women, gender diverse individuals and people whose gender identity does not align with the sex they were assigned at birth - Equality, diversity and inclusion | RCOG

What consent is – and isn't

6. Consent is a patient's ongoing agreement for healthcare staff to provide care or treatment. Before providing care or treatment, healthcare staff should be satisfied that the patient has given their **consent**. Consent will only be valid if:

- the patient has capacity to give consent
- it is given freely and not under duress
- the patient has been properly informed

7. Consent can be given in writing, verbally or even indicated non-verbally (for example by presenting an arm for a pulse to be taken). In all cases it is essential that an adequate record of the consent is maintained for future reference.

8. The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of advice from a healthcare professional. In some cases, the healthcare professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the healthcare staff will help the patient to decide between the available options.

The relevant questions to consider

9. In seeking to obtain valid consent, healthcare staff should ask themselves a series of questions, as follows.

Is there reason to doubt the patient's capacity to give consent?

10. In determining whether an adult or young person lacks the mental capacity (either temporarily or permanently) to give or withhold consent, healthcare professionals must act in accordance with the MCA and the MCA Code of Practice. It is important to remember that nobody can give consent on behalf of an adult, unless they are an appointed attorney with authority under a Health and Welfare LPA or Court Appointed Deputy. A patient who lacks capacity can, however, be given treatment if it is in their best interests in accordance with the MCA, unless there is a valid and applicable advance decision refusing treatment (advance decisions are valid only for adult patients).

11. When treating patients who may lack capacity, healthcare professionals should give careful consideration to chapter 8 of this policy and the Guide, particularly the paragraphs set out below.

Is the consent given freely?

12. Pressure to agree to a particular treatment can be intentionally or unintentionally applied by family, friends or healthcare professionals. Professionals should be alert to this possibility, and where appropriate, arrange to review the patient on their own to establish that the decision is autonomous.
13. When patients are seen and treated in environments where involuntary detention may be an issue, such as prisons and mental health hospitals, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent and care must be taken to ensure that the patient makes a decision freely. Coercion should be distinguished from providing the patient with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for their health. However, threats such as withdrawal of any privileges or loss of remission of sentence for refusing consent, or using such matters to induce the patient to give consent are not acceptable. Consent will not be valid in these circumstances.

Is the patient aware of all of the material risks and benefits of the proposed treatment and or any alternatives, including no treatment?

14. The healthcare professional must inform the patient about all the material risks, benefits and available alternatives, including no treatment. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and healthcare professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the healthcare professional's clinical knowledge.

15. The informed person may either be the patient or someone with parental responsibility. Where a patient lacks capacity to give consent to the specified treatment, the decision should be made in the patient's best interests in accordance with MCA 2005. It is important that a person acting under a Health and Welfare LPA or a CAD for health and welfare decisions is also aware of all material risks, benefits and available alternatives, including no treatment.

Cultural issues

16. Cultural diversity issues should be actively considered whilst obtaining patient's consent. Members of some religious faiths, for example, are extremely modest in relation to exposure of parts of the body and may only consent to examination or treatment if it is undertaken by someone of the same sex. Please refer to local organisational policies and guidelines.

17. If there is any doubt or uncertainty in relation to particular consent issues contact [insert details of local process].

2. Documentation

18. Healthcare professionals must clearly document the information provided to a patient and any related discussions during the consent process. This may be recorded on a consent form (with further detail in the patient's medical notes as necessary) or within an entry in the patient's medical notes. (See chapter 3).

19. Where the signing of a consent form is not required, healthcare professionals must document the consent process followed within an entry in the patient's medical notes, including details of any information provided or related discussions.

Valid forms of consent

20. It will not usually be necessary to obtain a patient's written consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be advisable to do so.

21. It is rarely a legal requirement to seek written consent[1],but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some healthcare professionals would describe as 'side-effects' or 'complications');
- the procedure involves general/regional anaesthesia or sedation;
- providing clinical care is not the primary purpose of the procedure;
- there may be significant consequences for the patient's employment or personal life;
- the treatment is part of a project or programme of research approved by this Velindre University NHS Trust (see chapter 17 of this policy).

22. If you are in doubt about whether a procedure requires written consent, then the

[1]The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances

safest course of action is to complete an appropriate consent form.

23. It is important to note that the place in which the treatment or procedure is to be carried out e.g. outpatients / theatre / clinic / in the patient's home, etc. should not affect the type of consent taken. The nature of the consent (i.e. written, verbal or implied) should be appropriate to the procedure concerned.

24. Abbreviations should never be used on consent forms.

25. Completed forms should be kept with the patient's medical notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and the relevant healthcare professional.

26. A patient's signature on a consent form does not prove that valid consent has been provided. If a patient has made a decision on the basis of inadequate information, or has not had sufficient time to make a decision, consent may not be valid. Conversely, if a patient has given valid verbal consent, the fact that they have not signed a consent form does not mean that consent is not valid. Patients may withdraw consent after they have signed a form; it is not a binding contract.

Standard consent forms – Consent Forms 1 and 2

27. There are two versions of the standard consent form:

- **Consent Form 1** for adults, young people or Gillick competent children:
- **Consent Form 2** for parental consent for a child under 16 who is not Gillick competent

28. The consent forms have been designed to allow the patient to be given a copy in either Welsh or English. It is essential that the original top copy, which is in English, is the one filed in the patient's medical notes. See appendix A.

Form for patients aged 16 years and over who are unable to consent for themselves – Form 4

29. The standard consent forms (**Consent Forms 1 and 2**) should never be used for adult patients and young people who are unable to consent for themselves. Where an adult patient or young person does not have the capacity to give or withhold consent to a significant intervention, this should be documented in **Form 4** - Treatment in best interests: form for patients aged 16 years and over who lack capacity to consent to examination and treatment. See appendix A.

30. Although Form 4 is referred to as a consent form, it should be noted that no-one, other than a person who has authority under a Health and Welfare LPA or a CAD for health and welfare decisions can give consent on behalf of an adult patient. If a person who has authority under an LPA or a CAD is giving consent then they should sign the appropriate section of Form 4. A copy of Form 4 should be offered

to this person.

31. Form 4 requires healthcare professionals to document why the patient lacks the capacity to make this particular healthcare decision, and why the proposed treatment would be in their best interests, in accordance with the Mental Capacity Act 2005. Where the patient's family and friends have been consulted about the patient's wishes and feelings (in order to inform the determination of what is in the patient's best interests) the details of this discussion must also be recorded on the form. For further information regarding patients who lack mental capacity to give or withhold consent, see chapter 8 of this policy. For more minor interventions, this information should be entered in the patient's medical notes

Patient information leaflet

32. Patients may find consent forms daunting or confusing and an explanatory leaflet "**About the consent form**" is available for patients with questions or concerns (Appendix E).

Availability of forms

33. Consent Forms 1 and 2 and Form 4 can be ordered via the Oracle system.

Procedure/condition specific consent forms

34. Procedure specific consent forms may offer advantages for clinical practice and service organisations, providing standardised information about significant risks, benefits and alternative treatment(s). Space must be provided on these forms so that any additional material risks, which are specific to individual patients, can be recorded. The forms should also meet Welsh language requirements in line with the Welsh Language Standards.

35. Velindre University NHS Trust must develop clear guidance on the development of procedure specific consent forms which must be approved through appropriate governance arrangements.

36. VCC approved to use Cancer Research UK (CRUK) and Royal College of Radiologists (RCR) procedure specific consent forms for systemic anti-cancer treatment (SACT) and radiotherapy. See appendix F for guidance on use of CRUK and RCR forms in VCC and Outreach clinics.

3. When should consent be sought?

37. Outside an urgent setting, it is good practice to seek the patient's consent to the proposed procedure well in advance, so that there is time to respond to questions and provide adequate information for the individual patient to make a fully informed decision. Seeking consent should be viewed as a process rather than a one off event, reflecting a dialogue between the individual patient and the healthcare professional. The provision of information and related discussion are components of the shared decision-making process.

38. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness and/or urgency of the situation. Healthcare professionals should take reasonable care to ensure that patients are made aware of all of the intended benefits, material risks and alternatives to the proposed treatment.

What is a "material risk"?

39. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the healthcare professional is or should be reasonably aware that the particular patient would be likely to attach significance to it.

40. All clinical staff should have regard to the ruling in the case of Montgomery v Lanarkshire Health Board[2] given on 11th March 2015.

41. Following this Supreme Court ruling, healthcare professionals are reminded of their professional responsibility to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."

42. This standard of consent is similar to that required in GMC Guidance – Good Medical Practice 2013 – namely, work in partnership with patients. Listen to, and respond to their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patients' right to reach decisions with you about their treatment and care[3].

43. Healthcare professionals must be satisfied that:

- The patient knows and understands all the material risks of the proposed treatment;

[2] https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf
[3] http://www.gmc-uk.org/guidance/good_medical_practice.asp

- The patient is aware of all reasonable alternatives[4];

- They have taken reasonable care to ensure that the patient understands all of the relevant information

- Valid exceptions to the duty to disclose apply.

44. The three exceptions to the duty to disclose are:

- The patient tells the healthcare professional that they prefer not to know the risks;

- The healthcare professional reasonably considers that telling the patient something would cause serious harm to the patient's health and wellbeing

- Consent is not required as the patient lacks capacity and urgent treatment is required.

45. The Informed Consent Flowchart set out at the beginning of this document provides a useful reference guide for staff on the practical implications of the Montgomery case and is also available online[5].

Single stage process

46. In many cases, it will be appropriate for a healthcare professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient gives their consent, the procedure can go ahead immediately. Verbal consent will often be provided in this situation. This should be recorded in the patient's medical notes.

47. If a proposed procedure/treatment involves significant and important material risks for the patient concerned, it may be appropriate to seek written consent. Healthcare professionals should also consider whether the patient has had sufficient opportunity or time to process the information required for them to make the relevant decision.

[4] McCulloch and others (Appellants) v Forth Valley Health Board (Respondent) (Scotland) (supremecourt.uk)

[5] http://howis.wales.nhs.uk/sitesplus/documents/861/Legal%20and%20Risk%20-%20Montgomery%20flowchart.pdf

Two or more stage process

48. In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure. This may be on just one occasion or it might be over a whole series of consultations with a number of different healthcare professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (verbal) decision, and the second being confirmation that the patient still wants to go ahead[6]. A careful record of the information provided and the related discussion with the patient should be detailed in the patient's medical notes. The consent form may be used as a means of recording the information stage(s), as well as the confirmation stage.

49. Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the consent form documenting the decision-making process (either in Welsh or English). They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. However, if a form is signed before patients arrive for treatment, a member of the healthcare team (for example a nurse admitting the patient for an elective procedure) **must** check with the patient at this point whether they understand the procedure and the risks involved, whether they have any further questions or further concerns and whether their condition has changed. This is particularly important where:

- there has been a significant lapse of time between the form being signed and the procedure;
- new information becomes available regarding the proposed intervention (for example, new evidence of risks or new treatment options);
- the patient's condition has changed significantly in the intervening period;
- the patient's responsible clinician has changed since the form was signed.

50. Similarly, if a patient is returning on multiple occasions for a course of treatment, a member of the healthcare team must check with the patient on each occasion that they still consent to the procedure. This confirmation of consent should be recorded on the consent form, or, if insufficient space, in the patient's medical notes.

51. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

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[6] https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/consent/

52. It should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

53. The patient's consent may be obtained by post, as this gives the patient time to read and reflect on the consent form and information provided. However, any person carrying out a procedure must ensure, at the earliest opportunity following admission, that the patient has understood the information and that they still give their consent. If the patient has queries or concerns they must be given time to consider any additional information. It is important to remember that, whether a patient does or does not have capacity to consent, no relative or carer can sign on their behalf (unless provided for in accordance with the MCA – see chapter 8 of this policy) and under parental responsibility: if the competent child or young person wishes the parent to take the decision for them).

54. Patients should not be given pre-operative sedation before being asked for their consent to proceed with treatment (although women in labour can consent to a caesarean section even if they have received sedation – see paragraph 274 of this policy). If a situation arises where a change to the consent form is required after the patient has received sedation, this should only be done if the doctor responsible for the patient's care is clearly able to demonstrate that the patient still has capacity to be involved in the decision to make the required change. This must be documented in the patient's medical notes. The outcome of the assessment, any changes made to the consent form and the reasons for the changes must also be clearly documented in the patient's medical notes it is found that the patient does not have capacity due to the administration of sedation, any changes to the consent form should be delayed until capacity is regained (i.e. the effects of the sedation have worn off). If the urgency of the situation is such that a delay in undertaking the procedure would lead to harm to the patient, any decision that is made about continuing has to be made in the best interests of the patient. Best interests decisions and the reasons for them should be documented in the patient's medical notes. Chapter 8 of this policy provides further guidance on assessing capacity and making best interest decisions.

Seeking consent for anaesthesia

55. Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and significant or material risks with the patient. In an elective setting it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient may not be able to make a considered decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in an outpatient setting, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the

discussion with the patient and their consent is recorded in the anaesthetic record, the patient's medical notes or on the consent form. Where the healthcare professional providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then they will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

56. Where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has been provided all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

Emergencies

57. Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) may follow straight on from each other, and it may often be appropriate to use the patient's medical notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality and should still include benefits, significant and important (material) risks and alternatives relevant to the individual circumstances of the patient.

Treatment of children and young people

58. When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law and consider carefully whether the child or young person is competent to give their consent to the treatment. Chapter 7 of this policy provides further information.

Withdrawal of consent

59. A patient with capacity is entitled to withdraw consent at any time. Where a patient does object during treatment, it is good practice for the healthcare professional, if at all possible, to stop the procedure, establish the patient's concerns, and explain the consequences of not completing the procedure. If the patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately.

60. The healthcare professional should try to establish whether at that time the patient has capacity to withdraw consent. This is particularly important if the patient has been given sedation. If a patient lacks capacity, it may be justified to continue in the patient's best interests in accordance with the MCA.

61. If a sedated patient or one who otherwise lacks mental capacity to consent begins to struggle or resists treatment either verbally or physically, it is the responsibility of the healthcare professional to act in the patient's best interests. If this event occurs at a crucial time, which will have an impact on a successful outcome, then it would be wise to pause, attempt to regain co-operation and complete, perhaps

with additional sedation. If the situation deteriorates, is irretrievable, and patient safety is likely to become compromised, then termination of the procedure is recommended. This must be recorded in the patient's medical notes.

62. Issues relating to withdrawal of consent by patients being treated in accordance with sections 57, 58 or 58A of the Mental Health Act are discussed in chapter 18 of this policy.

4. Provision of Information

63. The provision of information is central to the consent process. Before patients can make an informed decision about their treatment, they need comprehensible information about their condition and any reasonable treatment options and their risks and benefits (including the risks/benefits of doing nothing). Patients also need to know the scope of the intended treatment and whether additional procedures are likely to be necessary, for example blood transfusion or the removal of particular tissue.

64. Patients will differ in how much information they want about a proposed treatment. Some patients will want as much detail as possible, including details of rare risks, while others will ask healthcare professionals to make decisions for them. In such circumstances, the healthcare professional should explain the importance of understanding the significant risks and benefits of a recommended treatment, and making an informed decision. The *presumption* must be that the patient wishes to be well informed about the material risks and benefits of the various treatment options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented and the patient may be asked to sign the record to confirm their decision. It must be made clear to the patient that they can change their mind and have more information at any time.

Has the patient received sufficient information?

65. To give valid consent the patient needs to be provided with sufficient information to understand in broad terms the nature and purpose of the procedure. Information about any significant and material risks and benefits of the proposed treatment and any alternative options should be provided, including the option of no treatment. Any misrepresentation of these elements will invalidate consent. Where relevant, information about anaesthesia must be given (see paragraph 56 above) as well as information about the procedure itself.

66. The information provided should be tailored to the individual patient.

67. The use of patient information leaflets can help healthcare professionals to provide patients with the information they need, in order to arrive at an informed decision. Wherever possible patients should be sent information prior to their appointment so that they have time to read and absorb it, and can consider what questions they would like to ask when they meet with the relevant healthcare professional. This will help to ensure that they fully understand the treatment being proposed and can make an informed decision regarding consent. However, the use of leaflets does not remove the healthcare professional's responsibility to provide a verbal explanation of often much the same information. In this context, the use of patient information leaflets is considered to be an example of best practice. The use and provision of the patient information leaflet should be documented on the consent form or in the patient's health records. A copy of the patient information leaflet should be inserted into the patient's health record. If an EiDO information leaflet has been used, its name, number and date can be documented.

68. Patient information in different formats and languages must be made available.

Communication Issues

69. A patient must not be assessed as lacking capacity to consent to the particular investigation, treatment or care merely because they have a limited ability to communicate. Care should be taken not to underestimate the ability of a patient to communicate, whatever their condition. Healthcare professionals should take all reasonable steps to facilitate communication with the patient, using communication aids as appropriate. Particular consideration should be given to the way in which information is presented to the patient. Drawings, diagrams and models may be useful for example. In emergency situations, taking these steps may not be possible, but good practice would be to record the reasons for this in the patient's medical notes.

70. Where appropriate those who know the patient well, including their family, friends, carers or staff from professional or voluntary support services, may be able to advise on the best ways to communicate with the patient.[Insert details of local guidance].

Provision for Welsh speaking patients

71. The Welsh Language (Wales) Measure 2011 has given the Welsh language official status in Wales by placing Welsh Language Standards on organisations – (see the Trust's Welsh language policy - https://velindre.nhs.wales/about-us/welsh-language/policy/) The duties deriving from the standards mean that the Velindre University NHS Trust and its staff should not treat the Welsh language less favourably than the English language. In line with the Welsh Language Standards, the language preference of the patient must be offered, established, recorded, acted upon and relayed to others within the Velindre University NHS Trust. Welsh speaking healthcare professionals should ideally obtain consent from patients whose preferred language is Welsh. If the relevant healthcare professional is not Welsh speaking, consent should be obtained with the support of Welsh speaking colleagues or simultaneous translation.

72. The All Wales consent forms provided with this policy (see chapter 2 of this policy) have been designed bilingually so that the patient can be given a copy in either English or Welsh. It is essential that the top copy, which is in English, is completed and added to the patient's medical notes. Availability of bilingual consent forms ensures that:

- Welsh and English versions of consent forms are equally accessible to patients;
- both the patient and healthcare professional are clear about what is being agreed to in circumstances where a non-Welsh speaking healthcare professional is dealing with a Welsh speaking patient; and
- the needs of mixed-language families, other mixed-language audiences and Welsh learners are met.

Provision for patients whose first language is not English or Welsh

73. Velindre University NHS Trust is committed to ensuring that patients whose first language is not English or Welsh receive the information they need and are able to communicate appropriately with healthcare staff. This includes British Sign Language (BSL). In order to safeguard the consent process, unless the healthcare professional is fluent in the patient's language, an interpreter should ~~always~~ be used when seeking consent from the patient - except for minor or routine procedures, including most screening procedures. It is generally not appropriate to use children or family members to interpret for patients who do not speak English, however a clinician must balance the risk of delay whilst awaiting access to a professional interpreter with proceeding with a procedure using a family member as a translator. The clinician must be satisfied that the patient has understood all the risks, benefits and alternatives to a procedure - including no procedure. A formal translator must be instructed where the clinician has any doubts about the understanding of the patient and this may require the rescheduling of a procedure. Where a family member to assist with translation has been utilised, this should be documented within the clinical record where possible.

[Insert local details of how to access translation and interpreting service, what materials are available in which languages etc. Reference other relevant local policies or guidance – e.g. on use of interpreting.]

Access to more detailed or specialist information

74. Patients may sometimes request more detailed information about their condition or a proposed treatment than that provided in general leaflets.

Access to healthcare professionals between formal appointments

75. After an appointment with a healthcare professional, patients will often think of further questions which they would like answered before making a decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or wait until the date of an elective procedure, by which time it is too late for the patient to reflect upon the information. Patients should be provided with appropriate contact details at the time of their appointment.

76. The provision of advice over the telephone needs to be undertaken by suitably qualified staff and must follow agreed guidelines, policies and procedures. Advice given must be evidence based and up to date. A record must be kept in the patient's medical notes. Where advice deviates from accepted guidance, the advice given must be clearly documented and the reasons for such deviation stated.

Open access clinics

77. Where patients access clinics directly, it should not be assumed that their presence at

the clinic implies consent to particular treatment. You should ensure that they have the information they need to give their consent before proceeding with an investigation or treatment.

Consent and inpatients

78. Irrespective of whether the patient is an inpatient or outpatient, the process of seeking consent must be adhered to. Just because a patient is already in a hospital bed, consent for examination and treatment cannot be assumed. As stated previously, the patient needs to be provided with sufficient time and information to understand in broad terms the nature and purpose of the procedure.

5. Who is responsible for seeking consent? -

79. The healthcare professional carrying out the procedure is ultimately responsible for ensuring that the patient has given valid consent for the proposed treatment or procedure. They will be held responsible in law if the validity of consent is subsequently challenged.

80. Where verbal or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the healthcare professional responsible. However, team work is a crucial part of the way the NHS operates and, where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent e.g. providing information about the treatment or procedure.

Competence of those seeking consent

81. Consent must be obtained by a healthcare professional who is competent either because they themselves carry out the procedure or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit. Inappropriate delegation (e.g. where the healthcare professional seeking consent has inadequate knowledge of the procedure) may mean that the consent is not valid.

82. It is a healthcare professional's own responsibility:

- to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
- to work within their own competence and not to agree to perform tasks which exceed that competence.

83. If you feel that you are being pressurised to seek consent when you do not feel competent to do so, discuss with the Trust Quality and Safety team.

84. The Wales Deanery and the Welsh Government have made it clear that F1 doctors can only take consent in specific clinical situations where they have undertaken formal training and their competency has been assessed. Healthcare professionals are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary.

Completing consent forms

85. The standard consent form provides space for a healthcare professional to provide information to patients and to sign confirming that they have done so. The healthcare professional providing the information must be competent to do so.

86. If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a healthcare professional involved in their care on the day should sign 'Confirmation of Consent' section of the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

Attendance by students and trainees (i.e. pre-registration clinicians from any discipline)

87. Where a student or trainee healthcare professional is undertaking examination or treatment of the patient where the procedure will further the patient's care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the patient that the healthcare professional is a student, although it would always be good practice to do so and consent in the usual way will still be required.

88. In contrast, where a student proposes to conduct a physical examination which is not part of the patient's care, then it is essential to explain that the purpose of the examination is to further the student's training and to seek consent for that to take place. Verbal consent must be obtained and a record made in the patient's medical notes.

89. A patient's consent should be obtained when a student is going to be present during an examination or treatment purely as an observer. Patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment. Written consent must be obtained if students or trainees are going to be present during examination or treatment using sedation or anaesthetic.

90. Patients must be informed that they have the right to refuse consent to being observed, attended to or examined by students without any detrimental effect on their treatment.

91. It is essential that appropriate supervision of students is carried out in all of the above situations and that, where consent is required, the supervisor is reassured that valid consent has been obtained.

Attendance by company representatives

92. On occasions when company representatives need to be present for a procedure/treatment (e.g. where equipment is being used for the first time and the representative is there to assist with its use), written consent from the patient must be obtained.

6. Adults with Capacity – Refusal of treatment

Right to refuse treatment

93. An adult patient who has capacity can refuse any treatment, except in certain circumstances governed by the *Mental Health Act 198*3 (see chapter 13 of this policy). The following paragraphs apply primarily to adults. In determining whether a patient has capacity to make this decision the MCA must be applied. See chapter 8 of this policy.

94. An adult with capacity may make a decision which is based on their religious belief (e.g. Jehovah's Witnesses) or value system. Even if it is perceived by others that the decision is unwise or irrational, the patient may still make that decision if they have capacity to do so and it is a voluntary and informed decision. Any attempt to treat that patient against their wishes could amount to a criminal offence. It is the right of an adult patient with capacity to refuse treatment even if that refusal might result in their death. However in cases of doubt, healthcare professionals should always seek legal advice.

95. If, after discussion of possible treatment options, a patient refuses treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, the healthcare professional (and where possible the patient) should note this on the 'Patient has withdrawn consent' section of the consent form.

96. Where a patient has refused a particular intervention, the healthcare professional must ensure that they continue to provide any other appropriate care to which the patient has consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

97. If a patient consents to a particular procedure but refuses certain aspects of the intervention, the healthcare professional must explain to the patient the possible consequences of their partial refusal. If the healthcare professional genuinely believes that the procedure cannot be safely carried out under the patient's stipulated conditions, they are not obliged to perform it. They must, however, continue to provide any other appropriate care. Where another healthcare professional believes that the treatment can be safely carried out under the conditions specified by the patient, they must on request be prepared to transfer the patient's care to that healthcare professional.

98. Whilst a patient has the right to refuse treatment this does not mean that they have the right to require a particular course of treatment.

Self harm and attempted suicide

99. Cases of self harm present a particular difficulty for healthcare professionals but the same law and guidance, as set out above, applies to treatment of these cases. Where the patient is able to communicate, an assessment of their mental capacity should be made as a matter of urgency.

100. If the patient is judged not to have capacity, decisions about their physical health treatment need to be made in accordance with the MCA (see chapter 8 of this policy). If treatment is required for their mental health, the MHA will apply. If a patient has attempted suicide and is unconscious, and there is insufficient time to undertake the usual best interests decision making process then they should be given emergency treatment unless the healthcare professional is satisfied that an advance decision to refuse treatment exists which is valid and applicable to the life-sustaining treatment in these circumstances.

101. Adult patients with capacity do have the right to refuse life-sustaining treatment, both at the time it is offered and in the future even if the healthcare professional believes that the patient's decision is unwise. If a patient with capacity has harmed themselves and refuses treatment, it may be appropriate to consider obtaining a psychiatric assessment. Unless the adult patient with capacity is detained under the Mental Health Act 1983 and the treatment is for, or a symptom of, a mental disorder, then their refusal must be respected although attempts should be made to encourage them to accept help and healthcare professionals should consult legal advisers.

Patients who refuse blood or blood components (e.g. Jehovah's Witnesses)

102. The same legal principles apply to any patient who refuses treatment whether they do so out of religious convictions or otherwise. No patient should be considered to be likely to refuse blood products merely on the basis of their religion. Every patient needs to be asked and informed individually.

Further information on Jehovah's Witness Patients

103. It is important to remember that not all Jehovah's witnesses refuse blood products. Most practising Jehovah's Witnesses who do will carry with them a clear, signed and witnessed advance decision card prohibiting blood transfusions and releasing clinicians from any liability arising from this refusal. If an applicable and valid advance decision is produced, then this should be acted upon. If the patient does not have capacity and a valid and applicable advance decision cannot be produced, the clinical judgement of a doctor should take precedence over the opinion of relatives or associates.

104. Further information can be found at the following:

- Royal College of Surgeons (2016) Caring for patients who refuse blood: a guide to good practice for the surgical management of Jehovah's Witnesses and other patients who decline transfusion.

- Association of Anaesthetists of Great Britain and Ireland, 2nd Edition, (2005) *Management of Anaesthesia for Jehovah's Witnesses*.

- Hospital Information Services for Jehovah's Witnesses (2005) *Care plan for women in labour refusing a blood transfusion*.

- UK Blood Transfusion and Tissue Transplantation Services (http://www.transfusionguidelines.org.uk/index.asp?Publication=BBT&Section=22&pageid=510 *Better Blood Transfusion Toolkit: Appropriate Use of Blood: Pre-operative Assessment – Jehovah's Witnesses*.

- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee chapter 12: Management of patients who do not accept transfusion

105. Further information or advice on the clinical management of this group of patients can be obtained from:

- A Consultant Haematologist within the patient local Health Board

- The local Hospital Liaison Committee for Jehovah's Witnesses.

7. Treatment of children and young people

106. When treating or caring for children and young people, healthcare professionals should take account of chapter 5 of the Guide.

Children or young people with capacity to consent to treatment

107. When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law.

108. Careful consideration should be given to whether the child is competent to give their consent to the specified treatment. A child under the age of 16, who has sufficient maturity and intelligence to be capable of understanding the treatment and making a decision based on the information provided (Gillick competent) will have capacity to consent to treatment and care. If a competent child consents to treatment a parent cannot over-ride that consent. As with adults, consent will only be valid if it is given voluntarily by an appropriately informed patient who has capacity to consent to the particular treatment.

109. Young people aged 16 or 17 with capacity are assumed in law to be competent and can give consent for their own treatment. If a 16 or 17 year old consents to treatment a parent cannot over-ride that consent. This applies equally to young people with capacity who are to be admitted (informally) to hospital for treatment for a mental disorder.

110. It is not a legal requirement but it is advisable to include the child/young person's family in discussions regarding treatment. However, this can only be done with the consent of the child/young person.

See Appendix D for guidance on assessing whether a child is Gillick competent.

Children who are not competent to consent to treatment

111. If the child is not competent to give consent, then the healthcare professional may give treatment on the basis of parental consent. Parental consent may be given by any person who has parental responsibility for the child, provided that person has capacity to give such consent. This may not necessarily be the parents but, for convenience, "parents" in this policy means all persons with parental responsibility.

112. Healthcare professionals need to make reasonable enquiries as to who holds parental responsibility for the child. Every effort should be made to include all those with parental responsibility in discussions regarding treatment options.

113. Not all parents have parental responsibility for their children. For example, unmarried fathers do not automatically have such responsibility but they can acquire it. If you have any doubt about whether the person with the child has parental responsibility for that child, you must check. The Children Act 1989

(which applies to both children and young people) sets out the persons who may have responsibility for a child.

Parental responsibility is vested in:

- the mother automatically on the birth of the child
- the father if his name has been registered on the child's birth certificate (this only applies to births from 1st December 2003)
- the father/partner when they are married to the mother at the time of the birth
- an unmarried father can acquire parental responsibility in the following ways:-
    - by jointly registering the birth with the mother (only applies to births from 1st December 2003)
    - by entering into a Parental Responsibility Agreement with the mother
    - by applying to the courts for a Parental Responsibility Order
    - by being appointed as guardian either by the mother or the court (although he will usually only assume parental responsibility upon the mother's death)
    - by obtaining a residence order
    - by marrying the mother and agreeing with her that he will assume parental responsibility
    - marrying the mother and upon his application to the court
    - by adopting the child
- legally appointed guardian
- a person who has been granted a residence order in respect of the child
- a step-parent who has entered into a Parental Responsibility Agreement with the mother

- a local authority in whose favour a care order has been made[7]

- a person who has been granted an emergency protection order

- an adopter of a child in accordance with section 46 of Adoption and Children Act 2002

- a husband and wife in whose favour a parental order has been made under section 30 of the Human Fertilisation and Embryology Act 1990

- an adoption agency in accordance with section 25 of the Adoption and Children Act 2002

- the court in wardship procedures

- some same-sex partners in certain situations

114. If you are in any doubt about whether a person has parental responsibility or whether a parent is acting in the best interests of the child you should seek legal advice.

115. Consent is usually only needed from one person holding parental responsibility. However there have been legal cases where the Court has advised that all parties with parental responsibility must give consent; if consent cannot be agreed an order from the Family Division of the High Court must be obtained. Those cases have included:

- sterilisation for contraceptive purposes

- non-therapeutic male circumcision

- hotly contested issues of immunization.

116. Where consent is being given on behalf of a child who is not competent to consent, the healthcare professionals, the child and the person with parental responsibility must meet to discuss and consider treatment options. This is particularly important if more than one person has parental responsibility for a child.

117. When children who are not competent to give consent are being cared for in hospital, it may not seem practicable to seek the consent of the parents on every

[7]Care should be sought as a Local Authority has the power to restrict the parental responsibility of the parents in relation to health care. It should always be established who has parental responsibility when an order is made and in what circumstances the parental responsibility can be exercised.

occasion for every routine intervention such as blood or urine tests or X-rays. However, healthcare professionals should remember that, in law, such consent is required, although consent may be given in advance. Where a child is admitted, the healthcare professional should discuss with the parents what routine procedures will be necessary, and, if it is not practicable to seek consent for every intervention, they may ask the parents if they are content to give their consent in advance for these routine procedures. If the parents are not content to give their consent, then consent should be obtained on every occasion. The parents may specify that they wish to be asked before particular procedures are initiated. You must then do so, unless the delay involved in contacting them would put the child's health at risk.

118. It is important to be aware that neither an Emergency Protection Order (EPO) nor a Police Protection Order (PPO) confers the consent for examination. If the person who has parental responsibility in not available, consent with directions, must be obtained from the Family Division of the High Court.

119. A healthcare professional should not rely on the consent of a parent if they have any doubts about whether the parent is acting in the best interests of the child. In order to consent on behalf of a child, the person with parental responsibility must also have mental capacity themselves.

120. For forensic examinations different rules may apply.

Young people (age 16 to 17 years) without capacity to consent to treatment

121. Healthcare professionals must follow the Mental Capacity Act when the young person lacks capacity to decide about treatment.

Children who are competent or young people (aged 16 or 17) with capacity who refuse treatment

122. Healthcare professionals should be very careful in cases where a young person or child refuses treatment. Such cases can be controversial and raise complex legal issues. Healthcare professionals should have particular regard to chapter 3 of the Guide and contact the Clinical Director for further advice.

123. Where a young person of 16 or 17 who has capacity, or a child under 16 who has been assessed as "Gillick" competent, refuses treatment, a person with parental responsibility for the child / young person or the Courts can be used as alternative sources of consent[8]. In such circumstances legal advice should be sought. See Appendix C.

124. Where a child has refused treatment, and a decision is made to give treatment on the basis of parental consent, it must be exercised on the grounds that the welfare of the child is paramount. The psychological effect on the child of having their decision over-ruled must also be considered.

125. Where a young person aged 16-17 who has capacity is to be admitted to hospital for treatment for a mental disorder, the MHA provides that where that person refuses to be admitted to hospital for treatment for a mental disorder, a person with parental responsibility for that person cannot overrule that refusal. The MHA should be used where appropriate.

Person with parental responsibility refusing treatment

126. If consent for treatment is refused by one or more of those with parental responsibility, or where an agreement cannot be reached between the persons with parental responsibility, seek legal advice. See Appendix C.

Young people aged 16 and 17 who refuse life-sustaining treatment

127. Where a young person aged 16 or 17 refuses life-sustaining treatment (e.g. a blood transfusion on the basis of their religious conviction) healthcare professionals should exercise extreme caution. In these circumstances, legal advice should be sought and, if necessary, the matter should be referred to the court. See Appendix C

[8] NHS Trust v X (In the matter of X (A Child) (No 2)) [2021] EWHC 65 (Fam) (18 January 2021) (bailii.org)

128. The management of a young person in an emergency situation, who is likely to die or suffer serious permanent harm without immediate treatment, is viewed in law in a different light. There may not even be time for emergency application to the court. Senior clinicians may decide to treat without consulting the court. Parents may not prevent clinicians from administering treatment to their children if their child's life or health is in imminent danger. This includes cases where the parents wish to refuse blood products for their child on religious grounds. Staff may rely on the support of the courts to endorse decisions that are taken in good faith and in the best interests of the young person concerned. It is important, however that two doctors of consultant status should make an unambiguous, signed and dated entry in the patient's medical notes that the treatment is essential to save life or prevent serious permanent harm. The doctor who stands by and allows a 'minor' patient to die in circumstances where treatment might have avoided death may be vulnerable to criminal prosecution.

129. The courts have often commented that such a situation does not detract from the loving and responsible reputation of the parents involved, and they have stressed the need for parents to be fully informed of the clinical developments regarding their child and of the intended action by clinicians.

130. When treating children or young people in these circumstances, healthcare professionals should consider carefully the guidance in chapter 5 of the Guide.

Parents refusing life-sustaining treatment for a child

131. Where a parent or parents intend to refuse life-sustaining treatment for a child under the age of 16, staff must always seek legal advice (see Appendix C). The well-being of the child is paramount and, if the parents refuse to give permission for the treatment, it may be necessary to apply for a court order to administer the treatment lawfully. Healthcare professionals should note that a court order can be obtained out of hours when necessary.

Emergency treatment

132. A life threatening emergency may arise in connection with a child when consultation with either a person with parental responsibility or the court is impossible, or the persons with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of that child. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health.

8. Patients who lack capacity to give or withhold consent

133. In determining whether a patient aged 16 years and over lacks the mental capacity - either temporarily or permanently - to give or withhold consent for themselves, healthcare professionals must act in accordance with the MCA. A patient who lacks capacity can be given treatment if it is in their best interests, as long as the patient (when aged 18 years and over) has not made a valid and applicable advance decision refusing that specific treatment.

134. When treating patients who may lack capacity, healthcare professionals must have due regard for the MCA Code of Practice.

Does the patient have capacity?

135. The MCA applies in relation to determining whether a patient has capacity to give their consent. It is a key principle of the MCA that a patient is assumed to have capacity to make decisions for themselves unless it is established on the balance of probabilities that they do not.

136. In ascertaining a patient's capacity, the healthcare professional must not make a judgment on the basis of the patient's age, appearance, assumptions about their condition or any other aspect of their behavior. It is important to take all possible steps to try and help the patient make a decision for themselves (see chapter 3 of the MCA Code of Practice). Where there is doubt about a patient's capacity, an assessment should be carried out and the healthcare professional must be able to justify their conclusions.

137. It is the healthcare professional proposing treatment or examination who should assess the patient's capacity to consent. More complex decisions are likely to need more formal assessments, which may include a professional opinion (for example from a speech and language therapist/psychologist), but the final decision about the patient's capacity must be made by the person intending to carry out the action.

138. Healthcare professionals who carry out actions related to the care and treatment of patients who lack capacity to consent to them at that time may be protected from liability if they reasonably believe (having assessed the patient's capacity where there is doubt) that the patient lacks capacity to make that particular decision at the time it needs to be made and the action is in the patient's best interests. (For further guidance see chapter 6 of the MCA Code of Practice and note that the MCA imposes limitations on acts which can be carried out with protection from liability – including where there is inappropriate use of restraint or where the patient who lacks capacity is deprived of their liberty).

139. A patient lacks capacity if they are unable to make a specific decision for themselves in relation to a matter at the time it needs to be made because they

have an impairment or disturbance of the mind or brain. This impairment or disturbance can either be temporary or permanent.

140. The MCA provides that a patient with an “impairment or disturbance” is unable to make a decision if they are unable to do one or more of the following:

a) understand the information relevant to the decision; or

b) retain that information; or

c) use or weigh that information as part of the process of making the decision; or

d) communicate their decision, whether by talking, using sign language or any other means.

141. If a patient cannot do one or more of these as a result of their impairment they will be treated as being unable to make the decision. Point d) only applies in situations where the patient cannot communicate their decisions in any way.

142. The British Medical Association has published advice on the assessment of capacity - www.bma.org.uk/

143. Capacity should not be confused with a healthcare professional’s assessment of the reasonableness of the patient’s decision. The patient is entitled to make a decision which is based on their own religious belief or value system, even if it is perceived by others to be unwise or irrational.

144. Where there is any doubt about a patient’s capacity to make a particular decision, after support has been provided without success, an assessment must be carried out. This should be done in accordance with the requirements of the Mental Capacity Act 2005 and the assessment must be recorded e.g. using Form 4.

145. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. The healthcare professional undertaking the assessment of capacity is required by the MCA to take all practicable steps to help the patient make the decision, therefore they should involve appropriate colleagues, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient’s situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal formats where appropriate.

Advance decisions to refuse treatment (ADRT)

146. In accordance with the MCA, a person who is 18 or over and has capacity can make an ADRT. An ADRT may be withdrawn or altered at any time whilst the person has capacity.

147. Any ADRT that is valid and applicable to the treatment that is proposed is legally binding. A healthcare professional must follow a valid and applicable ADRT. If they do not, they could face criminal prosecution and or civil liability.

148. A valid and applicable ADRT that is made after a Health and Welfare LPA overrules the decision of any Attorney.

149. If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder, a healthcare professional may still give that treatment to the patient if they have authority to do so under Part 4 and 4A of the MHA and consent is not required. Informal patients are not covered by Part 4 of the MHA and their advance decisions refusing treatment are enforceable if valid and applicable.

Validity of an ADRT

150. An ADRT is valid if made voluntarily by an appropriately informed adult (aged 18 years or over) with capacity.

151. An ADRT is **not** valid if the individual:

a) was under 18 years of age when it was drawn up; or

b) did not have capacity when the decision was made; or

c) was acting under duress; or

d) has withdrawn the advance decision (verbally or in writing) at a time when they had capacity to do so; or

e) has done anything else clearly inconsistent with the ADRT remaining his fixed decision; or

f) creates an LPA after the date when the ADRT was made, conferring authority on the attorney to give or refuse consent to the treatment to which the ADRT relates.

152. Healthcare professionals should ensure that the ADRT that is being considered has been regularly reviewed and updated. However, ADRT made long in advance of incapacity are not necessarily invalid unless, for example, there are reasonable grounds for believing that circumstances have since arisen which mean the patient would have changed their mind if they still had capacity. For example, there may

be a medical advancement which the patient was unaware of at the time they made the advance decision, which could significantly improve their condition.

153. There are no specific legal requirements concerning the format of an ADRT (unless it involves life-sustaining treatment – see below). It may be a written document, a witnessed verbal statement, a signed printed card, a smart card, or a note of discussion recorded in a patient's health record. Although there is no legal requirement, if possible patients should be encouraged to put their ADRT in writing so that there is a clear record of their wishes

154. If an ADRT relates to refusal of life-sustaining treatment, it will only be valid if it is in writing, contains the words 'even if life is at risk' (or words to that effect) and is signed, dated and witnessed.

Applicability of an ADRT

155. An ADRT must clearly specify the treatment that is being refused and in what specific circumstances it applies. It must be unambiguous and applicable to present circumstances. If the decision to be made falls outside of the scope of the ADRT, it will not be applicable.

156. An ADRT cannot authorise anyone to do anything which is unlawful (for example assist an individual in committing suicide), or make anyone carry out a particular treatment.

Responsibility of healthcare professionals

157. It is the responsibility of the person making the ADRT to ensure that it will be drawn to the attention of healthcare professionals when it is needed. However, healthcare professionals are also responsible for asking patients or their representatives about the existence of ADRT.

158. If a healthcare professional knows or has reasonable grounds to believe that an ADRT exists, and time permits, then they should make reasonable enquiries regarding its existence and content. Emergency treatment should not be delayed in order to look for an ADRT if there is no clear indication that one exists.

159. If an ADRT relates to refusal of life-sustaining treatment, then the healthcare professional must see a written, signed and witnessed ADRT which contains the words 'even if life is at risk' (or similar).

160. A healthcare professional will not be acting unlawfully if they treat a patient and is genuinely unaware of the existence of an ADRT. Similarly they will not act unlawfully if they act in accordance with an ADRT that they believe is valid and applicable at the time but is later proved to be invalid/ not applicable.

161. If there is any doubt about the validity or applicability of an ADRT it may be necessary to refer the matter to the Court of Protection (CoP). In this situation, healthcare professionals may provide life-sustaining treatment or treatment that prevents serious deterioration in the patient's condition whilst the decision of the court is awaited.

162. If an ADRT is not valid and applicable, it should still be noted as an expression of the patient's feelings and wishes about what should happen to them, and should be taken into account in deciding what is in their best interests.

Advance statements

163. An advance statement is different to an advance decision to refuse treatment in that it generally outlines a patient's wishes or preferences in relation to care or treatment that they want to have, as opposed to being a refusal of treatment. Although an advance statement is not legally binding it should be noted as an expression of the patient's feelings and wishes about what should happen to them if they lack capacity to decide for themselves, and should be taken into account in deciding what is in their best interests.

164. Some advance statements will express the patient's wishes that a particular course of action should be taken or that they should receive a particular type of treatment in the event that they no longer have capacity. The healthcare professional is not under a legal obligation to provide treatment because the patient demands it. The decision to treat is ultimately a matter for their professional judgement acting in the context of a best interests decision. In making that decision the healthcare professional will, however, be required to take into account the patient's wishes as expressed in determining what is in their best interests.

165. Further information about ADRT is available in chapter 9 of the MCA Code of Practice.

Decisions made in the patient's best interests

166. In determining what is in the patient's best interests, the healthcare professional must look at the patient's circumstances as a whole and not just at what is in the patient's best medical interests. They must try to work out what the patient would have wanted if they had capacity, rather than what that professional believes to be in their best interests. The healthcare professional must make all reasonable efforts to ascertain:

- the patient's past and present wishes and feelings,
- any beliefs and values that would be likely to influence the patient's decision, and
- any other factors that the patient would be likely to consider if they were making the decision.

167. Lack of capacity to make the decision in question will not automatically mean that the patient is unable to participate in the decision making process, and every assistance should be given to enable them to do so.

168. A healthcare professional must not make assumptions about someone's best interests simply on their age, appearance, condition or behaviour. They should also consider whether the patient is likely to regain capacity and if so whether the decision can be deferred.

169. They must also, so far as is practicable, consult representatives of the patient to see if they have any information about the patient's wishes, feelings, beliefs and values. In particular, they should try to consult:

- any unpaid person who is named by the patient as a person who should be consulted on such matters
- anyone engaged in caring for the patient or interested in his welfare
- any person who has been granted an LPA by the patient; and
- any deputy appointed for the patient by the CoP to make decisions for that patient.

170. The purpose of consulting is to ascertain what the patient would have wanted if they had capacity, not what the persons consulted believe should happen. Where a patient has made a Health and Welfare LPA or a deputy of the CoP (for personal welfare) has been appointed, and if it is within their authority, it will be for the attorney or deputy to make the decision on the patient's behalf. However, they too must act in the patient's best interests and, where practicable and appropriate, consult the people indicated above.

171. If a patient has no one who can be consulted, healthcare professionals must consider whether the circumstances are such that an Independent Mental Capacity Advocate (IMCA) should be instructed (see below).

172. If the patient has made an advance statement (other than a valid and applicable ADRT), then the healthcare professional should still take that statement into account in deciding what is in the patient's best interests, as it is a reflection of the patient's wishes and feelings. However, if it is the healthcare professional's judgement that to act in accordance with the advance statement would not be appropriate and not in the patient's best interests, they are not bound to do so.

Temporary incapacity

173. Patients may suffer a temporary loss of capacity, for example, where they are under a general anaesthetic or sedation, or unconscious after a road accident. As with any other situation, an assessment of that patient's capacity must only examine their capacity to make a particular decision when it needs to be made. Unless the patient has made a valid and applicable ADRT of which you are aware, then they may be treated insofar as is reasonably required in their best interests pending recovery of capacity. This will include, but is not limited to, routine procedures such as washing and assistance with feeding. If a medical intervention is thought to be in the patient's best interests but can be delayed until the patient recovers capacity and is able to consent to (or refuse) the intervention, it must be delayed.

Fluctuating capacity

174. It is possible for a patient's capacity to fluctuate. In such cases, it is good practice to establish whilst the patient has capacity their views about any clinical intervention that may be necessary during a period of incapacity and to record these views. The patient may wish to make an advance decision to refuse certain types of treatment (see paragraphs 144 to 160). If the person does not make a relevant ADRT, the patient's treatment when incapacitated should accord with the principles for treating the temporarily incapacitated (see above).

Lasting Power of Attorney (LPA)

175. LPA was introduced by the MCA. An LPA may be executed by any person of 18 years or over whilst they have capacity and takes effect when they no longer have capacity. A Health and Welfare LPA appoints a person to act as an attorney to make decisions about a person's welfare and medical treatment when that person

lacks the capacity to make that particular decision. The attorney acting under a Health and Welfare LPA must make the decision in the person's best interests. The LPA must be registered with the Office of the Public Guardian (OPG) before it can be used and it is essential that healthcare professionals see the sealed (OPG stamp) LPA document to confirm that it has been registered, and to assure themselves of the authority that it confers on Attorney(s). An LPA does not authorise an attorney to refuse or give consent to life-sustaining treatment unless this is explicitly stated in the LPA. If two or more people have been appointed as attorneys, they may either be appointed to act jointly or jointly and severally. If they are acting jointly, any decision must be made by consensus. However if they are acting jointly or severally, then either of the attorneys can make a decision independently of the other.

176. If the patient has made a valid and applicable ADRT to refuse treatment, then this can be overridden by an attorney providing that the LPA was made after the advance decision and their authority under the LPA extends to making decisions about treatment that is the subject of the advance decision. An attorney, like any person who is making a decision on behalf of a patient who lacks capacity, must act in accordance with the MCA and must have regard to the MCA Code of Practice.

177. When acting on the basis of a decision by an attorney, a healthcare professional should, so far as is reasonable, try to ensure that the attorney is acting within their authority. Any disputes between a healthcare professional and an attorney that cannot be resolved, or cases where there are grounds for believing that the attorney is not making decisions that are in the best interests of the patient, should be referred to the CoP.

Court Appointed Deputies (CAD)

178. Whilst a decision made by the Court is always preferred, the MCA now provides that the Court can appoint deputies to make decisions on its behalf. This may be necessary if there are a number of difficult decisions to be made in relation to the patient. The CAD will normally be a family member, partner, friend or person who is well known to the patient. Healthcare professionals must always ensure that they see a sealed (CoP stamp) copy of the deputyship order so that they are clear what authority the CAD holds.

179. As with attorneys appointed under a LPA, a CAD may only make decisions where they have reasonable grounds to believe that the person they are acting for does not have capacity, and any decisions they take will be strictly limited to the terms specified by the Court and in accordance with the MCA. A CAD is also subject to a number of restrictions in the exercising of their powers. For example, a CAD cannot refuse consent to the carrying out or continuation of life-sustaining treatment for the patient, nor can they direct a person responsible for the patient's healthcare to allow a different person to take over that responsibility**.** A deputy cannot restrict a named person from having access to the patient.

180. Healthcare professionals should co-operate with the CAD with the aim of doing what is best for the patient. Where a CAD acting within their authority makes a decision that

a treatment (that is not life-sustaining) should be withheld or withdrawn the healthcare professional must act in accordance with those instructions. However a CAD cannot require a healthcare professional to give a particular type of treatment, as this is a matter of clinical judgement. In such cases where a healthcare professional has declined to give treatment, then it is good practice to seek a second opinion, although the CAD cannot insist that the healthcare professional steps aside to allow another professional to take over the case. A CAD is supervised by the OPG, and where a healthcare professional suspects that a deputy is not acting in the interests of the patient, they should refer the matter to the Public Guardian.

181. A valid and applicable ADRT overrules the decision of the CAD.

Independent Mental Capacity Advocates (IMCA)

182. If a patient aged 16 years or older who lacks capacity is to receive serious medical treatment, and that patient has no one else to consult and support them other than paid or professional staff, then unless a decision has to be made urgently (e.g. to save the person's life), an IMCA must be instructed. The duty to instruct rests with Velindre University NHS Trust in the case of treatment provided in hospital. (Note that there are other situations when an IMCA must be instructed – e.g. decisions about whether to place people into accommodation (for example a care home or a long stay hospital and under the Deprivation of Liberty Safeguards.)

183. The role of the IMCA is to represent and support the patient. They will not make decisions on the patient's behalf. Such decisions will still be made by the healthcare professional on the basis of what is in the patient's best interests. However the IMCA will speak to the patient and, so far as possible, try to engage them in the decision process. They will assist in determining what is in the patient's best interests and the healthcare professional must take into account the views of the IMCA in deciding what actions to take. The IMCA is entitled to information about the patient and to see their relevant health records.

184. Where serious medical treatment is proposed, they will discuss with the professional the proposed course of treatment or action and any alternative treatment that may be available and may, if they consider it necessary, ask for a second medical opinion.

185. Serious medical treatment for this purpose means treatment which involves providing, withdrawing or withholding treatment in circumstances:

- where there is a fine balance between the benefits and burdens the treatment would have on the patient and taking into account the likely risks
- where there is a choice of treatments, a decision as to which one to use is finely balanced or

- what is proposed would be likely to involve serious consequences for the patient

Referral to the Court of Protection

186. Where there are difficult or complex decisions to make on behalf of a patient who lacks capacity, the matter must be referred to the Court of Protection if all other options for making the decision or resolving differences have been exhausted.

187. The Court of Protection can deal with any matters covered by the Mental Capacity Act 2005, such as:

- whether the patient has capacity to make a particular decision
- whether an ADRT is valid and applicable
- what course of action/decision would be in a patient's best interests
- where there is a dispute between healthcare professionals, members of the family, partners, carers or any other interested persons such as an Independent Mental Capacity Advocate or the attorney of a Lasting Power of Attorney about what is in the patient's best interests
- where there is doubt about whether the patient lacks capacity to make a decision for themselves and is not likely to regain capacity in the short term
- where treatment of an experimental nature is proposed.

186. Where a patient lacks capacity then ***a referral to the Court must be made*** in the following circumstances:

- where it is proposed that the patient should undergo non-therapeutic sterilisation (e.g. for contraceptive purposes)
- cases involving organ or bone marrow donation by a patient who lacks capacity to consent;
- where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both permanent vegetative state (PVS) and minimally conscious state (MCS)

- where there are doubts or a dispute about whether a particular treatment would be in the best interests of the patient.

This is not an exhaustive list and the courts may extend the list of procedures that should always be referred. Legal advice should be sought

187. If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a second independent clinical opinion is available which supports the best interests decision and that the clinical decision to withdraw Clinically Assisted Nutrition and Hydration CANH is reasonable in the circumstances, given the diagnosis, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. The second clinical opinion should be sought from a consultant with experience of PDOC, who has not been involved in the patient's care and who should, so far as reasonably practical, be external to this Velindre University NHS Trust. The consultant should examine the patient and review the patient's medical notes and the information that has been collected. Healthcare professionals should make a very detailed) entry/record in the medical notes, outlining any relevant discussions or meetings that have taken place and the reasons for the opinion that has been provided. Legal advice can be sought to support the decision

188. The Court has held that therapeutic abortion and sterilisation where there is a medical necessity does not automatically require a referral, although such procedures can give rise to special concern about the best interests and rights of a patient who lacks capacity. In the case of a patient with learning disabilities, it is good practice to involve a learning disability consultant psychiatrist, the multidisciplinary team and the patient's family/partner as part of the decision-making process and to document their involvement. Less invasive or reversible options should always be considered before permanent sterilisation.

189. Appendix C provides advice for healthcare professionals who need legal advice when they are faced with a situation that may require the intervention of the Court of Protection. Guidance on referring matters to the Court of Protection has also been issued by the General Medical Council and the BMA.
http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp
https://www.bma.org.uk/advice/employment/ethics/mental-capacity/mental-capacity-toolkit/12-court-of-protection-and-court-appointed-deputies

190. Where an adult or young person has been assessed to lack the capacity to give or withhold consent to a significant intervention, this fact should be documented on Form 4: Treatment in best interests (see chapter 2 of this policy) along with full details of the assessment of capacity and best interests.

9. Human Tissue

Removal, storage and use of human tissue

191. The Human Tissue Act 2004 (HTA 2004) makes consent the fundamental principle underpinning the lawful retention and use of body parts, organs and tissue from the living or deceased for specified health related purposes and public display. Human tissue is defined as material which has come from a human body and consists of, or includes human cells. Live gametes and embryos are excluded as they are regulated under the Human Fertilisation and Embryology Act 1990 (HFEA).

192. The Human Tissue Act Codes of Practice and Standards issued by the Human Tissue Authority (HTA) contain detailed provisions on consent to the storage and use of relevant material from the living and the deceased. You can learn more about the HTA via this link "About the HTA | Human Tissue Authority". The Codes and Standards can be found on the following link: Codes of Practice | Human Tissue Authority (hta.gov.uk)

193. The HTA 2004 creates an offence of DNA theft. It is unlawful to obtain and store human tissue with the intention of its DNA being analysed, without consent of the patient from whom the tissue was obtained.

194. The HTA 2004 allows material taken from the living to be stored and used without consent for the following scheduled purposes on the basis that these are bound up with the general provision of clinical and diagnostic services:

- clinical audit
- education or training relating to human health
- performance assessment
- public health monitoring and
- quality assurance

195. However, if a patient actively objects to the use of their samples for such purposes, then that objection should be complied with. The Act and the Code contain a complex set of rules around the need for consent being required for the above purposes if the tissue is removed after death. There is also a set of rules about relevant material taken from a patient in their lifetime continues to be treated as such after death. It is the point at which the material is removed that determines how it is affected by the Act. The Code refers to concepts such as nominated representatives and qualifying relationships for the purpose of consent. It is too detailed to quote fully here and it should be consulted where relevant decisions need to be made.

196. In the living, consent is required to store and use tissue removed for:

- obtaining scientific or medical information about a patient which may be relevant to any other person (now or in the future)
- public display
- research into disorders, or the functioning of the human body and
- transplantation.

197. The system must be well-publicised and transparent, making provision for patients to record their consent or objection to the use of such tissue and for this to be notified to the laboratory. Patients must also be able to record any objections to particular uses or use of particular tissues.

198. Velindre University NHS Trust written consent must be obtained from the patient either at the time of their procedure, or retrospectively, to indicate whether or not they give their consent to the use of removed tissue for a specific research project.

Consent to post mortem examinations

199. Velindre University NHS Trust does not undertake post mortem examinations.

200. If a post mortem examination is ordered by the coroner, the consent of relatives is not required. However, consent is required for the removal, retention and disposal of any tissue or organs taken.

201. Other post-mortem examinations are hospital post-mortem examinations which are usually carried out at the request of doctors who have been caring for the patient or, sometimes, at the request of close relatives wishing to find out more about how a patient's illness or how they died. In some circumstances it may be appropriate to limit the examination to a particular region of the body.

202. The request for a hospital post-mortem should be made by the Clinician who, after discussions, will liaise with the appropriate persons to ensure all statutory requirements are met.

203. The staff member seeking consent for hospital Post Mortem examination should have relevant experience and a good understanding of the consent procedure. They will have been trained in dealing with bereavement and in the purpose and procedures of Post Mortem examinations. Staff involved with seeking consent are trained in how to obtain consent and training records are held by the Mortuary Post Mortem Service to demonstrate this.

204. All post mortems are carried out under an HTA licence held by the Health Boards. It is a requirement of the HTA 2004 that appropriate consent is taken before a post-mortem can be carried out or any other tissue removed from the body of a deceased person. This consent must be obtained from a person in a "qualifying relationship". Those in a qualifying relationship are found in the HTA Code A Guidance in the following order (highest first):
a) spouse or partner (including civil or same sex partner). The HT Act states that, for these purposes, a person is another person's partner if the two of them (whether of different sexes or the same sex) live as partners in an enduring family relationship;
b) parent or child (in this context a child may be of any age, but must be competent if under the age of 18, and means a biological or adopted child);
c) brother or sister;
d) grandparent or grandchild;
e) niece or nephew;
f) stepfather or stepmother;
g) half-brother or half-sister;
h) friend of long standing.

205. For further information on post mortems the *Human Tissue Authority Code of Practice – Post Mortem Examination (Code B, 2012)* should be consulted. For further information on retention of tissues, organs and body fluids, please seek advice from the pathologist.

Retention of tissue with the authority of the Coroner

206. When tissue is retained at a Coroners post-mortem, the Pathologist must inform the Coroner in writing. The Pathologist can retain tissue if they have reason to believe it relates to the cause of death or to the identity of the deceased. The Coroner determines the retention timeframe and informs the family that tissue is retained.

207. Tissue blocks and slides for use for scheduled purposes are stored in either the mortuary or corresponding laboratory while reporting is on-going.

208. Exceptions to this are storage of tissue for a deceased person for: the use for research approved by a recognised research ethics committee or whereby the sole purpose is analysis for a scheduled purpose, excluding research, and the material has come from, and is to be returned to, a licensed premises following analysis.

209. The wishes of the family regarding disposal of the tissue will be sought by the Coronial Service and must be adhered to by the HB, this must occur at the end of the retention timeframe.

210. A record of the disposal of tissue must be created and retained by the licensed premises.

Transplantation - Living Donation

211. The HTA is responsible for the regulation, through a system of approvals, of the donation from living people of solid organs, bone marrow and peripheral stem cells for transplantation into others. Information on the legal requirements is available - https://www.hta.gov.uk/

Transplantation - Deceased organ donation

212. Consent to organ donation in Wales is governed by the Human Transplantation (Wales) Act 2013. There is an associated Code of Practice - https://bts.org.uk/wp-content/uploads/2018/01/HTA_CoP_on_Human_Transplantation_Wales_Act_2013_-_Final_-_May_2014.pdf. This system operates on the basis of deemed consent; it is assumed that the individual had no objection to organ donation unless they have registered or expressed a decision not to donate their organs following their death. Patient representatives should be consulted to obtain any evidence that a patient did not wish to be an organ donor.

213. Express consent to organ donation is required where a patient has not been an ordinary resident in Wales for more than 12 months before dying

10. Clinical photography, video recordings and audio recordings

Making and using visual or audio recordings of patients

214. This chapter focuses on the consent aspect of making photographic, video or audio recordings of patients. 'Recordings' in this chapter means originals or copies of audio recordings, photographs and other visual images of patients that may be made using any recording device e.g. video.

215. Visual and audio recordings of patients may be made for any of the following reasons:

- As part of assessment, investigation or treatment of a patient, to be kept in the patient's medical notes.
- For use in teaching, training or assessment of fellow healthcare professionals and students or other appropriate groups e.g. at a conference.
- For use in clinical research.
- For publication e.g. in a book, a journal, a patient information leaflet, on a poster or in publicity material, any of which may also be accessible on the internet.
- As potential evidence e.g. following injuries sustained as the result of an accident or an assault or where there is suspected non-accidental injury see Trust Policy.

216. Because it is sometimes possible for people to be identified by tattoos or other distinguishing marks or features, or from the sound of their voice in an audio recording, it is this Trust's policy that written consent must always be obtained prior to making a visual or audio recording of a patient or their art work for any of the purposes described in paragraph 208 (for exceptions see paragraph 215 below).

217. Healthcare professionals should always ensure that they ask for a patient's written consent in advance if any photographic, video or audio recording will result from a procedure (unless the patient is temporarily unconscious – see paragraph 224).

218. If you only obtain consent for use of photographic, video or audio recordings as part of treating or assessing a patient you must not use them for any purpose other than the patient's care or the audit of that care, without obtaining further consent from the patient.

General Principles

219. When making or using recordings you must respect the patient's privacy and dignity and their right to make or participate in decisions that affect them. The following general principles apply to most photographic, video and audio recordings:

- seek permission to make the recording and get consent for any use or disclosure.

- give patients adequate information about the purpose of the recording when seeking their permission.

- make recordings only when you have appropriate consent or other valid authority for doing so.

- ensure that patients are under no pressure to give their permission for the recording to be made.

- stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment.

- do not participate in any recording made against a patient's wishes.

- eyes or faces must not be blacked out in an attempt to conceal identity after the recording has been made. Every effort must be made to conceal the identity of the patient whilst the recording is being taken. You must ensure that the patient is informed if their face will be visible in the recording.

- ensure that the recording does not compromise patients' privacy and dignity.

- do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent.

- make appropriate secure arrangements for storage of recordings.

220. Before the photograph, video or audio recording is made, healthcare professionals must ensure that patients:
    - understand the purpose of the recording, who will be allowed to see/hear it, the circumstances in which it will be shown/played, that copies are likely to be made if the recording is for educational purposes, and that the recording will be stored securely within the Trust.

- understand that, in the case of publication, they will not be able to withdraw their consent or control future use of the material, once the recording is in the public domain.

- understand that withholding permission for the recording to be made, or withdrawing permission during the recording, will not affect the quality of care they receive.

- are given time to read explanatory material and to consider the implications of giving their written permission. Explanatory material should not imply that permission is expected. It should be written in language that is easily understood. If necessary, translations should be provided.

- have completed and signed consent form which is broken down into granular statements for the various purposes, clearly indicating which statements they consent to and which ones they don't.

221. After the recording, the healthcare professional must ensure that:

- patients are asked if they want to vary or withdraw their consent to the use of the recording.

- recordings are used only for the purpose for which patients have given consent.

- patients are given the chance, if they wish, to see the recording in the form in which it will be shown.

- recordings are given the same level of protection as with patient's medical notes against improper disclosure.

- if a patient withdraws or fails to confirm consent for the use of the recording, the recording is not used and is erased as soon as possible

Recordings for which consent is not required

222. Permission and consent is not needed to make or use the recordings listed below, provided that, before use, they are effectively anonymised by the removal of any identifying marks (writing in the margins of an x-ray, for example):

- Images taken from pathology slides

- X-rays

- Laparoscopic or endoscopic images

- Images of internal organs (however, it is best practice to obtain written consent if the recording is to be used in education or publication and will be accompanied by verbal or written information which may enable inadvertent identification of the patient)

- Recordings of organ functions

- Ultrasound images

Children and young people

223. Where children lack the understanding to give their permission to photographic, video or audio recordings, healthcare professionals must get permission to record from the person with parental responsibility. Children under 16 who have the competence to give permission for a recording may sign the consent form themselves. Healthcare professionals should make a note of the factors taken into account in assessing the child's competence. Young people are assumed in law to be competent and can give permission to recordings themselves, unless they lack capacity.

224. In cases of suspected non-accidental injury of a child, photographs may be taken without parental consent if necessary. However these photographs must only be used as part of the clinical record, or as potential evidence. They must not be used for education, publication or research without written consent. If written consent is given for use in education, publication or research, it is recommended that images are not used for these purposes before or during likely legal proceedings.

Vulnerable adults

225. In the case of suspected non-accidental injury of a vulnerable adult, efforts should be made to obtain written consent to the taking and use of photographs as potential evidence.

226. If the patient is unwilling for recordings to be made for evidential purposes, then the patient should still be asked for consent to photographs being taken for their clinical record, if it is a valid addition to the record, or if it is not appropriate to seek their consent for evidential purposes at that time e.g. if the alleged perpetrator is present. Photographs taken for the clinical record cannot be used as evidence, unless, at a later date, the patient changes their mind. In this case the consent form can be modified at this later date, and these modifications must be signed and dated by the patient.

Fetal loss, stillbirth and neonatal death

227. Photographs taken solely for the purpose of giving them to the bereaved parents do not qualify as clinical photographs and therefore do not come under the auspices of this policy. Photographs taken on behalf of the bereaved must not be used for any other purpose without written consent from the person with parental responsibility.

228. If photographs are required for any other purpose (except during the course of a post mortem examination) the written consent of those with parental responsibility must be obtained.

Adults and young people who lack the capacity to consent for themselves

229. When adults or young people lack capacity to make a decision about an audio or visual recording for themselves, any decision must be made in accordance with the MCA.

230. As a general principle you should not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

231. The situation may sometimes arise where the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

Adults and young people who lack capacity - Recordings made as part of clinical care, or as potential evidence

232. If it can be demonstrated that it is in the patient's best interests, then photographs, video and audio recordings can be made as part of the patient's clinical care, or as potential evidence. If someone holds a Health and Welfare LPA or is a CAD, they should be asked to consent on behalf of the patient. Otherwise the healthcare professional making the recording must confirm that they have assessed capacity and are acting in the patient's best interests.

Adults and young people who lack capacity - Recordings made for education and publication

233. If adults or young people lack capacity to make a decision about photographs, video or audio recordings for themselves, then recordings can only be taken and used for education or publication if it has been determined to be in the patient's best interests.

Patients who have capacity but are unable to sign the consent form

234. Physical inability to sign a consent form does not detract from an individual's ability to give consent. Patients can indicate their consent verbally or non-verbally, in the

presence of a witness, who should then sign the consent form to confirm that the patient's consent was given. Recordings can then be used in the same way as if the patient had signed the consent form.

Withdrawal of consent

235. Patients have the right to withdraw consent for the use of their audio or visual records at any time. This should be documented on the consent form and the form, or the appropriate section of the form, should be scored through. In the case of publication, it is particularly important to make it clear to patients, when consent is originally obtained, that once the recording is in the public domain there is no opportunity for effective withdrawal of consent.

Further information

236. The above information is drawn from the GMC guidance: Making and using visual and audio recordings of patients (2011), which gives further detailed advice in the use of recordings when treating or assessing patients.

237. It is vital that confidentiality is safeguarded at all times, and in order to ensure the safe and secure storage and disposal of recordings this policy should be read in conjunction with all related Trust policies that are in place around information security, data protection and maintaining confidentiality. These include but are not limited to: -

- Information Governance Policy
- Data Protection & Confidentiality Policy
- Records Management Policy
- Information Security Policy

Telemedicine

231. Telemedicine should be viewed as a form of examination, and valid consent should be obtained in the same way as in any other examination, not just to the recording and exchange of information but to the process of telemedicine. The patient should understand that:

  - it is not the same as seeing a healthcare professional in a face-to-face meeting
  - the information/diagnosis received may be compromised by the technology
  - they have a right to decline review via telemedicine

Healthcare professionals must abide by their IT Security Policy and Data Protection Policies in the handling of all images/recordings and data

11. Consent to Specific procedures

Consent to screening

232. Healthcare professionals must ensure that anyone considering whether to consent to screening can make a properly informed decision. As far as possible, they should ensure that screening would not be contrary to the individual's interest. Particular attention must be paid to ensuring that the information the patient wants or ought to have is identified and provided. Those taking consent should be careful to explain clearly:

- the purpose of the screening;
- the likelihood of positive/negative findings and possibility of false positive/negative results;
- whether there are any reasonable alternatives
- the uncertainties and material risks attached to the screening process;
- any significant medical, social or financial implications of screening for the particular condition or predisposition;
- follow up plans, including availability of counselling and support services.

233. If healthcare professionals are considering the possibility of screening adults and young people who do not have capacity to consent to the screening they must act in accordance with the MCA and ensure that decisions made are in the patient's best interests. In appropriate cases, account must be taken of the guidance issued by bodies such as the Advisory Committee on Genetic Testing.

Consent to Cosmetic Treatments (surgical and non-surgical)

234. From **1 June 2016** new GMC guidance for Doctors applies to both surgical (such as breast augmentation) and non-surgical (such as Botox) procedures. A link to this guidance can be found here: http://www.gmc-uk.org/static/documents/content/Guidance_for_doctors_who_offer_cosmetic_interventions_080416.pdf

12. Seeking consent for genetic investigations (or investigations likely to reveal the diagnosis as being a genetic disorder)

236. Consent to genetic investigations is a particularly complex and controversial area.

Information and likely implications

237. When obtaining consent for investigations which may reveal genetic disorders, it is important that patients have been given full information about the likely implications of the test. There are points to note about the types of result that might come from a diagnostic genetic investigation, and which should be understood by the person giving consent:

- a clear explanation of the patient's problems or features
- no relevant findings, even if the problem has a genetic cause
- a variant of uncertain significance (VUS) (on chromosomal microarray or on the DNA sequencing of a gene, a panel of genes, the exome or the whole genome). It may become possible to clarify the interpretation of such a VUS at some point in the future, so a reinterpretation after a few years might be appropriate
- an incidental finding may emerge of no relevance to why the test was performed, but is still of some possible clinical importance to the patient and perhaps to other members of the family. For example, a test may be performed to investigate neurodevelopmental difficulties. The results may or may not explain those problems, but the test might find some other variant that indicates a serious risk of an inherited cancer or of cardiac disease or late-onset dementia etc.
- as understanding of genetics improves rapidly, the result may be subject to reinterpretation in the future. Regard must be given to many results issued now being somewhat provisional.

238. If healthcare professionals are considering the possibility of performing investigations on adults and young people who do not have capacity to consent to the investigation, they must act in accordance with the MCA and ensure that they make decisions in the patient's best interests.

239. It is recommended that reference should be made to specialist guidelines such as guidance issued by the Joint Committee on Medical Genetics: Confidentiality and genetic information - The British Society for Genetic Medicine (bsgm.org.uk)

13. Withholding or withdrawing life – sustaining treatment

General

240. The GMC guidance Treatment and care towards the end of life: good practice in decision making (2010) provides detailed guidance on withdrawing and withholding life - sustaining treatment.

241. A competent patient should always be consulted when making a decision to withhold or withdraw life-sustaining treatment unless the healthcare professional forms a view that involvement will actually 'harm' the patient. Recent case law has underlined the extent of the duty of the healthcare professionals to consult a competent patient[9] or those with an interest in the welfare of the patient, where that patient lacks mental[10] be involved in the decision.

242. Any valid and applicable ADRT is legally binding and must be respected unless a patient has subsequently made a Health and Welfare LPA giving the attorney authority to make decisions regarding the provision of life-sustaining treatment.

243. Where the patient lacks capacity to be involved in the decisions, and the patient has not made a Health and Welfare LPA giving an attorney appropriate authority, the healthcare professional must consult the patient's relatives, friends, or carers and other professionals involved in their care when making a best interests decision about the withholding or withdrawal of life-sustaining treatment. If there is no-one other than paid staff to consult with, an IMCA must be instructed. Where an urgent decision is required and a patient's representatives cannot be contacted, the reasons for this must be carefully recorded in the patient's medical notes. See reference in paragraphs 164 - 171 above.

244. There is an important distinction between withdrawing or withholding treatment which is of no clinical benefit to the patient or is not in the patient's best interests, and taking a deliberate action to end the patient's life. A deliberate action which is intended to cause death is unlawful. Equally, there is no lawful justification for continuing treatment which is not in a patient's best interests.

245. Once a decision has been reached to withhold or withdraw life-prolonging treatment, the basis of the decision and the details of any discussions with the patient and/or their representatives must be recorded in the medical notes. Decisions to withhold or withdraw life-prolonging treatment should be reviewed periodically and following any relevant change in a patient's circumstances.

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[9] Tracey v Cambridge University Hospital NHS FoundationTrust & Ors

[10] Elaine Winspear v City Hospitals Sunderland NHS Foundation Trust

Prolonged disorder of consciousness

246. If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a

second independent clinical opinion is available which supports the best interests decision, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. For more detail see paragraphs 186 and 187 above.

247. Additional information is available from:

- Royal College of Physicians – Prolonged disorders of consciousness: national clinical guidelines - 2015

- BMA (2007) Withholding and withdrawing life-prolonging medical treatment: guidance for decision making, 3rd edition.

- GMC (2010) Treatment and care towards the end of life: good practice in decision making.

- An Interim Guidance document produced in December 2017 by the GMC, BMA and RCP entitled "Decisions to withdraw clinically-assisted nutrition and hydration (CANH) from patients in permanent vegetative state (PVS) or minimally conscious state (MCS) following sudden-onset profound brain injury".

14. Medical treatment of patients with a mental disorder

Basic principles

248. This chapter provides information regarding consent issues relating to the medical treatment of patients with a mental disorder. It should not be read in isolation from the rest of this policy, since the principles contained throughout this document apply to all patients from whom consent is sought, irrespective of whether or not they have a mental disorder.

249. The principle of self-determination and autonomy of the individual, described in chapter 1 of this policy, applies equally to those who are suffering from mental disorder; a key distinction being that, in the circumstances authorised by the Mental Health Act 1983 (referred to as the MHA), treatment for a mental disorder may be given in the absence of the recipient's consent. Nevertheless, consensual treatment should always be sought in line with the principle of provision within the least restrictive context.

250. Part 4 of the MHA is concerned with consent to treatment. The reader should also refer to the MHA 1983 Code of Practice for Wales, 2016 generally and particularly chapters 24and 25 for further information about consent and the Mental Health Act 1983.

251. Patients suffering from mental disorder, including those detained under the MHA are not necessarily incapable of giving valid consent and each patient's capacity to consent has to be judged individually in the light of the decision required and the patient's mental state at the time. Lack of capacity can be permanent or temporary and can also vary over time. Assessment of capacity should follow the principles described in the Mental Capacity Act 2005 (see chapter 8 of this policy).

252. The approved clinician in charge of the treatment has a duty to ensure that the patient is provided with sufficient information to enable them to understand:

- the nature, purpose, likely and intended effects of the treatment,
- their right to withdraw consent at any time, and
- how and when treatment can be given without their consent, including the legal authority for the treatment.

253. A record of the discussion at which consent is obtained or sought must be fully recorded in the health records.

254. Inpatients in Wales, whether detained or informal, and those subject to conditional discharge, a community treatment order, or guardianship are eligible for an independent mental health advocate (IMHA). All patients being considered for s57 type treatments (i.e. psychosurgery or implantation of hormones to reduce male sex drive) and children under 16 years being considered for ECT are also eligible. The only exception is a patient detained in a place of safety under s135 or s136 of

the MHA. Further information about the role of the IMHA may be found in chapter 6 of the MHA Code of Practice for Wales, 2016.

Medical treatment for mental disorder

255. Psychiatric in-patients may be classified into three groups when considering consent to treatment for their mental disorder:

a. patients detained under the Mental Health Act 1983,

b. informal patients who possess capacity to consent to treatment, and

c. informal patients who lack capacity to consent to treatment.

a. Patients detained under the Mental Health Act 1983

256. Where a patient is capable of giving consent and refuses, non-consensual treatment may only be given if it is for a mental disorder and the healthcare professional has the legal authority in accordance with the provisions of the MHA and the necessary certification requirements. Medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation and rehabilitation and care the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.

257. Medical treatment for mental disorder (except treatments under s57 i.e. psychosurgery and implantation of hormones to reduce male sexual drive) may be lawfully administered without the patient's consent provided:

- the patient is detained under the Mental Health Act 1983 (excluding patients detained under ss4 (4) (a), 5(2), 5(4), 35, 135, 136, 37(4)), and
- the proposed medical treatment falls within the provisions of
  - s58 (a second opinion is required for patients who are refusing or incapable of consenting after three months of treatment),
  - s62 (urgent treatment), or
  - s63 (treatment for the first three months of detention) of the MHA.

b. Informal patients who possess capacity to consent to treatment

258. Where informal patients possess the required capacity to give valid consent to medical treatment for mental disorder or to a plan of treatment, then their consent must be obtained. Where appropriate, this should be written consent. Where informal patients with capacity refuse treatment for their mental disorder consideration may be given to detaining the patient under the provisions of the MHA.

c. Informal patients who lack the capacity to consent to treatment

259. An assessment of capacity should be undertaken in accordance with the MCA. If a patient is found to lack capacity to consent to treatment then a determination of their best interests must be undertaken before any treatment is provided. In assessing someone's best interests it is essential to consult people who are close to the patient.

~~260.~~ Section 5 of the Mental Capacity Act 2005 (MCA) provides that treatment may be given to a patient who lacks capacity to consent provided that it is in their best interests to do so. Section 6 of the MCA provides that a patient may only be restrained to give care or treatment if it is necessary to prevent harm and it is a proportionate response to the likelihood and severity of that harm. ~~*- provided that it is in his / her best interests.*~~

261. If a patient who lacks capacity to consent to treatment appears to be objecting to treatment, then consideration should be given to detaining the patient under the MHA.

Patients detained under the Mental Health Act 1983 requiring treatment for a physical disorder

262. Part IV of the MHA is concerned with medical treatment for mental disorder. The MHA cannot be used to enforce treatment for a physical disorder, which is unrelated to a mental disorder, where a patient refuses consent. For patients who lack capacity to consent to medical treatment for a physical illness the provisions of the MCA would be engaged.

263. The patient's mental disorder may affect their capacity to consent. This should be assessed as a priority in line with the MCA, as treatment for the physical disorder might proceed in the patient's best interests. However, it should not be assumed that the patient lacks capacity simply because they have a mental disorder.

264. Section 63 of the MHA may allow for the treatment of a physical disorder, without the patient's consent, where it is 'ancillary to the treatment of the mental disorder' for example:

- Nasogastric feeding a patient with anorexia nervosa (*Re KB (Adult)*(1994))
- Taking blood for patients on clozapine
- Treating self-inflicted wounds

265. The term 'medical treatment' in section 63 of the MHA refers to treatment which, taken as a whole, is calculated to alleviate or prevent a deterioration of the mental disorder from which the patient is suffering. This includes a range of acts ancillary to the core treatment including those which prevent the patient from harming themself or those which alleviate the symptoms of the disorder (B v Croydon HA [1995])

266. If uncertainty exists as to a patient's capacity to consent to treatment, or whether the physical disorder may be treated as a symptom of the mental disorder, legal advice should be sought. See appendix C.

15. Consent to research and innovative treatment

Research

267. Any research undertaken within the Trust must be registered with the Health Trust's Research & Development Office, from where additional advice can be obtained. All research and development must be approved before it can be commenced.

268. Consent to clinical trials is covered by the 'Medicines for Human Use Regulations (2004)

269. The same legal principles apply when seeking consent from a patient for research purposes. GMC guidance states that patients 'should be told how the proposed treatment differs from usual methods, why it is being offered, and if there are any additional risks or uncertainties'.

270. Where the proposed treatment is of an experimental nature, but not part of a research trial, this fact must be clearly outlined to the patient along standard alternatives – including no treatment – during the consent process.

Patients who lack capacity to consent to being involved in research

271. There are strict rules within the MCA concerning the involvement of people who lack capacity in research. (See MCA Code of Practice and Welsh Government's Guide to Consent for Examination and Treatment). In determining whether the patient should participate in the proposed research, the patient's wishes and feelings about being involved in research should be respected. It should be stressed that many research studies are non-therapeutic, i.e. they will not benefit the research participants personally. Carers or other persons who have an interest in the patient's welfare must be consulted. If there is no one who can be consulted, then a person who is unconnected with the research project must be appointed to advise on whether the patient should take part in the research. If at any time during the research it appears that the patient is upset or unhappy, it must cease immediately. [Insert details of organisation's requirements in relation to research].

272. Where a patient lacks capacity, experimental/innovative treatment cannot be given unless it is in their best interests. Where there is no alternative treatment available, it may be reasonable to consider an experimental treatment, with unknown risks and benefits, where treatment may benefit the patient.

Consent to research and innovative treatment in children

273. The legal approach to consent to therapeutic research in children is similar to any other proposed examination or treatment: the treatment must be in the child's best

interests.

274. Trust staff should contact the R&D Department for further advice on obtaining consent for children aged under 16 years. The approach will differ depending on whether the study is a clinical trial or not, and whether the proposed research will take place in an emergency setting.

16. Training

275. In line with Welsh Risk Pool requirements, Velindre University NHS Trust have made available the Decision Making & Consent Training e-learning module on consent to all registered healthcare staff involved in the consent process. As advised by the Welsh Risk Pool, the Trust have mandated this e-learning training to be completed every 3 years. The Trust will also provide updates and share any learning identified from concerns (complaints, claims and incidents) within the organisation as appropriate. The Trust will adopt and make available any further training as recommended by the All-Wales Consent to Treatment Group. Also, the Trust provides a wide range of safeguarding training, and such issues will be included as appropriate in the sessions.

Dated: February 2025

Person responsible for policy: Executive Medical Director

Policy approved by: Quality, Safety & Performance Committee

Policy to be reviewed by [date]: February 2028

Supplementary Guidance

17. Consent in obstetrics and gynaecology

Pregnant women

276. A pregnant woman (see Introduction – paragraph 5) with capacity may refuse any treatment, even if this would be detrimental to themselves and/or their fetus(es). Any treatment involving the fetus will require maternal consent. However, it should be stressed that maternal refusal of treatment thought to benefit one or both parties is a rarity.

Caesarean birth (including refusal)

277. If a caesarean birth is required, the standard Consent Form 1 must be used. Women in labour can consent to a caesarean birth even if they have received sedation.

278. It is important to ensure that all pregnant women have a good understanding of the different ways in which they may give birth and the associated benefits and material risks. This will include information about the circumstances in which a caesarean birth will be offered. A pregnant woman with capacity may refuse a caesarean birth, even if "the consequence may be the death or serious handicap of the child they bear, or their own death" (Court of Appeal Re MB). In other words a mentally competent woman in labour has the same right under common law to consent to or refuse consent to treatment as any other patient. United Kingdom law does not currently grant the fetus any legal rights, therefore a caesarean birth cannot be authorised by a Court against a competent woman will and action cannot be taken in the best interests of the pregnant woman or the fetus. In this situation all advice given to the woman should be recorded in their notes. Unequivocal assurances should be obtained from the woman (and recorded in writing) that the refusal represents an informed decision: that is, that they understand the nature of and reasons for the proposed treatment and the risks and the likely prognosis involved in the decision to refuse or accept it. It is good practice to ask the woman to sign the written indication of their refusal. It is also good practice to involve another senior colleague to indicate that a body of senior medical opinion considers caesarean birth to be the most appropriate course and that the patient has refused consent for a caesarean birth.

279. If the woman is unwilling to sign a written indication of this refusal, this too should be recorded in the notes. Such a written indication is merely a record for evidential purposes. It should not be confused with or regarded as a disclaimer.

280. There have been a number of cases where doubts have arisen, for various reasons, as to a pregnant woman's capacity to make a valid decision about a caesarean birth. Temporary factors such as fear, shock, fatigue, pain or drugs may affect capacity. If there is reason to doubt capacity, support should be provided to help the woman make a decision. If that fails, a capacity assessment must be undertaken.

281. Where there is any doubt about a pregnant woman's capacity and/or where a refusal would lead to serious consequences for the pregnant woman or their unborn child, then legal advice should be obtained. If a pregnant woman refuses a caesarean birth (or any other intervention) and it has been demonstrated (in line with the Mental Capacity Act) that they lacks the capacity to make such a decision, an application to the CoP will be required to decide whether or not such treatment can be carried out. In the case of Re S, the Court of Appeal laid down general principles that should be applied in future cases. If the woman lacks capacity, avoiding the fetus' death may be seen by the Court as being in the best interest of the woman.

282. Where a pregnant woman lacks capacity due to unconsciousness and so is incapable of giving consent, the caesarean birth may be carried out if it is in their best interests, unless a valid and applicable advance decision to refuse treatment exists. The most usual form of advance decision used by pregnant woman is the birth plan. However, if there is reason to doubt the reliability of the advance decision (e.g. it might sensibly be thought not to apply to the circumstances which have arisen – see chapter 8 of this policy) then legal advice should be sought. See Appendix C.

Sterilisation

283. Patients requesting sterilisation should be given information about alternative long-term reversible methods of contraception. This should include information on the risks, benefits and relative failure rates of each method. Non-operative methods of long-term contraception should have been specifically rejected by the patient before a decision is taken to proceed with sterilisation.

284. Both vasectomy and tubal occlusion should be discussed with all patients requesting sterilisation. Women in particular should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancy and there is less risk related to the procedure when compared with female sterilisation.

285. Patients should be told that the procedure is intended to be permanent, but should also be given the success rates of reversal procedures. They should be informed that the reversal operations of in vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI) are rarely provided by the NHS.

286. Patients requesting sterilisation should be informed that tubal occlusion and vasectomy can be unsuccessful and that pregnancies can occur several years after the procedure.

287. Written consent must be obtained for vasectomy, and the male patient should be advised to take other contraceptive precautions until there have been two consecutive negative semen analyses. It is important that the possibility of late failure is explained to the patient and their partner before vasectomy, so they can make informed decision about additional contraceptive methods.

288. Non theraputic sterilisation of someone who lacks the capacity to give their consent must be referred to the Court of Protection. The individual's capacity and best

interests must be thoroughly assessed in line with the Mental Capacity Act and legal advice should be sought at all times. (See chapter 8 and Appendix C).

Fertility

289. It is a legal requirement under the HFEA 1990, as amended, that consent to the storage and use of gametes must be given in writing after the patient has received such relevant information as is proper and had an opportunity to receive counselling. Where these requirements are not satisfied, it is unlawful to store or use the patient's gametes. Healthcare professionals should ensure that written consent to storage exists before retrieving gametes.

290. Outside specialist infertility practice, these requirements may be relevant to healthcare professionals whose patients are about to undergo treatment which may render them sterile (such as chemotherapy or radiotherapy) where a patient may wish to have gametes, or ovarian or testicular tissue, stored prior to the procedure. Healthcare professionals may also receive requests to remove gametes from a patient unable to give consent.

291. The HFEA 1990 as amended makes provision to address cases where the taking of gametes is in the patient's best interests but the patient is unable to give written consent or lacks capacity to consent to the storage of the gametes.

292. Further guidance is available from the Human Fertilisation and Embryology Authority.

Termination of pregnancy

~~293.~~ The termination of a pregnancy may only take place with the informed consent of the pregnant woman. Prior to obtaining written consent, discussion must take place concerning the type of procedure (medical or surgical) and the risk of complications. Written information should be given to support verbal information. ~~The husband or putative father's authority is not legally required.~~

294. If a pregnant woman opts for a medical termination of pregnancy then a realistic description should be given of the process, the number of visits necessary and the need for a health care professional to see products of conception or to perform a subsequent scan to ensure the termination is complete. It should be pointed out that there is a small risk of heavy bleeding at home before returning to hospital for the second part of the procedure, and that there is a high chance of miscarriage if the patient changes their mind between the first and second stages of the procedure.

295. If cervical ripening agents are to be used before surgical termination of pregnancy, the patient should understand that there is a high chance of miscarriage if they change their mind before completing the procedure.

296. Prior to taking consent for termination of pregnancy, the senior doctor (Registrar or above) must sign Certificate A (Abortion Act, 1967) to indicate that he is in agreement with the need for the termination. The pregnant woman will receive counselling in advance of the procedure and will then be scanned to assess

gestational age. If the procedure is to be undertaken, Consent Form 1 must be used.

297. Clinicians are advised to seek legal advice (see Appendix C) where:

- a pregnant woman lacks the mental capacity to understand and appreciate the nature or consequences of a termination of their pregnancy; or

- a pregnant woman is in a state of continuous unconsciousness and there is no reasonable prospect that they will regain consciousness in time to request and to consent to the termination of their pregnancy

- a partner wishes to over-rule a decision to terminate a pregnancy

Further information can be found here - 3270 RCOG Abortion guideline.qxd

Histological examination and disposal of non-viable fetal products

298. Consent should always be obtained with regard to the histological examination and disposal of non-viable fetal products up to the age of 24 weeks gestation.

18. Treatment in a Mental Health setting

S57 MHA: Treatment requiring capacity, consent and a second opinion

299. Section 57 treatments include surgical operations that destroy brain tissue or destroy the functioning of brain tissue, and the surgical implantation of hormones for the purpose of reducing male sex drive. S57 applies to all patients, whether or not they are subject to the MHA.

300. Treatment under s57 can only be given if all three of the following requirements are met:

- the patient consents to the treatment,
- a second opinion appointed doctor (SOAD) and two other people appointed by Healthcare Inspectorate Wales (HIW) certify the patient has the capacity to consent to the treatment and has done so, and
- the SOAD also certifies that it is appropriate for the treatment to be given to the patient on form CO1.

S58 MHA: Treatment requiring consent or a second opinion

301. The approved clinician (AC) in charge of treatment must obtain the valid consent of any patient before the administration of medicine by any means after three months, unless such medicine is being administered under s62 (emergency treatment).

302. There can only be one 3 month period for s58 treatment in any continuous period the patient is subject to detention. This includes a patient detained under s2 which is immediately followed by detention under s3 and the patient is then discharged onto s17A (supervised community treatment) followed by the patient being recalled and having the Community Treatment Order (CTO) revoked and again discharged onto s17A.

303. When the patient has given valid consent to take s58 type treatment form CO2 must be completed by the AC in charge of the treatment. All medicines must be designated by their classes (as described in the BNF) rather than individually. Moreover, the doses may be entered as within BNF limits, but specific doses must be included when the BNF limit is being exceeded. Any new addition to the classes of drugs requires a Form CO2 to be completed by the AC in charge of the treatment. A contemporaneous entry must be made in the clinical record to document the discussion between the AC and the patient at which consent was given. A copy of the completed Form CO2 must be attached to the current prescription card.

304. The patient may at any time, subject to s62, withdraw consent before the completion of the treatment (see s60 MHA).

305. Where a detained patient withdraws consent or refuses consent to the proposed treatment with medication under s58 the AC must trigger the safeguards of a second opinion from a SOAD appointed by HIW. The same safeguard of a second opinion will apply to detained patients unable to consent to treatment under s58 of the Act.

306. It is the responsibility of the SOAD to arrange to examine the patient and consult a minimum of two 'statutory consultees' (i.e. one of who is a registered psychiatric nurse and the other who is someone who has been professionally involved in the medical treatment of the patient) prior to making a clinical decision about treatment.

307. The SOAD and the two statutory consultees must record the outcome of their assessment in the patient's clinical notes. The AC in charge of the treatment should inform the patient of the decision of the SOAD.

308. The SOAD, if he concurs with the AC's treatment plan, will complete the appropriate new Form CO3 authorising the proposed treatment plan.

309. In the case of medication, the SOAD's Form CO3 will specify the classes of drug/drugs dosage (mostly within BNF limits) and the route of administration. A copy of the Form CO3 must be attached to the current prescription card and the clinical records with the original to be sent to the MHA Administrator's Office.

S58A: Electroconvulsive Therapy (ECT)

310. Section 58A applies to ECT and medication administered as part of ECT. It applies to all detained patients and to all patients who are under 18 years whether or not they are a detained patient.

311. The written consent of all patients with capacity to consent to receiving ECT must be obtained, whether or not they are subject to s58A. A record of the discussion with the patient and of the steps taken to confirm that the patient has capacity to consent should be made.

312. Patients of all ages to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose, and likely effects.

313. The key differences from s58 are that:

- ECT cannot be given to an individual who has the capacity to consent to that treatment but refuses to do so unless it is immediately necessary to save the patient's life or to prevent a serious deterioration in the patient's condition (s58A(1)(a) and (2) and s62(1)(a) and (1A) MHA),

- no patients under the age of 18 can be given ECT unless a SOAD has certified that the treatment is appropriate, and

- Certification from SOAD is always required.

S58A (3) Detained adult patients with capacity to consent to ECT

314. The AC in charge of treatment or a SOAD can certify on Form CO4 that the patient has attained the age of 18 and is capable of understanding the nature, purpose and likely effects of ECT and has consented to that treatment.

315. The original Form CO4 must be sent to the MHA administrator with a copy kept for the clinical record and one to go with the patient to the ECT department each time the patient is to receive the treatment. The patient may withdraw consent at any time. The certificate would not be valid if the patient subsequently lacks the capacity to make that decision during the course of treatment.

S58A (4) Detained or informal children and young people with capacity to consent to ECT

316. For children and young people ECT may be given if the patient has consented and a SOAD has certified, on Form CO5, in writing:

- that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it; and

- that it is appropriate for the treatment to be given.

S58A (5) and (6) Patients who lack capacity to consent to ECT

317. Patients who lack capacity to consent to treatment may be given ECT if a SOAD has certified in writing:

- that the patient is not capable of understanding the nature, purpose and likely effects of the treatment; but

- that it is appropriate for the treatment to be given; and

- that giving the patient the treatment would not conflict with:

- an advance decision which the SOAD is satisfied is valid and applicable, in accordance with s25 of the MCA; or

- a decision made by a donee or deputy or by the Court of Protection.

318. The SOAD must complete form CO6.

319. The SOAD shall consult a minimum of two other persons who have been professionally concerned with the patient's medical treatment. One shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner. Furthermore, neither shall be the responsible clinician (if there is one) or the approved clinician in charge of the treatment in question.

S60 Withdrawal of consent

320. Patients treated in accordance with s57, s58 or s58A may withdraw their consent to that treatment at any time. Fresh consent for the implementing of procedures as required by those sections will then be required before further treatment can be carried out or reinstated, except as provided for under the urgent treatment provisions within s62.

321. Where the patient withdraws consent they should receive a clear explanation:

- of the likely consequences of not receiving the treatment;
- and in the case of s58 treatments that a second medical opinion under Part 4 of the Act may or will be sought, if applicable, in order to authorise treatment in the continuing absence of the patient's consent; and
- of the power of the approved clinician in charge of the treatment to begin or continue urgent treatment under s62, if applicable.

322. The patient's withdrawal of consent and explanations given to the patient in light of that withdrawal of consent must be clearly documented in the patient's case notes.

S62 Treatment not requiring consent

323. The consent of a patient subject to s56 i.e. most detained patients subject to the exceptions described in para 9(a) is not required for the administration of urgent treatment under s62. The forms of treatment are expected to include only those authorised under s58 and s58A. In urgent situations, such treatments can be administered without a second opinion. Whenever s58 or 58A type treatment is administered under s62, a simultaneous request must be made for a second opinion.

324. The same principle applies to a patient who has consented to take medication and then withdraws their consent after the three month period. HIW will be requested to arrange for the visit of a SOAD. Where the treatment is urgent, s62(2) may be used to continue with the treatment plan if the AC in charge of the treatment considers that discontinuance of the treatment or treatment under the plan would cause serious suffering to the patient.

325. There is no statutory prescribed form to record the use of treatment under s62, but a local record form should be completed each time s62 is used to treat a patient.

S63 Treatment not requiring consent

326. Section 63 authorises medical treatment for mental disorder without consent and includes treatments that may alleviate the underlying causes of mental disorder, but not including treatments covered by s57, s58 or s58A, provided the treatment is given by or under the supervision of the AC in charge of treatment.

Advance Decisions to Refuse Treatment

327. A patient with a mental disorder is able to make a valid and applicable ADRT, as long as they have mental capacity at the time the advance decision is made. The fact that a patient was/is detained under the Mental Health Act when the ADRT advance decision was made does not render them incapable.

328. If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder a healthcare professional may still give that treatment to the patient if they have authority to do so under Part 4 or 4A of the Mental Health Act 1983 and consent is not required. An ADRT can override the provisions in s57 of the Act, but not those contained in s58, s62 and s63. In respect of ECT (s58A), a valid and applicable ADRT would prevent a SOAD from issuing a certificate but would not necessarily prevent the AC in charge of the treatment from giving urgent ECT treatment as described in s62.

329. Chapter 8 of this document provides more information in relation to advance decisions.

PART 4A Treatment of patients on a Community Treatment Order (CTO) not recalled to hospital

330. The purpose of a community treatment order (CTO) is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm to the patient or others.

331. Only patients who are detained in hospital for treatment under s3 of the MHA or are unrestricted part 3 patients (i.e. s37 without a s41) can be considered for a CTO.

332. Patients not recalled to hospital include patients on a CTO who are in hospital if they have been admitted informally.

CTO Patients (aged over 16 years) with capacity to consent to treatment

333. Compulsory treatment cannot be given to a patient on a CTO who has not been recalled to hospital and who has capacity to consent or refuse treatment and is refusing. There are no exceptions to this rule, even in emergencies.

334. A Part 4A certificate is not required for the first month for s58 type treatment after a patient's discharge onto a CTO.

335. The Responsible Clinician completes form CO8 for s58 and s58a for patients with capacity to consent to treatment who are consenting to treatment.

336. A new CO8 form will need to be completed if there is a change of responsible clinician.

337. The Part 4A certification requirement does not apply if the treatment is immediately necessary and the patient has capacity to consent to it and does consent to it.

S64D Adult CTO patients lacking capacity to consent to treatment

338. A person is authorised to give medical treatment for mental disorder to a CTO patient who lacks capacity to consent to treatment if the following conditions are met:

- before giving the treatment, the person takes reasonable steps to establish whether the patient lacks capacity to consent to the treatment;

- when giving the treatment, he reasonably believes that the Supervised Community Treatment (SCT) Order patient lacks capacity;

- he has no reason to believe that the patient objects to be given the treatment; or he does have reasons to believe that the patient so objects, but it is not necessary to use force to give the treatment;

- he is the approved clinician in charge of the treatment, or the treatment is given under the direction of that clinician; and

- giving the treatment does not conflict with an advance decision which he is satisfied is valid and applicable, or a decision made by a done or deputy of the CoP.

339. A Part 4A certificate is not required for the first month for s58 type treatment after a patient's discharge onto supervised community treatment.

340. The Responsible Clinician must request a SOAD, who completes form CO7, if a patient lacks capacity to consent to s58 or s58A treatment.

341. Before giving a Part 4A certificate, the SOAD shall consult a minimum of two other persons who have been professionally concerned with the patient's medical treatment. Of those persons s/he shall consult:

- at least one shall be a person who is not a registered medical practitioner; and

- neither shall be the patient's responsible clinician or the person in charge of the treatment in question.

342. The Part 4A certification requirements do not apply if the treatment is given in accordance with s64G (emergency treatment in patients lacking capacity), or the treatment is immediately necessary and a donee or deputy or the Court of Protection consents to the treatment on the patient's behalf.

S64G Emergency treatment for CTO patients lacking capacity or competence

343. A practitioner is authorised to give emergency treatment to a patient who lacks capacity to consent to treatment, and who is subject to a CTO, if the following conditions are met:

- the practitioner reasonably believes that the patient lacks capacity to decide or is not competent to consent to it;

- the treatment is immediately necessary; and

- if it is necessary to use force against the patient in order to give the treatment; the treatment needs to be given to prevent harm to the patient; and the use of such force is a proportionate response to the likelihood of the patient suffering harm, and to the seriousness of that harm.

344. The responsible clinician will fill in the appropriate form.

What does 'immediately necessary' mean?

345. Treatment is immediately necessary if:

- It is immediately necessary to save the patient's life; or

- It is immediately necessary to prevent a serious deterioration of the patient's condition and is not irreversible; or

- It is immediately necessary to alleviate suffering by the patient and is not irreversible or hazardous; or

- It is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themself or others and is not irreversible or hazardous.

346. However, ECT may only be given in an emergency if it is immediately necessary to save the patient's life or to prevent a serious deterioration of the patient's condition.

S64E Child CTO Patients (aged under 16)

347. Medical treatment may be given when there is authority to give it and the certificate requirements are met.

348. Certification is not needed for the first month after discharge onto the CTO or if it is immediately needed and the child is competent to consent to the treatment.

S64F Child CTO patients lacking competence to consent to treatment

349. A person is authorised to give medical treatment for mental disorder to a patient subject to a CTO under the age of 16 years if the following conditions are met:

- the person takes reasonable steps to establish whether the patient lacks competence to consent to the treatment;
- he reasonably believes that the child lacks competence to consent to the treatment;
- he has no reason to believe that the patient objects to being given the treatment, or he does have reason to believe that the patient so objects, but it is not necessary to use force to give the treatment; and
- he is the approved clinician in charge of the treatment; or the treatment is given under the direction of that clinician.

CTO patients recalled to hospital

350. CTO patients who are recalled to hospital are subject to s58 or s58A. Certification for s58 or s58A type of treatment is needed unless:

- less than one month has passed since the patient was discharged onto the CTO;
- the s58 or s58A treatment is already explicitly authorised for administration on recall by the Part 4A certificate; or
- if the AC in charge of the treatment considers that discontinuance will cause the patient serious suffering, he may continue with the treatment pending a fresh certificate.

351. For more detailed information regarding Community Treatment Orders, please refer to chapter 24 of the HA 1983 Code of Practice for Wales, 2016.

Appendix A - Link to current consent forms in use in this organisation

All Wales Consent Forms: Patient Consent to Examination or Treatment - NHS Wales Shared Services Partnership

Please see Velindre Cancer Service intranet site for up to date consent forms

Appendix B - Useful contact / link details

Head of Safeguarding and Professional Groups

Velindre Cancer Service Clinical Director

Head of Corporate Governance

Appendix C – How to obtain legal advice

The Trust's Procedure for Accessing Legal Advice can be accessed below via the Trust website.

http://howis.wales.nhs.uk/sitesplus/972/opendoc/486660

If you need to obtain legal advice or apply for a court ruling in relation to a complex consent issue you should contact the Trust Quality and Safety team.

You should ensure that you have all the relevant information about the case to hand so that you can brief legal services / the solicitor appropriately. You should keep a clear record of the legal advice you have been given.

Where a decision is made to apply to a court, the lead clinician should, as soon as possible, inform the patient and their representative of the decision and of their right to be represented at the hearing. The patient's solicitor should be informed immediately and, if practicable, should have a proper opportunity to take instructions and apply for legal aid where necessary.

There may be occasions when the situation may be so urgent, and the consequences so desperate, that it is impractical to attempt to comply with these guidelines. Where delay may itself cause serious damage to the patient's health, or put their life at risk, then rigid compliance with these guidelines would be inappropriate.

The Court of Protection deals with serious decisions affecting personal welfare matters, including health care. Cases involving any of the following decisions should be regarded as serious medical treatment, and should be brought to the court:

a) cases involving organ or bone marrow donation by a patient who lacks capacity to consent;

b) cases involving non-therapeutic sterilisation of a patient who lacks capacity to consent;

c) where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems ‘finely balanced’, or where there are differences of opinion between treating clinicians, or between treating clinicians and patients’ families as to whether ongoing treatment is in the patient’s best interests or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both permanent vegetative state (PVS) and minimally conscious state (MCS)

d) all other cases where there is dispute about whether a particular treatment will be in a patient’s best interests (including cases involving ethical dilemmas in untested areas).

Appendix D - Assessing and documenting Gillick Competence in Under 16s

Assessment of Gillick competence should document the following[10]:

- The age of the child
- The intervention being offered
- The child's ability to understand that there is a choice and that choices have consequences, both risks and benefits
- The child's understanding of the nature and purpose of the proposed intervention
- The child's understanding of the proposed intervention's risks and side effects, both in the short and long term
- The child's understanding of any alternatives to the proposed intervention, and the risks and benefits attached to them
- The child's ability to weigh the information and arrive at a decision
- The child's willingness to make a choice (including the choice that someone else should make the decision)
- An estimate of the child's freedom from undue pressure

[10] BMA - Children and Young People Toolkit

Appendix E - About the consent form: information for patients

Before a doctor or other healthcare professional examines or treats you, they need your consent – in other words, your agreement. Sometimes you can simply tell them whether you agree with their suggestions. However, sometimes a written record of your decision is helpful – for example if your treatment involves sedation or general anaesthesia. In this case, you will then be asked to sign a consent form. If you later change your mind about having the treatment, you are entitled to withdraw consent – even after signing the form.

What should I know before deciding?

Healthcare professionals must ensure you know enough to enable you to decide about treatment. They will write information on the consent form and offer you a copy to keep (in either Welsh, English or both languages) as well as discussing the choices of treatment with you. Although they may well recommend a particular option, you do not have to accept that option. People's attitudes vary on things like the amount of risk or pain they are prepared to accept. That goes for the amount of information, too. The person who is treating you will encourage you to listen to all of the information about your treatment but if you would rather not know about certain aspects, discuss your worries with them.

Should I ask questions?

Healthcare professionals will encourage you to ask questions and you should always ask anything you want. As a reminder, you can write your questions down. The person you ask should do their best to answer, but if they don't know they should find someone else who is able to discuss your concerns. To support you and prompt questions, you might like to bring a friend or relative. Ask if you would like someone independent to speak up for you.

Is there anything I should tell people?

If there is any procedure or treatment you **don't** want, you should tell the people treating you. It is also important for them to know about anything that is particularly important to you and any illnesses or allergies which you may have or have suffered from in the past.

Who is treating me?

Amongst the healthcare professionals treating you may be a “doctor in training” – medically qualified, but now doing more specialist training. They range from recently qualified doctors to doctors almost ready to be consultants. They will only carry out procedures for which they have been appropriately trained. Someone senior will supervise – either in person accompanying a less experienced doctor in training or available to advise someone more experienced. Other healthcare professionals such as nurses and therapists may also provide you with treatment.

What about anaesthesia?

If your treatment involves general or regional anaesthesia (where more than a small part of your body is being anaesthetised), you will be given general information about it in advance. You will also have an opportunity to talk with the anaesthetist when they assess your state of health shortly before treatment. For some procedures you will be invited to a pre-assessment clinic which will provide you with the chance to discuss things a few weeks earlier.

Will samples be taken?

Some kinds of operation involve removing a part of the body (such as a gall bladder or a tooth). You would always be told about this in advance. Other operations may mean taking samples as part of your care. These samples may be of blood or small sections of tissue, for example of an unexplained lump. Such samples may be further checked by other healthcare professionals to ensure the best possible standards. Again, you should be told in advance if samples are likely to be taken.

Sometimes samples taken during operations may also be used for teaching, research or public health monitoring in the future interests of all NHS patients. If a healthcare professional wishes to use your samples for research purposes they will ask for your written consent.

Students

One of the ways that student doctors, nurses or other healthcare professionals learn is by watching care or treatment being given. If the healthcare professional treating you would like a student to watch your examination or treatment, then they have to ask your permission first. If you are having sedation or anaesthetic during your treatment, then they need your written consent for a student to watch your procedure. This is why there

is a section on the consent form for you to say whether or not you agree to students being present. If you are happy for the student to be present, they will be supervised by a qualified member of staff at all times. Your care will not be affected in any way if you decide that you prefer not to have students in the room during your procedure.

Advance decisions to refuse treatment

Some people chose to make "advance decisions" refusing certain care or treatment (sometimes referred to as "living wills" or "advance directives"). If you have made, or wish to make an advance decision refusing a treatment or procedure which may become necessary during the course of your care or treatment, then you must tell the healthcare professional caring for you. This will make sure that your decisions are followed, for example, whilst you are under anaesthetic. This is why there is a section on the consent form for you to say whether or not you have made a relevant advance decision.

Photographs, videos and audio recordings

As part of your treatment it is sometimes helpful for a photographic, video or audio recording to be made – for example to record changes to a skin lesson. You will always be told if this is going to happen. The use of photographs and recordings is also extremely important for other NHS work, such as teaching or medical research. If the healthcare professional would like to take photographs, video or audio recordings, then you will be asked to sign a consent form giving your permission. The photograph / video / audio recording will be kept with your notes and will be held in confidence as part of your medical record. This means that it will normally be seen only by those involved in providing you with care or those who need to check the quality of care you have received, unless you have given permission for it to be used in other ways e.g. teaching, publication, research. We will not use the photograph / recording in a way that might allow you to be identified or recognised without your express permission.

What if things don't go as expected?

Amongst the 25,000 operations taking place every day, sometimes things don't go as they should. Although the doctor involved should inform you and your family, often the patient is the first to notice something amiss. If you are worried – for example about the after-effects of an operation continuing much longer than you were told to expect – tell a healthcare professional right away. Speak to your GP, or contact your clinic - the phone number should be on your appointment card, letter or consent form copy.

What do I need to know?

You should be aware of all of the significant risks (including important (material) risks to you), benefits and alternative treatments (including no treatment) so that you can make an informed decision

What are the key things to remember?

It's your decision! It is up to you to choose whether or not to consent to what is being proposed. Ask as many questions as you like, and remember to tell the team about anything that concerns you or about any medication, allergies or past history which might affect your general health.

Can I find out more about giving consent?

Velindre University NHS Trust has a policy on patient consent to examination or treatment, which will be made available to you on request. The Welsh Government has also issued a *Guide to Consent for Examination or Treatment* which can be accessed at: Patient Consent - NHS Wales

Questions to ask healthcare professionals

As well as giving you information healthcare professionals must listen and do their best to answer your questions. Before your next appointment, you can write some down.

You may want to ask questions about the **treatment itself**, for example:

- What are the main treatment options?
- What are the benefits of each of the options?
- What are the risks, if any, of each option?
- What are the success rates for different options (nationally, for this unit or for the surgeon)?

- Why do you think an operation (if suggested) is necessary?
- What are the risks if I decide to do nothing for the time being?
- How can I expect to feel after the procedure?
- When am I likely to be able to get back to work?

You may also want to ask questions about how the treatment might affect your future state of health or style of life, for example:

- Will I need long-term care?
- Will my mobility be affected?
- Will I still be able to drive?
- Will it affect the kind of work I do?
- Will it affect my personal/sexual relationships?
- Will I be able to take part in my favourite sport/exercises?
- Will I be able to follow my usual diet?

Health care professionals should welcome your views and discuss any issues so they can work in partnership with you for the best outcome.

Unacceptable behaviour

Our staff deserve the right to do their jobs without being verbally or physically abused. Most of our patients and visitors respect this right. Thank you for being one of them. We will work with the police to prosecute those who abuse our staff.

Complaints and compliments

We would like to hear your views about your experience of our services. Our aim is to provide you with the highest standards of care at all times, but we recognise that things can sometimes go wrong. If you have any concerns, speak to the ward sister or senior therapist who will be able to assist and, hopefully, resolve matters to your satisfaction. Where this is not successful, ask for our leaflet regarding the Putting Things Right process. This advises you how to make a formal complaint and the various stages of the procedure.

In making a complaint, advice and assistance is available to you from Llais advocacy service, which represents the interests of patients and the public in the NHS. Llais are skilled in handling complaints. Their Complaints Advocates can provide a range of support during the process of your complaint.

Llais can be contacted as follows:

https://www.llaiswales.org/have-your-say/raising-concern-about-health-and-social-care-services

Data Protection Act/General Data Protection Regulations (2016) or any subsequent legislation having the same effect

Under current Data Protection Legislation, we are committed to protecting the privacy of patient information. If you require an explanation of why information is needed, or how you can access information or your health records, please contact Health Records Manager on 029 2061 5888. You are entitled to receive a copy but should note that a charge will usually be made. You should also be aware that in certain circumstances your right to see some details in your health records may be limited in your own interest or for other reasons.

If you require further electronic copies of this publication please access All Wales Consent to Examination and Treatment Improvement Programme - NHS Wales Shared Services Partnership

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Appendix F – Use of CRUK and RCR consent forms in VCC

When undertaking consent for systemic anti-cancer treatment (SACT) and radiotherapy, CRUK and RCR must be used as opposed to the All-Wales Consent Form or any other procedure specific consent form.

CRUK and RCR have developed and ratified consent forms for use when consenting a patient for SACT and radiotherapy respectfully. The CRUK and RCR consent forms outline the intended benefits, common and occasional side effects, and other known risks of the treatment. Use of these consent forms provide assurance to the patient, clinician, and organisation that the patient is fully consented to all known intended benefits, side effects and risks of the treatment.

Process

CRUK and RCR provide specific consent forms for the majority of SACT and radiotherapy treatments available. In occasions where there is no treatment specific consent form available, there are generic SACT and radiotherapy consent forms available.

The consent forms are available in numerous ways -

- Online via CRUK and RCR websites
- On the dedicated “Consent” page on the VCC intranet
- Printed versions available in outpatients which are maintained by the outpatients’ staff
- For outreach clinics, the consent forms can be printed in preparation for the clinic by the medical secretary’s team

To provide the patient with a copy of the consent form they must be photocopied. In VCC outpatients the outpatient staff will undertake the photocopying. In outreach clinics with no access to a photocopier or colleagues to support the clinicians, the consent form is to be returned to VCC for the medical secretary to photocopy and post the copy to the patient.

All the consent forms need to be scanned and uploaded to the patients Welsh Clinical Portal records by administration staff.

Appendix 2: IPC 04 - Decontamination of Equipment



Ref: IPC 04

DECONTAMINATION POLICY

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Sciences
Document Author:	Infection Prevention and Control Team
Approved by:	Trust Executive Management Board Quality, Safety & Performance Committee
Approval Date:	
Date of Equality Impact Assessment:	January 2025
Equality Impact Assessment Outcome:	*This policy has been screened for relevance to equality. No potential negative impact has been identified.*
Review Date:	January 2028
Version:	6

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ABBREVIATIONS

ADR	Alternative Dispute Resolution
EMB	Executive Management Board
HBN	Health Building Note
HCAIs	Healthcare Associated infections
HCW's	Healthcare Workers
IPCMG	Infection Prevention and Control Management Group
IPCT	Infection Prevention and Control Team
MHRA	Medicines and Healthcare products Regulatory Agency
NIPCM	National Infection Prevention and Control Manual
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
WHTM	Welsh Health Technical Memorandum
WHTM	Welsh Hospital Technical Memorandum

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1 POLICY STATEMENT

1.1 Medical devices play a key role in healthcare, vital for diagnosis, therapy, monitoring, rehabilitation, blood collection and care. Effective management of this important resource is required to satisfy high quality patient and donor care, clinical and financial governance, including minimising the risks of adverse events.

Decontamination of reusable devices is a combination of processes, which if not correctly undertaken, individually or collectively, may increase the likelihood of micro-organisms being transferred to patients, donors, or staff. This combination of processes includes acquisition, cleaning, disinfection, inspection, packaging, sterilisation, transportation, and storage.

2 SCOPE OF POLICY

2.1 This policy applies to all staff within Velindre University NHS Trust (VUNHST) who are involved with decontamination of medical devices/ healthcare equipment. It is also applicable to staff who are involved with decontamination of healthcare equipment prior to inspection, service, maintenance, or repair.

2.2 Cleaning and environmental cleanliness is not addressed in this policy and reference should be made to Policy IPC 05 National Infection Prevention and Control Manual.

2.3 Please refer to local Standard Operating Procedures for decontamination of specific reusable medical devices.

3 AIMS AND OBJECTIVES

3.1 Eliminating preventable healthcare associated infections (HCAIs) requires the proactive involvement of every member of staff across all healthcare settings. In conforming to the principles of Prudent Health and Care, healthcare organisations and individuals involved in providing services are obliged to prevent cross infection when using medical devices in patient care. It is essential that medical devices and care equipment are managed safely to ensure they are used within manufacturer guidance, cannot harbour organisms, and can be effectively decontaminated in accordance with this policy. This policy has been produced to ensure the safety of both VUNHST staff and outside contractors who are employed to use, maintain, and repair medical equipment.

3.2 To ensure that there is a system in place that ensures as far as is reasonably practicable all reusable medical devices are appropriately decontaminated prior to use and after use and the risks associated with decontamination facilities and processes are adequately managed appropriately. (in alignment with manufacturer's instructions and national guidance).

3.3 Effective decontamination of medical devices/ healthcare equipment will be carried out to ensure the device is:

- Safe for further use
- Safe for staff to handle
- Safe for use on the patient/ donor
- Safe for disposal

3.4 The policy objectives are to:

- Provide guidance on the appropriate decontamination of medical devices and healthcare equipment.
- Establish processes to ensure that equipment is kept clean, fit for purpose and in a good state of repair at all times during its operational life.

- Identify individuals' responsibilities for cleaning and maintaining medical devices/ healthcare equipment within VUNHST, ensuring consistency.
- Ensure safe systems of work are adopted to protect patients, donors, and staff from the transmission of infection from medical devices and other equipment that comes into contact with patients and donors.

4 RESPONSIBILITIES

4.1 Trust Roles and Responsibilities

Trust Accountability

The Chief Executive has overall responsibility to ensure this policy is adhered to. Other responsibilities are outlined below.
The Trust Executive Management Board is collectively responsible for minimising the risks of infection to patients, donors, healthcare workers (HCW's) and the public. The Executive director for Director of Nursing, Allied Health Professionals & Health Science is board lead for the IPC organisational structure for the service.

Trust Responsibilities

The Trust has a responsibility to ensure that:

- All Divisional Directors make staff aware of the policy and provide appropriate equipment and training in the use and decontamination of devices.
- An Executive Board Decontamination Lead (representing the Chief Executive) and the Operational Decontamination Lead are identified.
- The Infection Prevention and Control Team (IPCT) will assist with training as appropriate.
- The IPCT will advise on the use of decontamination processes and products as well assess new devices to ensure they comply with this policy.
- Facilities and equipment used by the Trust for decontamination comply with relevant Welsh Health Technical Memoranda (WHTM) and Health Building Note (HBN) requirements for good practice as well as Medicines and Healthcare products Regulatory Agency (MHRA) directives.
- Medical devices are managed in accordance with Health Safety & Welfare Policy (QS 18).
- Incidents relating to decontamination processes are monitored and reviewed in a timely manner.

4.2 Decontamination Executive Lead/ Operational Decontamination Lead

The Executive Decontamination Lead will provide the strategic lead for decontamination and will be responsible in ensuring that this policy is implemented in relation to the organisation and takes proper account of relevant national guidelines.

The Operational Decontamination Lead with support from the Consultant microbiologist and the IPCT will be responsible for the production, review, and audit of evidence-based policy to provide the Trust with up-to-date information on the decontamination or reusable medical devices and will provide staff with training on this policy where needed.

Assess risks associated with ineffective decontamination processes; determine remedial action and recognise areas for development. Report risks on the Boards Risk Register.

Identification and implementation of lessons learnt to inform and improve future practice.

4.3 Infection Prevention and Control Management Group

The role of the Infection Prevention & Control Management Group (IPCMG) is to provide strategic direction and develop a structured approach to the decontamination of reusable medical devices that eliminates or reduces as far as possible the risks associated with the decontamination processes to the patient, user and third parties. The Group is accountable to the Trust and reports to the Quality & Safety Committee and Executive Management Board.

4.4 Authorised Engineer (Decontamination)

The Authorising Engineer (Decontamination) provides independent auditing, and advice on decontamination, together with reviews and witness/validation of processes. This role is fully independent of the Trust and currently supports & advises All Wales Health Boards.

4.5 Infection Prevention & Control Team

- Provide specialist advice for the suitability of equipment prior to purchase and during use. This will include approving the design of equipment e.g. difficult to clean areas, dust traps etc. Such advice must be copied to the Decontamination lead.
- Provide information and advice to enable managers and users to undertake risk assessments on levels of decontamination required.
- Assist in and undertake risk assessments as required by the Infection Prevention & Control Management Group.
- Conduct investigations into areas of special risk advising on safe practice.
- Audit practice and monitor standards in line with current legislation and guidance.

4.6 Manager Responsibilities

Managers/supervisors have responsibility to ensure that:

- All staff are notified of this policy and must have access to and understand the contents and local procedures derived from this policy.
- All relevant staff are trained on how to decontaminate equipment and reusable devices as well as manage single use devices appropriately.
- Staff are trained to recognise the symbol for single use and other packaging marks, and expiry dates on all products are checked before use.
- Single use devices are used in accordance with MHRA guidance – Single-use medical devices: implications and consequences of reuse (2013, last updated 2021) and chosen according to risk over reusable.
- The manufacturer guidance and Trust Waste Policy PP08 are followed in the disposal of such devices.
- Failure or inappropriate use of a medical device is reported accordingly via the incident reporting mechanisms i.e. DATIX.
- New equipment is not purchased until it has been risk assessed against this policy to ensure it can be adequately decontaminated.

4.7 Staff responsibilities

All staff are responsible for ensuring effective decontamination takes place and they are competent to carry out the appropriate process. Staff involved in any aspect of the decontamination process of reusable medical devices are responsible for adhering to this policy.
In addition, key persons and responsibilities as defined in detail in WHTM 01:01 Part Aare in place as follows.

The Executive Lead is identified as the person with ultimate management responsibility for the operation of the premises and the decontamination process.

The Microbiologist is designated to be responsible on microbiological aspects of decontamination.

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4.8 Distribution

The policy will be available via the Trust intranet site, Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5 DEFINITIONS

5.1 Please see Appendix 1.

6 IMPLEMENTATION/POLICY COMPLIANCE

6.1 Requirements for Effective Decontamination

To undertake decontamination effectively all the processes illustrated in the life cycle (below) must be implemented correctly and consistently with all appropriate controls and monitoring in place.

The reusable surgical instrument cycle



Fig 1.1

The essential requirements for good decontamination practice are:

- Management controls are in place
- Medical devices are used appropriately and are:
  - fit for purpose;
  - in accordance with manufactures' instructions;
  - properly maintained, monitored and validated;
  - used by staff who are fully trained and competent;
  - conforming to standards and requirements;
  - track and trace systems link device usage to individual patients;
  - robust records are maintained throughout the process;
    - appropriate facilities are provided for the decontamination process

- single use instruments are not re-used
- decontamination is undertaken in a dedicated Sterile service Department accredited to the Medical Device Directive department wherever possible (WHTM 01:01 Part A)

Risk Assessment

The decontamination methods must be chosen according to the risk of infection associated with the use of a particular piece of equipment and according to the risk that inadequate decontamination poses to patients and staff (Table 1).

	Application	Recommendation	Examples
HIGH	• Items in close contact with broken skin or broken mucous membrane • Items which penetrate the skin or are introduced into sterile body cavities • Invasive devices	• Use sterile single use devices where available • Thorough cleaning followed by: • Sterilisation in accredited SSU or high-level disinfection using approved chemicals and processors	IV cannula Vaginal or rectal probes Flexible endoscopes e.g. bronchoscopes, nasoscopes Dental equipment Theatre instruments Implants/prostheses
MEDIUM	• Items in contact with intact mucous membranes • Items/ environment contaminated with particularly virulent or readily transmissible organisms • Items prior to use on immuno-compromised patients	• Thorough cleaning followed by disinfection and/or sterilisation or high-level disinfection • Single use	Shared patient equipment (as below) after use on any known or suspected infected patient e.g. MRSA, *C. diff.*
LOW	• Items in contact with healthy intact skin • Items/environment not in contact with the patient/ donor	• Thorough cleaning with detergent solution or detergent /disinfectant impregnated wipes	Shared patient equipment e.g. BP cuffs, Tourniquets, Commodes, Stethoscopes, Beds, IV Pumps, Mattresses

Table 1 Risk Stratification for Decontamination of Medical Devices

Decontamination processes are referred to in Appendices.

6.2 Purchasing Medical Devices

Please refer to Quality and Safety Policy QS 24: Medical devices and Equipment Management Policy.

6.2.1 Storage

All devices following decontamination should be stored correctly in a designated area that is controlled and secure and inaccessible to the public.

Sterile packs

- Strict rotation of stock (first in, first out) to control inventory.

- Shelving should be easily cleaned and allow the free movement of air around the stored product.
- Products must be stored above floor level away from direct sunlight and water in a secure, dry and cool environment. Do not store clean or sterile supplies:
    - in corridors
    - on window sills
    - on the floor
    - under sinks

Before being used the sterile product should be checked to ensure that:

- The packaging is intact, and the product is still within expiry date.
- The sterilization indicator confirms the pack has been subjected to an appropriate sterilization process.

6.2.2 Decontamination of equipment prior to inspection, service, or repair.

Anyone who inspects, services, repairs, or transports medical, dental or laboratory equipment, either on hospital premises or elsewhere, has a right to expect that medical devices and other equipment have been appropriately decontaminated; appropriate documentation must be provided to indicate the decontamination status of the item (MHRA 2021).

6.2.3 Transportation of Contaminated/Sterile medical equipment.

As per WHTM 07-01 Safe management of healthcare waste (2013). Where healthcare organisations are obliged to carry used medical devices or equipment by road to a centralised sterile services facility, a recent "multilateral agreement" now exempts these from the terms of alternative dispute resolution (ADR), providing the following conditions are met:

a. They are packed in packaging's designed and constructed in such a way that, under normal conditions of carriage, they cannot break, be punctured, or leak their contents, and the packaging's are designed to meet the construction requirements listed in 6.1.4 or 6.6.4 of ADR.
b. The packaging's meet the general packaging provisions of 4.1.1.1 and 4.1.1.2 of ADR and are capable of retaining the medical devices when dropped from a height of 1.2 metres.
c. The packaging's are marked "USED MEDICAL DEVICE" or "USED MEDICAL EQUIPMENT". When using overpacks, if the mark is not visible, they need to be marked.

This agreement does not apply to: a. clinical waste (UN 3291); b. medical devices or equipment contaminated with, or containing, infectious substances in Category A (UN 2814 or UN 2900); and c. medical devices or equipment contaminated with or containing other dangerous goods that meet the definition of another hazard class.

Where contaminated instruments are to be transported outside of the healthcare premises onto a public highway, they must be handled collected and transported to their decontamination area in a way that avoids the risk of contamination to patients, staff, and any area of the healthcare facility. Those responsible for such transportation must refer to the requirements of the Health and Safety at Work Act 1974 and The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009.

Medical Instruments subject to inspection, maintenance, repair, or disposal, either on site or at the manufacturer's or agent's premises, should be decontaminated beforehand. Any loaned items being returned to a manufacturer or supplier should also be decontaminated (see Table.1). Devices intended for single use only do not require decontamination, except where they are implicated in an adverse incident and may need to be sent to the

manufacturer for investigation. In this situation, contact the manufacturer to find out the most appropriate method of decontamination.

If the manufacturer's instructions appear inappropriate or incomplete, the organisation should report this to the MHRA as an adverse incident.

Adverse incidents can be easily reported online through the Yellow Card scheme:
https://yellowcard.mhra.gov.uk/

Once decontamination has been completed, the items should be labelled accordingly, and a declaration of contamination status form/label completed.

6.2.4 Decommissioning and disposal of devices

Please refer to QS 24: Medical devices and Equipment Management Policy.

6.2.5 Single Use / Single Patient Use Devices

Single-use medical devices

The expression single use on the packaging of medical devices means that the manufacturer:

- Intends the device to be used once and then discarded.
- Considers the device is not suitable for use on more than one occasion.
- Has evidence to confirm that reuse would be unsafe.

Single- use:



The above symbol is used on medical device packaging indicating **'DO NOT RE-USE'** and may replace any wording.

Single Patient Use Devices

Some devices are designated for **Single Patient Use.** This will be clearly stated on the packaging. These devices include such items as nebulisers, disposable pulse oximeter probes, and certain specified intermittent catheters.

Always follow the manufacturer's instructions regarding cleaning and disinfection between uses **on a named patient only. Never reprocess and use on another patient.**

6.3 Audit and Monitoring

Audits as per Annual Audit programme for Infection Prevention & Control.

6.4 Implementation

This policy will be implemented and maintained by the IPCT.

Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

7 REFERENCES

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Health and Safety at Work etc Act (1974)
https://www.hse.gov.uk/legislation/hswa.htm

The Management of Health & Safety at Work Regulations (1999)
https://www.legislation.gov.uk/en/uksi/1999/3242/made

The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations (2009) (CDG Regs)
https://www.legislation.gov.uk/uksi/2009/1348/introduction/2014-04-01

8 GETTING HELP

8.1 Further information and support

Infection Prevention and Control Team: 02920196129.

9 RELATED POLICIES

This policy should be read in conjunction with:

- QS24 Medical Devices and Equipment Management Policy
- QS33 Control of Substances Hazardous to Health (COSHH) Policy
- PP08 Trust Waste Management Policy

10 INFORMATION, INSTRUCTION AND TRAINING

10.1 Training

Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Divisional Nurse, Departmental Manager, Head of Nursing and Head of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are adhered to at all times.

11 MAIN RELEVANT LEGISLATION

Legislation considered in the development of this policy includes:

- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part A: Management and Environment (2018)
- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part B: Common Elements (2018)
- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part C: Steam Sterilisation and Steam for Sterilisation (2018)
- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part D: Washer Disinfectors (2018)
- WHTM 01-01 Decontamination of Medical Devices Within Acute Services Part E: Alternatives to Steam for the Sterilisation of Reusable Medical Devices (2018)
- WHTM 01-06 Parts A-D Decontamination of Flexible Endoscopes (2018)
- WHTM 01-06 Part F Decontamination of Medical Devices within Acute Services Part F: Decontamination of flexible endoscopes. Decontamination of Semi-Critical Ultrasound Probes; Semi-invasive and Non-invasive Ultrasound Probes (2023)
- The Alternative Dispute Resolution for Consumer Disputes (Competent Authorities and Information) Regulations 2015

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- Medical Device Regulation (EU) 2017/745
- Provision and Use of Work Equipment Regulations (PUWER), 1998
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Appendix 1 - Definition in Terms

Medical Device	Medical device' means any instrument, apparatus, appliance, software, implant, reagent, material or other article intended by the manufacturer to be used, alone or in combination, for human beings for one or more of the following specific medical purposes: — diagnosis, prevention, monitoring, prediction, prognosis, treatment or alleviation of disease — diagnosis, monitoring, treatment, alleviation of, or compensation for, an injury or disability — investigation, replacement or modification of the anatomy or of a physiological or pathological process or state — providing information by means of in vitro examination of specimens derived from the human body, including organ, blood and tissue donations, and which does not achieve its principal intended action by pharmacological, immunological or metabolic means, in or on the human body, but which may be assisted in its function by such means The following products shall also be deemed to be medical devices: — devices for the control or support of conception — products specifically intended for the cleaning, disinfection or sterilisation of devices as referred to in Article 1(4) and of those referred to in the first paragraph of this point
Cleaning	A process that physically removes contaminants but does not necessarily destroy micro-organisms. The reduction in microbial contamination will depend upon many factors including the efficiency of the cleaning process and the initial level of contamination.
Disinfection	A process following cleaning that is used to reduce viable micro-organisms but not necessarily inactivate some bacterial agents, such as viruses and bacterial spores. Once disinfected, equipment should be stored in a clean environment to prevent recontamination.
High-Level Disinfection	A process following cleaning that is used to significantly reduce the number of viable micro-organisms including viruses and bacterial spores using designated chemicals in a validated reprocessing machine e.g. washer disinfector.
Sterilization	A process following cleaning and disinfection used to render an object free from all viable micro-organisms including viruses and spores but not necessarily prion proteins. Sterilization can be achieved using steam or gas.
Single Use	Items labelled "single-use" or "not for reuse" or with the international single use sign that must not be reused or reprocessed in any way (QS 24).
Single Patient Use	A medical device labelled as 'single patient use' that may be use for more than one episode on **one patient/ donor only** which can undergo some sort of reprocessing as specified by the manufacturer guidance e.g. nebuliser.
Reusable or Multi Use	May be used more than once for different patients/ donors subject to proper decontamination. This may include care equipment that is shared e.g. BP cuffs, stethoscopes, beds, infusion pumps etc., or surgical instruments, endoscopes that require a higher level of decontamination.

Appendix 2 – Decontamination Methods (Velindre Cancer Centre)

Operator Protection
Staff should be instructed on how to handle disinfectants carefully and advised what protective clothing is required. Reference should always be made to the COSHH risk assessment for each product and COSHH advisor for further advice. Disinfectants should never be mixed with other products and always be used in the correct dilution: higher or lower concentrations are wasteful and potentially harmful.

Expiry dates
Certain disinfectants will bear expiry dates and they should not be used after that date. Where chemicals need to be diluted or mixed always use freshly prepared solutions that are dated and labelled accordingly with strength and do not store for longer than advised (usually 24 hours but refer to manufacture guidance).

Note: Welsh Blood Service methods are written into operational procedures

1. Cleaning
Please refer to Cleaning Standards Manual for specific details on cleaning products for clinical and non-clinical areas.
Cleaning removes organic material and many, but not all, microorganisms.

1.1 General purpose detergent and water or detergent wipes
This is the preferred method of decontamination for the vast majority of items such as furniture, fittings and general equipment e.g. mattresses, bed frames, washing bowls etc.

1.2 General principles:
- Where possible immerse the item in a designated bowl or sink of warm water and detergent. If immersion is not possible surface clean with detergent wipes.
- If using detergent wipes, use a sufficient number to prevent drying out.
- Do not use wash-hand basins in ward areas for cleaning equipment. Use a designated sink or bowl.
- Dry thoroughly.
- Store items dry.
- When cleaning equipment check for signs of damage e.g. covers on mattresses, pillows, cushions. If there are signs of damage report this to the department manager who can initiate replacement or repair.

1.3 Cleaning of Surgical Instruments before Sterilization
Effective cleaning to remove all organic material is an essential pre-requisite for sterilization or high-level disinfection. **Automated cleaning** in a washer disinfector is the **preferred option**; however, some instruments cannot be processed in a washer disinfector or may need manual cleaning prior to processing in a washer disinfector.

To minimise the contamination risk to personnel, splashing and the creation of aerosols must be avoided at all times.

- Always wear appropriate protective clothing when cleaning contaminated equipment e.g. gloves, apron and eye protection
- Fill the clean sink or container (not hand wash basin) with the appropriate amount of water and enzymatic detergent or other appropriate detergent to achieve a working solution (refer to manufacturer's instructions)
- Dismantle or open instrument
- With the exception of power tools*, fully immerse the instrument in the solution for a minimum of 2 minutes
- Drain any excess detergent prior to rinsing with clean water
- Drain the item before drying with a clean non- linting clean cloth
- Visually check to ensure organic material has been removed

- Complete any relevant documentation
- If cleaning solution or rinse water is obviously soiled or contaminated, replace immediately

* Power tools must not be immersed but should be surface cleaned only using a non- linting cloth impregnated with an enzymatic detergent solution. This should be followed by a non- linting cloth dampened with clean water and then dried using a dry non -linting cloth. Alcohol impregnated wipes can be used following the manual cleaning procedure.

2. Disinfection

Disinfection reduces the number of micro-organisms to a safe level for a defined procedure but does not kill bacterial spores and does not necessarily inactivate all viruses.

The following disinfection methods and products are used locally. The use of alternative methods/products must be approved by the Infection Control Team prior to introduction.

2.1 Heat Methods

2.1.1 Washer/Disinfectors

Washer disinfectors can be used to clean and disinfect equipment, such as bed pans, that can withstand wet heat.

2.1.2 Steam cleaners

Steam cleaners can be used to clean and disinfect fabric that cannot be laundered and surfaces that require surface disinfection. To achieve this a steam cleaner with a continuous vacuum extraction facility must be used.

The steam cleaner produces dry steam at temperatures exceeding 130ºC. The water is turned into high temperature microfine vapour, the microscopic water particles penetrate the surface of the item being decontaminated and are subsequently removed by continuous vacuum extraction. The contaminated water then goes into a separate dirty water tank.

2.2 Chemical Methods

Chemical disinfectants are often irritant when allowed contact with skin and mucous membranes or when inhaled as vapor. They can also be corrosive and flammable. A risk assessment, under the Control of Substances Hazardous to Health (COSHH) Regulations, must be undertaken before chemical disinfectants can be introduced.

There is a potential fire hazard associated with all chemical disinfectant products. It is advisable that these products are stored in appropriate sealed containers/cupboards.

Chemical disinfectants may also be damaging to equipment. It is vital, therefore, that equipment manufacturers instructions are reviewed to ascertain compatibility. This should be clarified prior to purchase of new equipment and a decontamination procedure written by the users and approved by the Infection Prevention & Control Team.

2.2.1 Low level chemical disinfection

Alcohol

- Usually in the form of ethyl or isopropyl alcohol this is most active at a concentration of 60 – 90%. It has good bactericidal and fungicidal activity but whilst ethyl alcohol is effective against most viruses, isopropyl alcohol is not.
- Alcohol is available as a bottled solution or, more commonly, as wipes, in tubs or individually wrapped sachets e.g. Cliniwipes, Sanicloth 70.
- Alcohol is useful for surface disinfection of instruments such as power tools, prior to sterilization.
- Alcohol does not penetrate well into organic matter and must only be used on visibly clean surfaces. If an item is obviously contaminated with organic matter, it must be cleaned before disinfection.

Chlorine releasing agents

- This includes sodium hypochlorite and di-isochlorocyanurate (NaDcc).
- Wide range of bactericidal, virucidal and fungicidal activity.
- Corrosive to some metals
- A chlorine-based disinfectant solution at a dilution of 10,000 parts per million (ppm) should be used for the disinfection of any equipment contaminated with blood or blood stained body fluids.
- A chlorine-based disinfectant solution at a dilution of 1,000 ppm should be used for the disinfection of equipment that has been in contact with an infected service user, non-intact skin, body fluids (not blood stained) or mucous membranes.

Chlorine dioxide

This is sporicidal disinfectant that can be used in a wipe system i.e. Tristel Trio, for cleaning and disinfecting non lumened flexible endoscopes and ultrasound probes e.g. nasoendoscopes and bladder scanners.

2.3 High level disinfection

This process must be preceded by thorough cleaning.

2.3.1 Vaporised Hydrogen peroxide for disinfection of the environment

Vaporised hydrogen peroxide may be used to achieve high level disinfection of the environment following outbreaks of infection such as Clostridioides *difficile* and Norovirus. It will only be used with the agreement of the IPCT and operated by housekeepers/domestic assistant who have received training to operate the vaporiser. The area to be treated must be free of people when the vaporiser is in use.

2.3.2 Trophon2

is an automated high-level disinfection for endocavity probes. The device has high-frequency ultrasonic vibrations that generate a 'sonically activated', hydrogen peroxide (H_2O_2) mist that kills bacteria, fungi and viruses.

2.3.3 Ultraviolet (UV) Light Systems for disinfection of the environment

Ultraviolet light systems aid in reducing environmental contamination after terminal cleaning and disinfection and can be used following outbreaks of infection such as *Clostridioides difficile* and Norovirus. It will be used with the agreement of the IPCT and operated by housekeepers/ domestic assistants and nursing staff who have received training to operate the system.

2.3.4 AE1 Antigermix®

Is an automated system which uses patented UV-C technology to provide High-Level Disinfection of endocavity ultrasound probes, transoesophageal ultrasound probes, and ENT endoscopes without operating channels.

2.3.5 Heat labile endoscope disinfection

There are no flexible endoscopes at VCC.

3. Sterilization

Sterilization is the complete removal or destruction of all viable microorganisms including viruses and bacterial spores. All reusable medical devices used in acute healthcare settings requiring sterilization will be reprocessed in a Medical Device Directive (MDD) accredited facility.

Autoclaving for VCC will be carried out in the Sterile Services Unit at Llandough Hospital as part of the Service Level Agreement.

4. Tracking and Traceability of Surgical Instruments

It is important to be able to trace products through the decontamination processes and to the patient on whom they have been used. The ability to track and trace surgical instruments and equipment enables corrective action to be taken when necessary. For example, in the unlikely event of a sterilisation cycle failure products can then be recalled.

Records should be maintained for all the sets cleaned and sterilised identifying:

- The cleaning and sterilisation method used.
- The name of the person undertaking the decontamination.
- Details of the item being processed.
- Records should be maintained for a minimum of eleven years.

5. Transportation of contaminated surgical instruments and associated equipment

All contaminated reusable medical devices must be handled collected and transported to their decontamination area in a way that avoids the risk of contamination to patients, staff and any area of the healthcare facility. All contaminated surgical instruments present a risk of infection.

To minimise this risk:

- The instruments must be placed in closed, secured containers and transported to the decontamination area as soon as possible following use.
- Contaminated medical devices and equipment are kept separate from clean during transportation; this is achieved by using separate containers to provide physical barriers between clean and dirty items.
- Personnel are trained to handle collect and transport contaminated medical devices/equipment and should wear protective clothing as appropriate.
- Contaminated and clean/sterile instruments must be segregated during transportation. (Records should be kept of vehicles and containers used).
- Transport containers must protect both the product during transit and the handler from inadvertent contamination and therefore must be:
    - Robust
    - Rigid
    - Leak-proof
    - Easy to decontaminate
    -
    - Capable of being closed securely
    - Sealed with cable ties, to prevent tampering, or spillage of items
    - Clearly labelled to identify the user and the contents

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Appendix 3 - Spills of blood and body fluids (Velindre Cancer Centre)

Note: Welsh Blood Service methods are written into their organisational standard operational procedures

Spills of blood or body fluids must be removed immediately. The removal of blood and bodily fluid spills is the responsibility of the clinical staff in that department, not the cleaning staff. Domestic supervisors are responsible for spillage in non-clinical areas within the building. Estates staff are responsible for the grounds of the hospital. However, some common sense and flexibility must be adopted with the priority being to remove the spill as soon as possible.

Do not use your hands if a spillage contains broken glass or sharps use a brush and pan for example and discard into an appropriate sharp's container.

Sodium hypochlorite should be used to disinfect equipment or surfaces contaminated by blood or body fluids.

When a spillage occurs, if practical, close off the immediate area.

WEAR APPROPRIATE PROTECTIVE CLOTHING. (Standard Infection Control Precautions (SIPCs) Policy IPC 05 National Infection Prevention and Control Manual)
Note: Welsh Blood Service methods are written into operational procedures

Spills of blood
Make up a solution of Sodium Hypochlorite 10,000ppm - pour on to spillage, leave for 5 mins before mopping up with disposable paper towel then cleaning with detergent and water.

Sodium Dichloroisocyanurate (NaDCC) Granules
These granules are stocked in Velindre Pharmacy and can be used to soak up larger spillages of body fluids. Use protective clothing and follow directions on containers.

Do not use on urine spillages for these soak up urine in paper towels discard into clinical waste and clean the area with Sodium Hypochlorite 1000ppm or Chlor clean Tablets diluted to 1000 ppm. Wear appropriate protective equipment.

Spillage Kits
Spillage Kits are available in some divisions; the instruction on the kits should be followed.

Spills of body fluids not visibly contaminated with blood

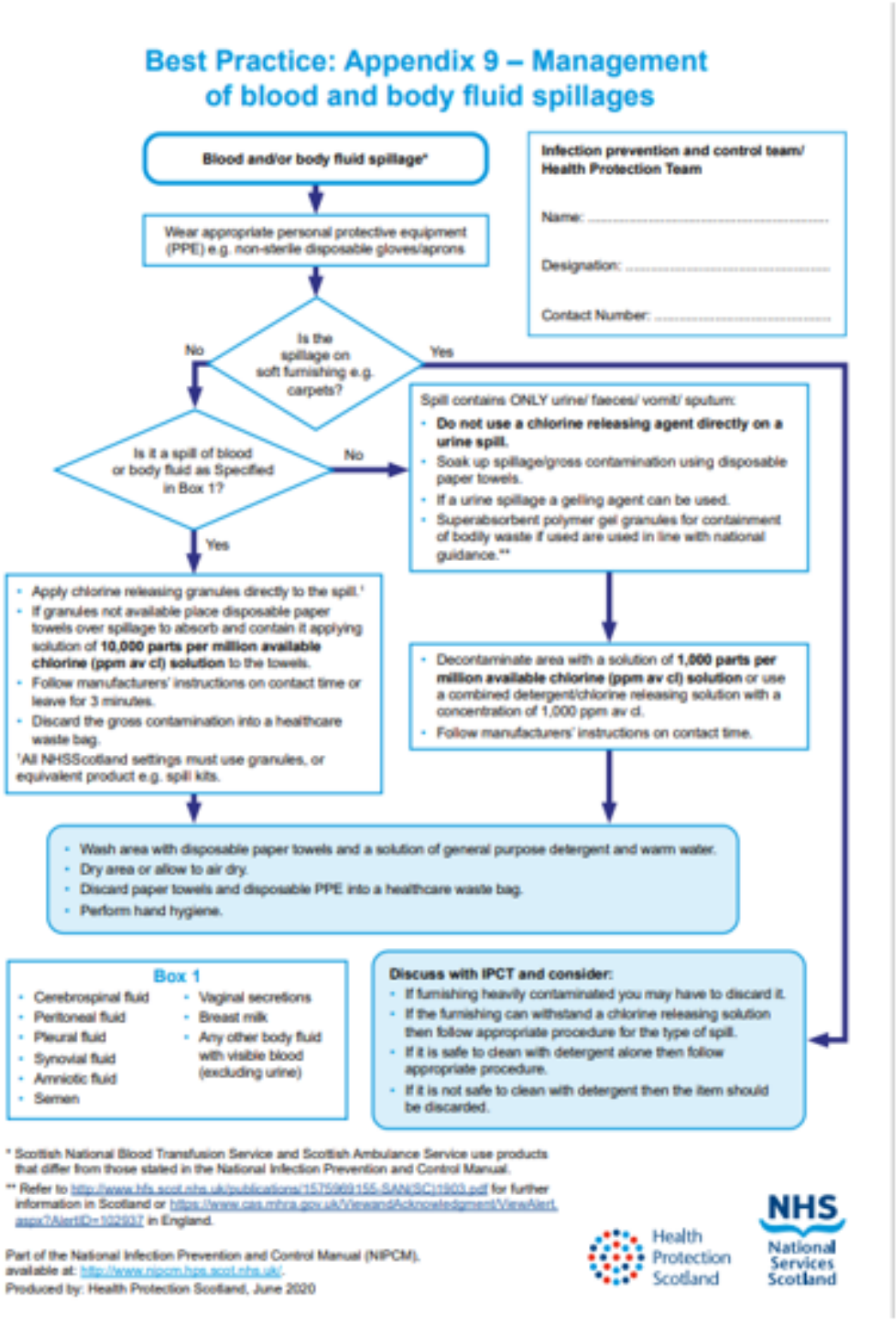
- These include spills of faeces, vomit, urine and sputum.
- Soak up the spill as thoroughly as possible with paper towels.
  Discard the paper towels and any other waste from the spillage into a clinical waste bag.
- Clean and disinfect the area.
- Discard personal protective equipment into the clinical waste bag.

Divisions should follow their Standard Operating Procedures.

Appendix 4. Best Practice: Management of Blood and Body fluid spillages

Part of the National Infection Prevention and Control Manual (NIPCM) - Chapter 1 Standard Infection Control Precautions (SICPs). Best Practice: Appendix 9

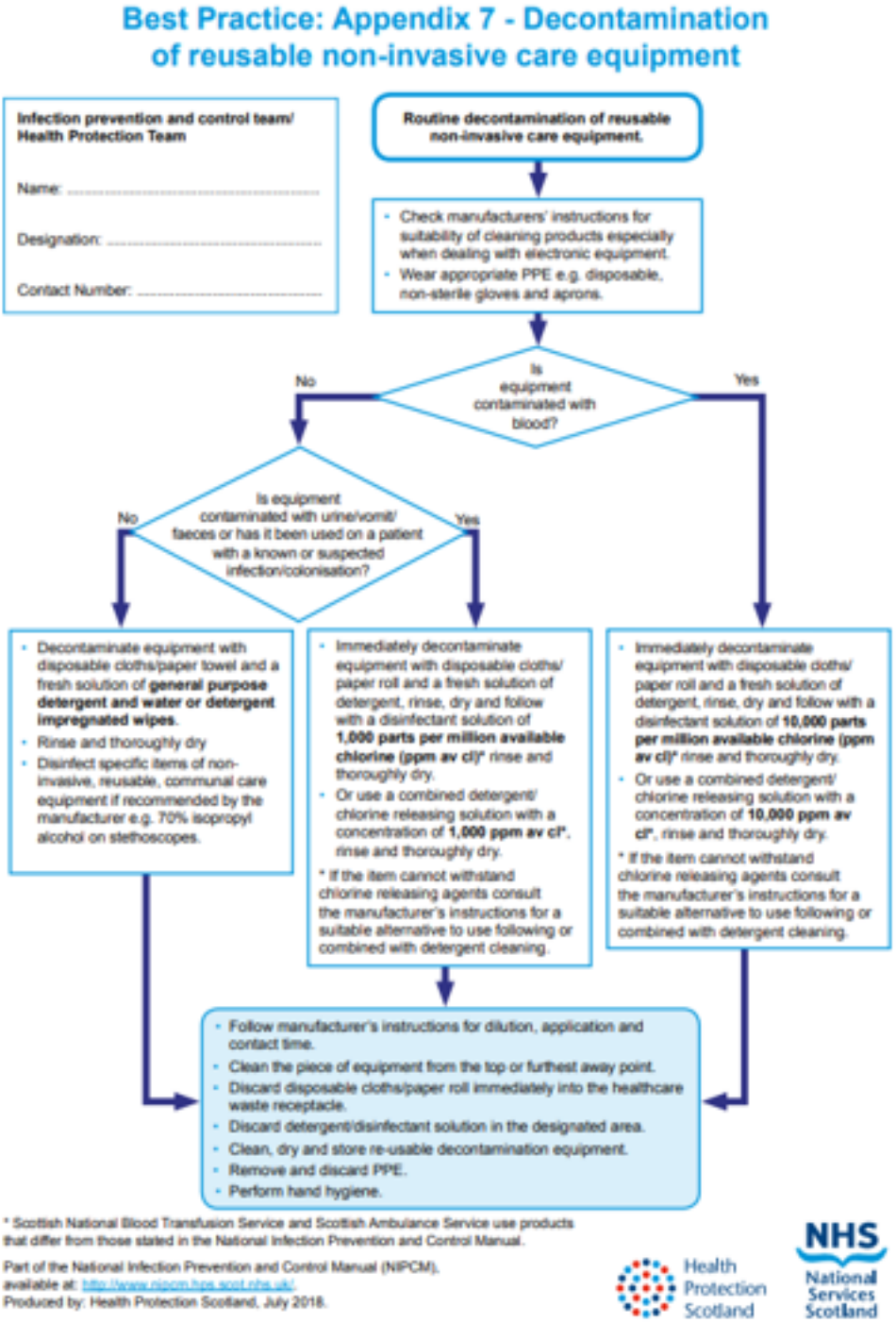
Available at: https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/nipcm/chapter-1-standard-infection-control-precautions-sicps/



Appendix 5 - Decontamination of reusable non-invasive equipment

Part of the National Infection Prevention and Control Manual (NIPCM). Chapter 1 Standard Infection Control Precautions (SICPs). Best Practice: Appendix 7

Available at: https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/nipcm/chapter-1-standard-infection-control-precautions-sicps/



Appendix 3: IPC 07 - Meticillin Resistant Staphylococcus Aureus (MRSA)



Ref: IPC 07

Policy for the Prevention and Control of Meticillin Resistant Staphylococcus Aureus (MRSA)

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Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Sciences
Document Author:	Infection Prevention & Control Nurse
Approved by:	Trust Quality and Safety Committee
Approval Date:	
Date of Equality Impact Assessment:	December 2024
Equality Impact Assessment Outcome:	*This policy has been screened for relevance to equality. No potential negative impact has been identified.*
Review Date:	December 2027
Version:	5

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ABBREVIATIONS

CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CP's	Contact Precautions
CRA	Clinical Risk Assessment
HCW's	Health Care Workers
HICK	Broviac Implants
ICNet	ICNet Clinical Surveillance Software
IPCT	Infection Prevention and Control Team
IV	Intravenous
LRA	Local Risk Assessment
MRSA	Meticillin Resistant *Staphylococcus Aureus*
MSSA	Meticillin Sensitive *Staphylococcus Aureus*
OCCH	Occupational Health
PICC	Peripherally inserted central catheter
PPE	Personal protective clothing
UHB	University Health Board
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
WCP	Welsh Clinical Portal

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1 POLICY STATEMENT

Staphylococcus aureus and Meticillin Resistant Staphylococcus Aureus

Approximately 30% of the population is colonised by Staphylococcus aureus (meticillin sensitive Staphylococcus aureus), which is usually present on the nose and/or skin (Sakr et al 2018). S.aureus infections acquired outside a healthcare setting typically involve the skin and soft tissue (e.g., impetigo, folliculitis, boils, and infected minor breaks of skin) and more rarely the bone and joints.

Healthcare associated S.aureus may infect the skin and soft tissue, usually as surgical wound infection, but also colonise the foreign bodies frequently used in patient care causing infections (e.g. intravascular line infection, prosthetic-related infections, urinary catheter-associated infections, ventilator-associated pneumonia). Infections can sometimes be severe and spread to the bloodstream.

Meticillin Resistant Staphylococcus aureus (MRSA) is resistant to antibiotics such as Flucloxacillin, an initial option for treating some infections. Some MRSA strains may also be resistant to a wider range of antibiotics leaving a limited choice of antibiotics to treat infections.

Meticillin Sensitive Staphylococcus aureus (MSSA) and MRSA are mainly transmitted by direct and indirect physical contact e.g. through the contaminated hands of health care workers (HCWs) and / or re-useable equipment if not decontaminated correctly after use on another MSSA / MRSA colonised patient.

This policy sets out appropriate controls and clinical procedures in place to minimise the risk of transmission of MRSA between service users, patient's visitors, and staff. The policy has been reviewed and updated for MRSA Decolonisation.

2 SCOPE OF POLICY

The policy applies to all staff in all locations including those with honorary contracts and student's placement.

3 AIMS AND OBJECTIVES

Provide Velindre University NHS Trust (VUNHT) with structured and appropriate guidance to staff for the prevention and management of MRSA colonisation/ infection.

- Set out the requirements for all HCW's involved in the care and management of patients with MRSA.
- Ensure best practice and high quality of care.
- Provide staff with the screening process for admission to hospital.
- Ensure that patients with MRSA have effective and appropriate care wherever that care is delivered.
- Reduce the risk of transmission, acquisition, colonisation, and infection with MRSA.

4 RESPONSIBILITIES

4.1 Trust Accountability

The Chief Executive has overall responsibility to ensure this policy is adhered to. Other responsibilities are outlined below.

The Trust Executive Management Board is collectively responsible for minimising the risks of infection to patients, donors, healthcare workers (HCWs) and the public. The Executive director for Director of Nursing, Allied Health Professionals & Health Science is board lead for the IPC organisational structure for the service.

4.2 Clinical and Operational Managers

Clinical and Operational Managers have responsibility to ensure that:

- Staff are informed of the policy.
- Practice complies with this policy.

4.3 Clinical staff working directly with patients and the public

Clinical staff working directly with patients and the public have responsibility to ensure that they:

- Familiarise themselves with the policy.
- When appropriate clinically risk assess patients for MRSA on every admission.
- Manage patients at risk of, or diagnosed with MRSA in a way that will reduce the risk of transmission from patient to patient or patient to staff.
- Report cases transferred in from other hospitals.

4.4 Infection Prevention & Control Team (IPCT)

The IPCT is responsible for:

- Providing advice on appropriate placement of patients with MRSA in hospital.
- Producing timely feedback on surveillance of MRSA acquisition for wards/units, departments, and Trust.
- Ensuring that patients with first time isolates of MRSA have an Infection Prevention and Control alert placed currently on Welsh Clinical Portal (WCP).
- Ensuring that clinical teams are informed about their patients following identification of MRSA either in pre admission assessment clinics/ outpatient department or when the patient has been an in-patient.
- Producing reports to relevant committees and groups and for the Trust Board on MRSA.
- Ensuring that all MRSA bacteraemias are reported to Public Health Wales.
- Supporting the investigation of and learning from any MRSA bacteraemia post infection review.
- Investigating suspected incidents of cross infection.
- The Infection Prevention and Control Team will provide training as appropriate.

4.5 Domestic/Housekeeping Staff

Housekeeping are responsible for:

- Ensuring that they comply with the infection control management of MRSA patients as detailed and that they challenge or report any poor practice.
- Ensuring that enhanced cleaning is carried out for all MRSA patients in their area.
- Terminal cleans on discharge/ negative results.

4.6 Distribution

The policy will be available via the Trust intranet site and from the IPCT. Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5 DEFINITIONS

5.1 Staphylococcus Aureus

Is a Gram-positive bacterium often found on the skin or in the nose of individuals. It colonises the skin or anterior nares (nose) of approximately 20 - 30% of healthy individuals but this percentage can rise in hospitalised patients (Sakr et al 2018). The organism can cause abscesses, wound infections, and septicaemia. One strain of S. aureus known as MRSA is resistant to an antibiotic called meticillin and other antibiotics used to treat infection. This strain accounts for 6% of all S.aureus strains but is no more virulent or more readily spread than MSSA (NICE, 2022-23)).

5.2 Meticillin Resistant *Staphylococcus Aureus* (MRSA)

Methicillin resistant Staphylococcus aureus is a significant cause of healthcare associated infection. It can result in blood stream infection (bacteraemia) that can be life threatening. MRSA can also cause skin and wound infections, urinary tract infections and pneumonia. These infections require treatment with antibiotics.

It can be easily transmitted by direct skin contact or by indirect contact via equipment and fomites. It has the capacity to survive in the environment for prolonged periods and is resistant to a wide range of antibiotics.

5.3 Carriage

A person who harbours MRSA with no overt signs or symptoms of clinical disease, but who is a potential source of infection. Recognised carrier sites for MRSA include the nose and throat and certain skin sites, such as perineum, groin, axilla, and buttock. The carriage of MRSA can be transient, intermittent or of long duration (chronic).

Transient carriage

Occurs when MRSA is present on the hands, arms, face or inside the nose for a short period of time, i.e. a few hours. Staff often become transient carriers when caring for patients with MRSA.

5.4 Colonisation

Colonisation by MRSA is harmless and asymptomatic to the patient but in a small number of cases it can cause infection ranging from minor skin infections to blood stream infections (BSI's). MRSA colonisation can only be identified by taking swabs from the following sites: nose, groin, wounds, stomas, sputum (if the patient has a productive cough) and urine sample (if the patient has a catheter in situ).

Patients colonised with MRSA can be a significant issue in healthcare settings because:
Patients colonised with MRSA who undergo invasive procedures are at risk of developing an MRSA infection.
The presence of patients colonised with MRSA in hospitals is a potential source of infection for other patients.
Should MRSA infections develop they are harder to treat as the antibiotics they are susceptible to are more limited.

5.5 Infection

The presence of MRSA can cause clinical consequences, e.g. inflammation, swelling and pus formation. MRSA infection can occur in the skin and soft tissues, lungs, bones, and joints or in the blood stream i.e. MRSA bacteraemia.

5.6 Panton Valentine Leukocidin

Panton-valentine Leukocidin (PVL) is a toxin that destroys white blood cells and is a virulence factor in some strains of *Staphylococcus aureus* (SA). In the UK the genes encoding PVL are found in < 2% of *S. aureus* clinical isolates submitted to the National Reference Laboratory (GOV UK, 2013).

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The infection control measures used to prevent the spread of PVL-positive MRSA are the same as for any type of MRSA infection; this includes screening and the decolonisation regime.

PVL MRSA affects healthy children and young adults and is usually community acquired. Staff should wear face masks during intubation and chest physiotherapy. Closed suction should be used.

Patients identified on screening as having a PVL producing strain of MRSA may need specific screening and treatment. In this instance advice should be sought from the IPCT as family members may require screening.

Guidelines for the diagnosis and management of PVL-SA can be found on the government webpage for PVL- Staphylococcus aureus infections: diagnosis and management.

6 IMPLEMENTATION/POLICY COMPLIANCE

6.1 Background

Patients may be carriers of MRSA or contract it through transmission from another affected person. MRSA can cause wound, respiratory, urinary or blood stream infections. The clinical risk assessment (CRA), (Appendix 7) in this policy ensures staff screen patients that are at a higher risk of infection from MRSA (for example, previous MRSA history or admission).

The 'Implementation of modified admission MRSA screening guidance for NHS from the Department of Health in 2014 wanted MRSA screens for acute and elective admissions in England to be streamlined to the following:

- All patients admitted to high-risk units.
- All patients previously identified as colonised with or infected by MRSA.

Routine MRSA screening has been shown to detect MRSA colonisation early and provides the opportunity to eradicate carriage to prevent transmission and/or infection. Targeted MRSA screening was implemented across Wales following Chief Medical Officer (CMO)/ Chief Nursing Officer (CNO) letter (February 2013), based on evaluation of Health Protection Scotland's Pathfinder Programme. CMO/CNO letter stipulates the introduction of routine MRSA screening for all patients in the following patient groups, as a minimum and includes:

A requirement to use LRA to assess each admission as to whether the patient:

- Has a past history of colonisation/infection with MRSA at any time
- Is resident in a care home, other institutional setting or is a transfer from another hospital
- Has a wound or in-dwelling device (e.g. gastrostomy, urinary catheter, stoma, long term intravascular device) present on admission

A requirement to swab screen any patient who answers yes to any of the above questions using a minimum of 2 swab sites (nasal/perineum or nasal/throat if perineum/ groin is deemed difficult or unacceptable).

- A record of the assessment and results of the swab.

- Prioritisation (within existing schemes of prioritisation) for pre-emptive isolation/cohorting pending swab results.

6.2 Risk Factors for MRSA carriage

Patients who are at risk from colonisation or infection from MRSA are those who;

- Are known to be carrying MRSA, or to have done so previously.
- Are admitted from care homes.
- Have been in hospital within the past 12 months.
- Are transferred from other hospitals or from abroad.
- Have received repeated course of antibiotics.
- Have renal disease or diabetes.
- Have skin breaks for example for pressure sores, leg ulcers, central/peripheral venous catheter, percutaneous endoscopic gastrostomy tubes and any other indwelling devices.
- Have certain active dermatological conditions, for example psoriasis or eczema.
- Oncology patients with head and neck cancer (based on local data).

6.3 Diagnosis of Infection

Any patient found to be a carrier of MRSA should be assessed for evidence of infection, for example sepsis syndrome, skin and soft tissue infection, pneumonia, bone/joint infection, device related infection, endocarditis. The need for in dwelling catheters and intravascular devices should be reviewed and they should be removed, when possible, to minimise risk of subsequent infection.

MRSA isolated from sputum or from urine, usually represents colonisation but patients should be carefully assessed for active infection.

Eradication of MRSA from catheterised patients usually requires catheter removal or at least change, with or without systemic antibiotic therapy. Advice should be sought from the microbiologist.

MRSA isolated from non-inflamed skin or ulcers, or from other sites where there are no overt signs of infection implies colonisation rather than infection and should be managed as such without oral or parenteral antibiotics on the advice of the microbiologist. MRSA isolated from a clinically infected wound, or inflamed ulcer, should be interpreted according to the clinical picture.

6.4 Screening

Screening should be carried out according to the guidance below or as directed by the IPCT. A patient screen should only include:

- Nasal swab.
- Perineal swab (or groin if perineum not accessible).
- Swabs of any breaks in skin, including wounds, stoma site, vascular access devices and drain exit sites (see appendix 1).

*Charcoal (black) swabs should be moistened with sterile saline or sterile water prior to use.

The MRSA screen is requested via the Welsh Clinical Portal. Give additional information if submitting additional swabs of any indwelling devices/ and or wounds and provide the relevant clinical information.

6.5 Who should be screened?

All patients who will have planned admissions for long courses of daily radiotherapy or inpatient chemotherapy should be screened for MRSA on their first appointment with the Oncologist, or at the time the treatment plan is devised. This will ensure that screen

results are returned before admission and that no patient colonised or infected with MRSA is placed on an open ward.

6.5.1 Patients requiring peripherally inserted central catheters (PICC) and Broviac Implants (Hickman Line)

All patients scheduled to receive a PICC, or a Hickman line must be screened where possible, two weeks before insertion of the device. This will allow time for turnaround of results and decolonisation if necessary. If the PICC or Hickman line is an emergency, a screen for MRSA should be taken as soon as possible. (See appendix 3).
The same principles apply to patients for whom a Hickman line is planned.

6.5.2 Patients undergoing radiotherapy as inpatients

All planned admissions to the inpatient wards, for example those undergoing prolonged courses of radiotherapy, should be screened no later than one week prior to admission or at their first appointment at Velindre Cancer Centre (VCC).

6.5.3 Patients undergoing chemotherapy as an inpatient

All planned admission to the inpatient chemotherapy ward should be screened for MRSA no later than one week prior to admission or at the first outpatient appointment in VCC.

6.5.4 Patients with head and neck cancers.

Patients with a head and neck cancer should be screened for MRSA at least one week prior to admission or at their first appointment in VCC.

Historical data shows that some patients with head or neck cancers are positive for MRSA in the throat and on that basis throat screens may in special circumstances be requested by the IPCT but should not be included as part of a routine screen.

6.5.5 Outreach patients.

A number of patients do not attend VCC instead they attend "Outreach" clinics hosted by surrounding Health Boards. These patients are attended by Velindre oncologists and Velindre specialist nurses. For those patients for whom an admission to VCC is planned, the specialist nurse or oncologist must screen or arrange for the patient to be screened for MRSA. Staff who place PICC lines or admit the patient must then access the results of the MRSA screen from the relevant UHB microbiology department. Please seek help from the IPCT if difficulties are experienced.

6.5.6 GP screening

It may on occasion be more convenient for patients to be screened for MRSA by their own GP. If this is the case the fact should be documented, and the responsible clinician should obtain the results of the screen from the patients GP. A written record from the GP handed to the patient is acceptable.

6.5.7 Unplanned emergency admissions

In the case of unplanned or emergency admissions patients should be screened for MRSA within 48 hours of admission. Use the clinical risk assessment when deciding which patients to isolate. For example, where possible isolate patients with head and neck cancers who have not been screened. Contact the IPCT for advice.

6.5.8 Patients known or suspected to be MRSA positive

Any patient known to be or suspected to be MRSA positive should be isolated and screened with contact precautions continuing until the MRSA screen results are returned.

6.5.9 Isolation of patient with MRSA

Separation of patients with MRSA (in an individual room) from others to prevent or limit the direct or indirect transmission of MRSA to other people who are susceptible.

6.5.10 Cohort nursing of patients with MRSA

A group of patients with MRSA who are separated from patients who do not harbour MRSA in a geographically distinct area or with physical separation in the same room. Isolation in separate rooms is preferable to cohort nursing. Ideally, the same nursing staff should provide daily care for the same cohort for the duration of the isolation.

6.5.11 Previously decolonised patients

Patients for whom there is documented evidence of a successful decolonisation programme can be nursed on the main ward but should be screened on each further inpatient admission.

6.5.12 Patients who have been hospitalised elsewhere since screening

Patients who have previously screened negative for MRSA should be rescreened if they have been admitted to another hospital, hospice or care home since their last admission to VCC e.g. patients who are admitted on a 3-weekly cycle of chemotherapy.

7 Decolonisation

Decolonisation should be prescribed to treat a patient who has tested positive for MRSA. An assessment of previous history must be taken prior to starting treatment to identify previous colonisation/ or any decolonisation treatment already received.

The IPCT will direct decolonisation and rescreening, maintain records, and enter Information into the patient electronic record and alert system. The prescription chart for MRSA Decolonisation should be completed by doctors or nurse prescribers.

7.1 Treatment

Mupirocin nasal ointment and Octenisan body wash are the agents used for decolonisation.

Mupirocin Nasal Ointment

Mupirocin nasal ointment 2% should be applied to the inner surface of each nostril, (anterior nares) three times daily for 5 days. The patient should be able to taste the Mupirocin at the back of the throat after application (See appendix 2).

7.1.1 Octenisan wash lotion

Octenisan is a mild and gentle antimicrobial wash lotion for whole body cleansing including the hair. It is suitable for all skin types with a skin-neutral pH value and is free of artificial colours and perfumes. Daily showers or baths should be taken using Octenisan wash lotion for five days. The skin should be moistened and the Octenisan applied thoroughly (without dilution) to all areas before rinsing in the bath or shower. Special attention should be paid to known carriage sites such as the axilla, groin and perineal area. The Octenisan should also be used for all other washing procedures and for bed bathing (See appendix 2).

The hair should be washed with Octenisan twice in the five days then washed with normal shampoo. Clean clothing, bedding and towels should be provided after each application of Octenisan.

7.1.2 Failure to decolonise

Patients should normally receive only two attempts at decolonisation as more are thought likely to promote resistance to the products used. Patients who still test positive for MRSA after two attempts are regarded as chronically colonised and should be managed with CP's thereafter. Further courses of decolonisation treatment may be recommended if the patient is to have surgery or other invasive procedure. If a third attempt is required

Neomycin nasal ointment may replace Mupirocin nasal ointment on advice from the IPCT or microbiologist only.

7.1.3 Throat colonisation

In cases where throat colonisation is proved the IPCT may advise that patients gargle with 0.2% chlorhexidine gluconate mouthwash (e.g. Corsodyl®) mouthwash twice a day. If the patient has dentures or other dental prostheses, these should be soaked daily in 0.2% chlorhexidine gluconate mouthwash.

7.1.4 Rescreening

Three negative screens are required to prove decolonisation has been effective.
The first screen should be collected at least 48 hours after the completion of decolonisation and parenteral antibiotics. Rescreens two and three must only be collected after the results from the previous test have been received.

7.1.5 Staff screening and management

Do not routinely screen staff for MRSA unless there is a clear epidemiological reason for doing so.

If staff are identified as MRSA positive, consider excluding staff from work, reducing their Interaction with patients, and offering decolonisation therapy as deemed appropriate.

8. Clinical management and infection control procedures

8.1 Control Measures

Control measures include:

- Hand hygiene.
- Appropriate use of protective equipment.
- Maintenance of appropriate cleaning procedures (and correct use of appropriate cleaning products).
- Rational use of antibiotics.
- Appropriate disposal of waste.
- If a patient is colonised with MRSA, a single room is preferred. Decisions on individual cases should be risk assessed by clinicians/patient access with the support of IPCT.

8.1.1 Standard Infection Control Precautions

Standard infection control precautions include the use of gloves and aprons (personal protective clothing – PPE) when handling body fluids, decontaminating the clinical environment and medical equipment, and the disposal of sharps, linen, and waste. Hand hygiene is the foundation of standard precautions and the prevention of infection.

8.1.2 Isolation of the patient

Please see appendix 5 & 6 for additional information on precautions & decontamination.

Patients known to be MRSA positive must be isolated ideally in an ensuite room. A Contact Precaution Isolation sign (see appendix 4) must be fixed to the cubicle door. If ensuite is not available a commode must be placed in the isolation cubicle. Where possible the cubicle door must remain closed. Monitoring equipment, for example blood pressure cuffs and stethoscope must be dedicated to the isolated patient.

Staff who will have direct contact with the isolated patient or the patients' environment must don personal protective equipment (PPE) before entering an isolation cubicle. Gloves and aprons must be changed between care procedures and hand hygiene must be performed after glove removal. The PPE must be removed before leaving the cubicle

and disposed of into the infectious waste stream (orange) located inside the cubicle. Hands must be washed after removal of gloves and before leaving the isolation cubicle. Once outside the cubicle staff must decontaminate their hands. All staff must employ CP's if they are to have direct contact with the patient, or the patients' environment.

Prior to transferring the patient to a single room, the implications of MRSA colonisation, infection and treatment should be clearly explained to the patient or relative. Leaflets which provide information on MRSA should be available on all wards.

- Isolate patients for as short a time as possible to minimise feelings of stigma, loneliness, and low mood.
- Provide clear information to patients about the need for the use of protective equipment to reduce feelings of stigma.
- Be consistent in the use of protective equipment to ensure that patients have confidence in the decision to place them in isolation.

8.1.3 Rehabilitation

For rehabilitation purposes, for example mobilising and practising the stairs patients can leave the cubicle. Therapy staff must use CP's and decontaminate any equipment before use on the next patient. Patients must decontaminate their hands before leaving the cubicle.

8.1.4 Patients who wish to leave their room

Patients who wish to see visitors in the hospital gardens or merely wish to sit in the garden can do so provided they:

- Decontaminate their hands before leaving the cubicle **and**
- Do not have direct contact with other patients **and**
- Do not go into the bed areas of other patients.

8.1.5 Transfer of patients who are colonised or infected with MRSA between wards/other care settings

- Do not transfer patients between wards, units, hospitals, or other clinical settings unless it is clinically necessary.
- Inform the receiving ward/unit and the ambulance/transport service that the patient is colonised/ infected with MRSA.

8.1.6 Visitors and relatives

Visitors and members of staff from other departments must report to the nurse-in-charge before entering the room.

There is no restriction on the number or type of visitors to the patient. Visitors do not need to wear gloves and aprons unless giving direct care to the patient. Relatives must decontaminate their hands with soap and water before entering and leaving the cubicle or apply alcohol foam/gel to the hands. Visitors should not visit other patients after visiting a patient with MRSA.

8.1.7 After death

Use standard infection control measures. Lesions and puncture sites should be covered. In VCC a body bag is used for all diseased patients. Relatives, friends, and carers may view the body without restriction.

8.1.8 Using the public washrooms and toilets

Whenever possible patients with MRSA should be last to use the showers or bath which should be decontaminated using detergent and disinfectant after that use. If for any

reason a patient needs to use the shower ahead of the other patients, the shower/bath should be decontaminated immediately after use.

8.1.9 Outbreaks

In the case of outbreaks, the IPCT will investigate the source of the outbreak and manage accordingly. Where there are not enough cubicles the affected patients will be cohorted, (nursed together in the same bay with access to restricted bathroom and toilet facilities). Only rarely has carriage by healthcare workers (HCW's) been implicated in an outbreak, however, carriage of MRSA by HCW's must be considered in when there has been failure to control outbreaks.

8.2 Communication

Clinical Staff must

- Check the patients' Welsh Clinical Portal (WCP) record and front sheet/page for "alerts" which will indicate that patient has MRSA.
- Inform portering staff of the patient's status and the infection control precautions required when requesting movement of the patient.
- Inform the receiving ward / department that the patient is MRSA positive.
- Inform the receiving healthcare establishment of the patient's status.
- Inform ambulance control when requesting transport.

Where possible confirmed MRSA cases should attend at the end of the treatment list to reduce contact time with fellow patients.

Patient information which advises on MRSA is available from the IPCT on request.

8.3 Healthcare Personnel

- Routine screening of staff is not recommended but may be considered in an outbreak situation or if transmission continues on a unit despite active control measures.
- It must be emphasised that MRSA colonisation poses a little to no risk to healthy individuals. If a staff member does become colonised and shares accommodation with other healthcare workers or other vulnerable individuals (e.g. immunocompromised), they should contact the IPCT for further advice.
- Decolonisation of known MRSA positive staff members is attempted to prevent transmission of MRSA to vulnerable patients.
- All decolonisation and follow-up screening are undertaken by the Occupational Health Department (OCCH) and not done at ward level. OCCH should be informed immediately when a staff member is known to be MRSA positive.

8.3.1 Nasal Carriage

Nasal carriers should be given 2% Mupirocin which is part of the decolonisation pack obtainable via OCCH on prescription. If the staff member works in a non-high-risk area they can continue to work once treatment has started. If they work in a high-risk area the IPCT, in conjunction with OCCH will review their work status on an individual basis.

8.4 Decontamination of the patient environment and medical equipment

Please refer to Appendix 6 for further detail.

9 References/ Bibliography

Department of Health (2015) The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

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10 GETTING HELP

10.1 Further information and support:

Velindre IPCT: 02920196129, internal extension 6129.

The IPCT have access to patient leaflets relating to MRSA in a wide range of languages and also access to language line for interpretation when required.

11 RELATED POLICIES

11.1 This policy should be read in conjunction with:

- IPC 04 Decontamination Policy
- IPC05 National Infection Prevention and Control Manual
- IPC 10 Hand Hygiene
- IPC 15 Control & Management of Multi Drug Resistant Bacteria
- IPC 21 Management of Respiratory Infections
- Cleaning Standards Manual 2015
  https://publichealthwales.nhs.wales/services-and-teams/antibiotics-and-infections/infection-prevention-control/environmental-cleanliness/national-standards-for-cleaning-in-wales-key-standards-for-environmental-cleanliness-revision-2-0-dec-2021/

12 INFORMATION, INSTRUCTION AND TRAINING

12.1 Training

Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Divisional Nurse, Departmental Manager, Head of Nursing and Head of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are adhered to at all times.

12.2 Key guidance

- NHS Wales. Healthcare Associated Infection Wales. Commitment to Purpose; Elimination preventable healthcare associated infections (HCAIs) 2011
- Healthcare Associated Infection (HCAI): Guidance Set. Healthcare Associated Infection and Antimicrobial Resistance and Prescribing Programme (HARP) 2019.
- Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of meticillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities. September 2021
- National Infection Prevention & Control Manual (NIPCM)

13 MAIN RELEVANT LEGISLATION

- Health and safety act at Work Act 1974
- The Control of Substances Hazardous to Health Regulations (COSHH) 2002
- Personal Protective Equipment at Work Regulation (2002)

Appendix 1 – Screening for MRSA

All inpatients should be screened prior to admission. For unplanned admission screening for MRSA must be carried out within the first 48 hours of admission. Please inform IPCT when a patient known to be MRSA positive is admitted. Ext. 6129.

Use standard wound swabs in charcoal medium.

Swabs Should Include
Nose (anterior nares)
Perineum (or groin if perineum inaccessible)
Any wounds, including stoma sites
Any invasive device

If possible, soak the swab in normal saline (it improves pick up)

- Swab left and right anterior nostril with five strokes, using the same swab.
- Swab the perineum/groin with five strokes, one swab.
- All swabs should be identified, labelled and put into **one** microbiology clini-pac.
- The nature of the specimen should read "nose and perineum swabs".
- The investigation requested should read "MRSA screen".

Wound screening.

Any wounds the patient may have at the time of screening should also be swabbed.

Each wound swab should be identified, labelled and have a separate form requesting for Culture & Sensitivity (not MRSA screen). Wounds swabs and screens should not be taken until at least forty-eight hours after the course of decolonisation is completed.

Three negative screens are required before contact precautions can be discontinued.

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Appendix 2 – Guidelines for Administration of MRSA Decolonisation Therapy

Infection Control Precautions

The aim of decolonisation is to eradicate the carriage of MRSA and/or treat localised infection. Staff must adhere to standard precautions for infection control and isolation when caring for MRSA positive patients. Hand decontamination and the use of protective clothing (gloves and apron) are essential in prevention of cross infection of other patients.

1. **Mupirocin (Bactroban) Nasal Ointment 2% - Administer three times daily**

   Instruct the patient to wash his/her hands and then apply the preparation with a fingertip to inner surface of each nostril covering the posterior and anterior nares then wash hands afterwards. If the patient is unable to do this then the nurse is to apply the preparation to a cotton bud/swab and gently apply to inside of each nostril. **Duration of treatment – 5 days.**

2. **Octenisan – Daily Wash**

   If there is a pre-existing skin condition a dermatological opinion should be sought. If skin irritation occurs discontinue treatment and seek advice from the infection control nurse.
   Use a washing agent instead of soap. Preferably the patient should bath or shower. If a blanket bath is performed apply solution to a wet disposable flannel or sponge and wash all parts of the body, thoroughly, making lather. Rinse off with clean warm water. Shampoo hair with Octenisan twice during the course of the treatment (suggest day 2 and 5). Apply to wet hair, lather and rinse off with warm water. Can use shampoo or shower gel after rinsing off Octenisan. **Duration of treatment – 5 days.**

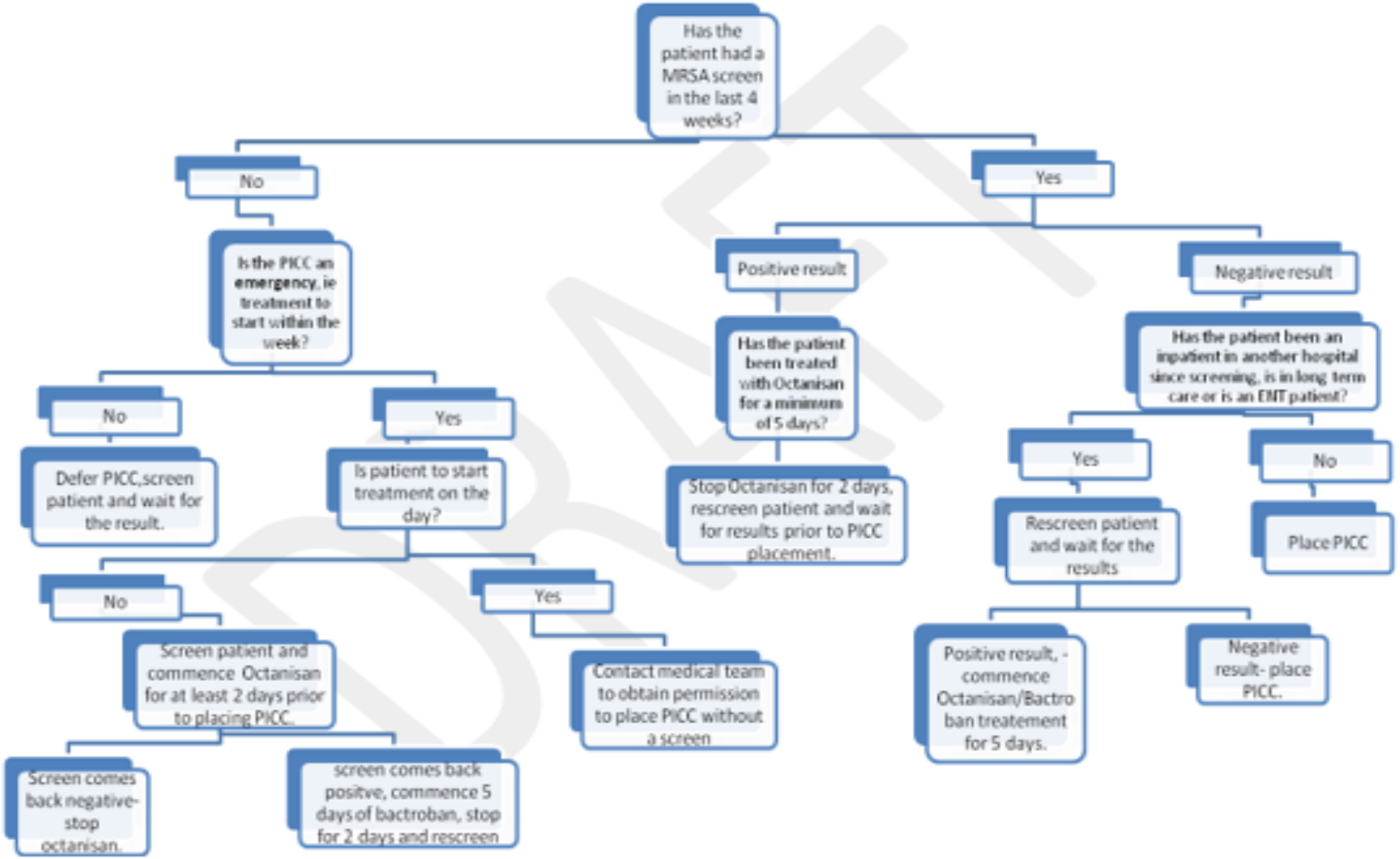
   Patient Screening
   After 5 days decolonisation wait 48 hours before screening patient. Screening sites:

   - Nose
   - Perineum or Groin
   - Any wounds, cuts, broken skin
   - IV sites

   Send for C&S rather than part of the MRSA screen

   Await result, if positive recommence decolonisation for a further 5 days if negative rescreen and await result. Continue until 3 negative screens obtained. Seek advice from the IPCT if eradication has not been achieved after two treatments.

Appendix 3 – Screening for MRSA pre-implantation of a PICC



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Appendix 4 – Isolation nursing door sign

Canolfan Ganser Felindre
Velindre Cancer Centre

GIG CYMRU NHS WALES

Contact Precautions

STOP

Visitors:
Report to nurse in charge before entering this room.

Staff members:



Hands

Decontaminate hands before entering this room.



Personal Protective Equipment

Wear disposable apron and gloves before entering this room.



Door
Keep door closed

Risk assessed ☐
Door required to remain open.
Initials: ☐ Date: ☐



Before leaving

Decontaminate equipment prior to removal from room.
Discard gloves and apron in healthcare waste bin.
Decontaminate hands.

Developed by the infection control team 2018

Appendix 5 – Contact Precautions

Personal Protective Equipment (PPE)

- Gloves should be worn if there is any risk of contact with blood and body fluids. If gloves have been worn they should be removed and hands decontaminated before leaving the room/area.
- Plastic aprons must be worn when direct contact with the patient or the patient's equipment is anticipated.
- Face protection e.g. masks, visors/goggles must be worn if there is a risk of aerosol production or splashing from blood or body fluids and secretions. Face protection e.g. masks, visors/goggles must be worn if there is a risk of aerosol production or splashing from blood or body fluids and secretions.
- All PPE should be disposed of before leaving the room and hand decontamination performed.

Disposal of Waste

- All infected waste should be disposed of into the appropriate clinical waste bag (WHTM 07-01 Safe Management of Healthcare Waste2013).

Linen

- All linen should be placed in the appropriate bag for infected linen and returned to the laundry.
- Curtains, including window curtains, adjacent to MRSA positive patients should be changed when a patient has been transferred/discharged or when visibly soiled.

Instruments or Equipment

Whenever possible instruments and equipment such as writing materials, sphygmomanometers and stethoscopes should be designated for MRSA positive patients.

If this is not possible, such items should be cleaned and disinfected before use on another patient. For more information, see IPC 04 Decontamination Policy.

Cleaning

Daily Cleaning

If the patient is in a single room, the nurse-in-charge must ensure that the appropriate cleaning is carried out by liaising with Operational Services teams.

If the patient is not in a cubicle, the bed space where the patient is present should be cleaned twice a day with a hyper chloride releasing disinfectant, (e.g. Chlorclean.

Cleaning On Discharge

The patient's room must be cleaned thoroughly with hyper chloride releasing disinfectant. Curtains will also need to be changed.

All hospital furniture (e.g. bed frame, tables) and any dust collecting ledges should also be wiped with hyper chloride releasing disinfectant.

The mattress should be decontaminated with hyper chloride releasing disinfectant and the mattress checked for strike through damages.

Ultraviolet light clean should then be carried out in accordance with instructions.

Management of spillages of blood and body fluids
Body fluids should be mopped up using a mop with an absorbent washable mop heads or wiped up with an absorbent disposable material and the surface then cleaned and disinfected using hyper chloride releasing disinfectant.

- Protective clothing (gloves, aprons, and goggles) should be worn.
- The spillage must be covered with absorbent disposable pad to remove excess fluid.
- Absorbent granules can be applied to larger spillages.
- Hyper chloride releasing disinfectant should be applied to the spillage.
- Disposable cloths/mops should be used to remove spillage.
- Finally wash affected area with detergent and water.

Disposal of sharps waste
No special precautions required dispose of as per normal routine.

Collection and transportation of biological specimens.
No special precautions or labelling required. Other Clinical Specimens for histology or cytology investigations do not require special precautions.

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Appendix 6 – Decontamination of the patient environment and medical equipment

Decontamination of the patient environment and medical equipment

Domestic staff. Cubicles should be cleaned and disinfected daily using yellow coded cleaning materials. The isolation cubicle should be cleaned last to avoid cross contamination during the cleaning process. All waste clinical and domestic should be disposed of into the infectious waste stream.

Nursing staff. All medical equipment should be cleaned and disinfected following discharge of the patient. Patients should be encouraged to keep possessions to a minimum to aid cleaning. Medical/surgical supplies not used by the patient should be disposed of into the infectious clinical waste stream (orange bag) and not returned to stock. In order to minimise waste and facilitate cleaning supplies of medical/surgical stock kept in the patients' room must be kept to a minimum.

Long stay patients (over one week). Domestic staff must clean and disinfect isolation cubicles daily. Nursing staff must clean and disinfect all medical equipment including the bed and wall mounted equipment once weekly.

Portering staff. Gloves and aprons should be donned before entering the cubicle. After assisting the patient into the wheelchair or onto the trolley porters should dispose of gloves and aprons into the orange infectious waste stream before leaving the cubicle. Hands should be decontaminated outside the cubicle using alcohol foam before touching the wheelchair or trolley. On reaching the receiving department the porter should don gloves and aprons before assisting with the patient. The areas of the wheelchair or trolley which have come into direct contact with the patient should be decontaminated using disposable wipes, gloves and aprons should then be disposed of on the spot and hands decontaminated.

Radiotherapy staff. Gloves and aprons should be worn by staff attending the patient. Following treatment, the areas with which the patient has had direct contact for example treatment couches should be cleaned and disinfected with Chlorclean after use by the patient (NB: This will change to hyper chloride releasing disinfectant in the future).

Radiology staff. Gloves and aprons should be worn by staff attending the patient. Treatment chairs, beds, couches, and wheelchairs with which the patient has had direct contact should be cleaned and disinfected using hyper chloride releasing disinfectant after use by the patient.

Outpatient staff (including phlebotomy and chemotherapy). Gloves and aprons should be worn by staff attending the patient. Treatment chairs, beds, couches, and wheelchairs with which the patient has had direct contact should be cleaned and disinfected using hyper chloride releasing disinfectant after use by the patient.

Appendix 7 – IPC Clinical Risk Assessment

Adapted with permission from Cardiff & Vale University Health Boards' MDRO procedure (Reviewed November 2019)

Infection Prevention and Control (IP&C) Admission Risk Assessment	NO	YES	If 'YES' to any question action the following immediately	Initial
CRO				
In the last 12 months has the patient had any healthcare contact outside of the U.K.? Healthcare abroad includes the whole range of in-patient care, also dental care, cosmetic surgery, elective surgery (including day surgery) and fertility treatments			Isolate (High priority) and contact precautions Seek advice from IP&C / Microbiology out of hours. Screen for CRO & MRSA	
In the last 12 months has the patient been an in-patient in a hospital outside of Cardiff and Vale UHB (NHS or Private)?			Refer to UHB MDRO Procedure Screen for CRO & MRSA Discuss with IP&C	
Does the patient have any IP&C flags (on Clinical Workstation) for any multi-drug resistant organisms?				
Does the patient have a history of MDRO infection/colonisation (inc. Candida auris)?			Discuss with IP&C	
MRSA				
Is patient screened for MRSA routinely on admission to specific clinical areas or prior to specific procedures ?(e.g. Critical Care, Renal , Orthopaedic Surgery)			Screen for MRSA: Nose Groin Invasive device site(s) Wound(s) ...../...../..... (Screen sent date / time / initial) Refer to UHB MRSA Procedure / Clinical Risk Assessment	
Does the patient have a previous history of MRSA?				
On admission does the patient have a wound or invasive device?				
Has the patient been transferred from a hospital outside of the Cardiff and Vale UHB?				
Has the patient been admitted from a Nursing Home or Long-term care facility?				
Diarrhoea and Vomiting				
Does the patient have a history of diarrhoea / vomiting within the last 48 hours that may be infectious?			Isolate / cohort (High priority) Contact Precautions Send two separate diarrhoea samples for Microbiology and Virology Refer to UHB Viral Gastroenteritis Procedure	
Any contact with someone with symptoms of D&V in the last 72 hours? (e.g. from a care home with an outbreak of D&V)			Isolate if possible. Commence Stool chart. Monitor closely.	
C. difficile				
Current diagnosis or suspected of having *C difficile* infection?			Isolate (High Priority) Refer to UHB *Clostridium difficile* Algorithm / Procedure	
Does the patient have a history of *C difficile* infection? (Check workstation flags)			Recurrence possible, isolate if diarrhoea develops.	
Other infections				
Suspected or confirmed acute viral respiratory infection? e.g. flu (Check Admission notes)			Isolate or cohort Respiratory precautions Refer to Transmission Based Precautions	
Suspected or confirmed open TB?			Isolate (high priority) & Respiratory precautions. Refer to UHB TB Procedure	
High risk rash of infectious or unknown origin e.g. Chicken Pox, disseminated or exposed Shingles (refer to Admission Notes)?			Isolate (high priority) & Respiratory precautions Refer to Transmission Based Precautions. Seek advice from IP&C	
If patient due to have surgery / endoscopy, has the patient ever been suspected or confirmed CJD or vCJD?			Refer to CJD Procedure	
For Emergency Unit / Assessment Unit and Infectious Disease Ward only: Travel or clinical history consistent with very high risk infection e.g. Ebola or Middle East Respiratory Syndrome (Refer to Admission Notes)?			Isolate (high priority) in a negative pressure isolation facility according to agreed pathway. Inform IP&C / Microbiology	
Person completing assessment: **Sign / Print:**			**Date:**	

Appendix 4: IPC 18 - Tuberculosis Management

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: IPC 18

TUBERCULOSIS MANAGEMENT

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Science
Document Author:	Infection Prevention & Control Nurse
Approved by:	Trust Executive Management Board and Quality, Safety & Performance Committee
Approval Date:	
Date of Equality Impact Assessment:	December 2024
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	December 2027
Version:	5

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ABBREVIATIONS

AFB	Acid Fast Bacilli
AIDS	Acquired immune deficiency syndrome
BCG	Bacillus Calmette–Guérin immunisation.
CNS	Clinical Nurse Specialist
ECDC	European Centre for Disease Prevention and Control
FFP3	Filtering Face piece
HCW's	Healthcare Workers
HIV	Human immunodeficiency virus
ICD	Infection Control Doctor
ID	Infectious Diseases
IFN	Interferon - gamma
IPCT	Infection Prevention and Control Team
MDRTB	Multi Drug resistant TB
NTBS	National TB Surveillance System
NICE	National Institute of Clinical Excellence
NOID	Notification of infectious disease
OCCH	Occupational Health
PPE	Personal Protective Equipment
TB	Tuberculosis
UKHSA	UK Health Security Agency
WHO	World Health Organization
XDR	Extensively drug resistant
ZN	Ziehl-Neelsen

1 POLICY STATEMENT

This policy outlines the overarching standard process for the management of Tuberculosis (TB) to prevent and control infection in patients and to prevent the occupational exposure of healthcare workers (HCW's). It covers all Divisions within the Trust and is to ensure compliance with national guidelines. It is essential that a patient known or suspected of TB is managed in accordance with this policy. Patients at Velindre Cancer Centre are at a higher risk of infection as they may be immunocompromised due to disease and its complications and/or immunosuppressed due to their treatment e.g. chemotherapy. The policy and processes acknowledge best practice and reflects the guidance from National Institute of Clinical Excellence (NICE) (ng33), Health departments and World Health Organisation (WHO) and the British Thoracic Society in the protection of patients and HCW's.

This policy has been developed in line with current guidance and advice from Integrated TB services of Cardiff and Vale University Health Board. It is intended for All Trust HCW's.

Tuberculosis (TB) is a curable infectious disease caused by a type of bacterium called Mycobacterium tuberculosis ('M. tuberculosis' or 'M.Tb'), or other bacterium in the M. tuberculosis complex (that is, M. bovis or M. africanum). It is spread by droplets containing the bacteria being coughed out by someone with infectious TB, and then being inhaled by other people (NG33, 2024).

In 2006, The National Institute for Health and Clinical Excellence (NICE) developed guidelines for TB, 'Clinical diagnosis and management of tuberculosis, and measures for its prevention and control'. This guidance (NG33) was updated in 2016, 2019 and again in 2024.

In 2016 the WHO implemented their "End Tuberculosis Strategy". The strategy aims to end the global TB epidemic, with targets to reduce TB deaths by 95% and to cut new cases by 90% between 2015 and 2035, and to ensure that no family is burdened with catastrophic expenses due to TB. There was a major global recovery in the number of people diagnosed with TB and treated in 2022, after 2 years of COVID-related disruptions. This has started to reverse or moderate the damaging impact of the pandemic on the number of people dying from or falling ill with TB. However, TB remained the world's second leading cause of death from a single infectious agent in 2022, after COVID-19, and caused almost twice as many deaths as HIV/AIDS. Global targets for improvements in TB treatment, TB preventive treatment and funding set at the first UN-high-level meeting on TB in 2018 have been missed and global TB targets for reductions in TB disease burden remain off track. Ending the global TB epidemic requires translating the commitments made at the 2023 UN high-level meeting on TB into action.

Globally in 2022, TB caused an estimated 1.30 million deaths (95% UI: 1.18–1.43 million). This was down from best estimates of 1.4 million in both 2020 and 2021 and almost back to the level of 2019.

TB notification rates in the UK in 2023 increased by 12.5% compared with 2022, the largest year-on-year increase in the current reporting period (2000 to 2023).

TB notification rates increased for all UK nations, with the largest increase (41.2%) in Scotland and the lowest increase in England (11.0%).

The increase in 2023 was preceded by a decrease in 2020 (12.6% decrease compared with 2019) occurring at the same time as the coronavirus (COVID-19) pandemic. This decrease during and rebound after the pandemic is observed in many countries, as reported in the WHO Global TB report 2023.

The number of newly diagnosed TB cases in Wales increased from 71 in 2022 to 84 in 2023, representing an increase in annual incidence from 2.3 to 2.7 per 100,000 population. Despite this increase, there is an overall decreasing trend in TB incidence in Wales since a peak of

3.7 per 100,000 population in 2014. Whilst overall Wales remains within the WHO definition of a low incidence country.

In 2023, the highest number of new TB cases reported were resident in the Aneurin Bevan University Health Board and Cardiff and Vale University Health Board areas (26 and 22 cases respectively), representing a rate of 4.4 per 100,000 population for both health boards. The lowest rate was reported in Cwm Taf Morgannwg University Health Board at 0.2 per 100,000 population.

Within health board area there is substantial variation in case rates by local authority of residence, as shown in Figure 3, with Newport and Cardiff reporting the highest rates year on year, with 5-year average rates (2018-2022) of 11.6 and 6.4 per 100,000 population respectively (PHW 2023).

https://www.ecdc.europa.eu/en/publications-data/tuberculosis-surveillance-and-monitoring-europe-2024-2022-data

In 2023, the new Tuberculosis action plan for the WHO European Region 2023–2030 came into force, operationalising the global End TB Strategy through Region specific actions and placing people at the heart of the response, in line with the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe". Ending the TB epidemic requires implementing the commitments made by Member States through actions articulated in the regional action plan (WHO 2023).

2 SCOPE OF POLICY

2.1 The policy applies to all clinical staff who have the potential for contact with patients or clinical specimens that may carry TB.

2.2 This policy has been developed in line with current guidance and strategy and is intended for use within Velindre Cancer Centre.

3 AIMS AND OBJECTIVES

3.1 This policy aims to provide appropriate advice to staff for the prevention and management of tuberculosis at Velindre University NHS Trust based on current NICE guidance.

3.2 To ensure appropriate management of a patient with suspected/diagnosed Tuberculosis infection and ensure prevention of spread and protection of patients and staff within the hospital, and wider community.

3.3 The policy objectives are to outline:

- To describe the characteristics of the organism and the infection.
- To identify individual responsibilities.
- To describe the management of specimens and actions for positive results.
- To provide advice on appropriate precautions in managing the patient.
- To detail the management of staff and exposed HCW's.

4 RESPONSIBILITIES

4.1 Trust Roles and Responsibilities

The Chief Executive has overall responsibility to ensure this policy is adhered to. Other responsibilities are outlined below.

The Trust has a responsibility to ensure that:

- All Divisional Directors make HCW's aware of the policy and provide appropriate equipment and training in the management of a TB patient.
- The Infection Prevention and Control Team (IPCT) will assist with training as appropriate.
- The IPCT will advise on the management of a TB patient and monitor compliance with this policy.
- It accepts its responsibility under the Health and Safety at Work Act etc. 1974 and the Control of Substances Hazardous to Health Regulations 2002, to take all reasonable precautions to prevent exposure to tuberculosis in patients, staff and other persons working at or using its premises.

4.2 Manager Responsibilities

Managers have responsibility to ensure that:

- All HCW's are notified of this policy and must have access to (via Trust intranet site) and understand the contents and local procedures derived from this policy.
- All procedures are followed according to this policy.
- HCW's are provided with appropriate supplies of personal protective equipment (PPE).
- All relevant HCW's are trained in the use of specific PPE and Fit Tested for use of Filtering Face piece (FFP3) face masks. (Manager to maintain a record of staff fit tested).
- HCW's classified as high-risk contacts of TB patients are identified for referral to the Occupational Health (OCCH) department.
- Failure or inappropriate management is reported accordingly via the incident reporting mechanisms.
- All relevant HCW's have had occupational clearance regarding Bacillus Calmette–Guérin (BCG) immunisation.

4.3 Health Care Worker Responsibilities

Health care workers have responsibility to ensure that:

- They practice safely according to policy.
- They participate in the quality improvement methods relevant to their area e.g. hand hygiene compliance audits, use of care bundles, and audit of cleansing of donor arms.
- They co-operate with the IPCT in providing data, acting on advice given and recording related incidents.
- They attend the relevant level of training.

4.4 Distribution

The policy will be available via the Trust intranet site. Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5 DEFINITIONS

Every year, 10 million people fall ill with TB (WHO 2023). Despite being a preventable and curable disease, 1.5 million people die from TB each year – making it the world's top infectious killer.

TB is the leading cause of death of people with HIV and a major contributor to antimicrobial resistance (WHO 2024).

Human TB is caused by infection with bacteria of the *Mycobacterium tuberculosis* complex and may affect almost any part of the body. The most common form is pulmonary TB, which

accounts for almost 55% of all cases in the UK. Pulmonary TB typically causes a persistent productive cough which may be accompanied by blood-streaked sputum or, more rarely, frank haemoptysis. Almost all cases of TB in the UK are acquired through the respiratory route, by breathing in infected respiratory droplets from a person with infectious respiratory TB. Transmission is most likely when the index case has sputum that is smear positive for the bacillus on microscopy, and often after prolonged close contact such as living in the same household. The initial infection may be eliminated; may remain latent (the individual has no symptoms, but the TB bacteria remain in the body); or progress to active TB over the following weeks or months.

Latent TB infection may reactivate in later life; particularly if an individual's immune system has become weakened, for example by disease (e.g. HIV), certain medical treatments (e.g. cancer chemotherapy, corticosteroids, anti-TNF (tumour necrosis factor) or in old age.

In addition, there are several occupational groups who are working with persons at higher risk of acquiring TB. These include staff working with prisoners, homeless persons, persons with drug and alcohol misuse and those who work with refugees and asylum seekers. BCG vaccination may also be considered for these groups.

6 IMPLEMENTATION/POLICY COMPLIANCE

6.1 General guidance

6.1.1 Transmission of TB

TB is transmitted almost exclusively through the airborne route. Droplet nuclei of tubercle bacilli of approximately 1 to 5 microns (μ) in diameter, are expelled from the lungs of the infectious person, and inhaled deeply into the lungs of the exposed person.

Large respiratory droplets produced during coughing, talking, and sneezing can cover large distances of up to 6 horizontal feet before settling on the ground or surfaces. The smaller respiratory droplets evaporate quickly leaving even smaller droplet nuclei of TB. These can be spread through small, aerosolised particles which are suspended in the air for long periods.

6.1.2 Diagnosis

Patients can be identified as:

- **Smear positive** pulmonary disease (or **open TB**) - these patients will have sufficient tubercle bacilli in sputum to be seen on direct microscopy and are infectious. Smear positive describes TB in an individual whose sputum is positive for Acid Fast Bacilli (AFB) on Ziehl-Neelsen (ZN) staining. If diagnosed elsewhere, patients whose bronchial lavage specimens alone are ZN stain-positive are not considered to have open TB.
- **Smear-negative** pulmonary disease (or **closed TB**) – these patients have 3 smear-negative sputum samples but are potentially still infectious, but much less so than smear-positive patients. AFB may be seen on samples obtained at bronchoscopy, or sputum may be culture positive.
- **Non-pulmonary disease** (or **closed TB**) - These patients are considered **non-infectious**; although patients whose urine or other secretions contain tubercle bacilli should be subject to the procedures outlined below.

In asymptomatic person's, exposure to, and potential infection with, TB is demonstrated by a positive skin test, or from a positive blood-based immunological linterferon-gamma (IFN test). Those with a strongly positive skin test or with a positive IFN gamma test are regarded as having been infected with TB. These individuals are at risk of developing clinical disease. The risk of developing TB reactivation is increased in immunocompromised individuals.

Skin testing is sometimes used diagnostically to demonstrate previous exposure, but false negative tuberculin results can occur in the immunocompromised (e.g. co-infection with HIV, cytotoxic or immunosuppressant treatment).

6.1.3 Pathology Specimens

If TB is suspected, 3 sputum specimens should be sent on different days (ideally on 3 consecutive days, including one early morning sample) for AFB test (or as directed by the Consultant microbiologist or respiratory physician). For TB at non-pulmonary sites, please send appropriate clinical samples (i.e. pleural fluid, urine etc.) and discuss with microbiologist.

6.1.4 Infectivity

The infectiousness of patients with TB depends on whether the disease is pulmonary or non-pulmonary, and whether sputum has tubercle bacilli visible on direct microscopy (classed as smear positive). A patient in whom there is a strong clinical suspicion of pulmonary TB should be treated as infectious until 3 smear-negative sputum specimens have been obtained on 3 separate days. Patients who are smear positive only on bronchial lavage but not by sputum are regarded as non-infectious, however patients whose induced sputum is smear positive should be managed as infectious (Appendix 1).

6.1.5 Notification

All forms of TB are notifiable; clinicians must report all suspected cases to the TB Clinical Nurse Specialist (CNS) in Cardiff and Vale University NHS Board (CAVUHB), Tel 02920335125, who will notify the Consultant in Communicable Disease Control / Consultant in Health Protection Tel 0300 0030032. Failure to notify in some circumstances could lead to action for medical negligence. This ensures appropriate advice is given, close contacts are identified to be screened and epidemiological data is collected.

The TB CNS will then ensure the patient is officially notified on the national TB Surveillance System (NTBS). This is used to monitor tuberculosis control and includes treatment outcome monitoring.

Inform the IPCT of any known or suspected case of TB, whether diagnosed at Velindre or elsewhere. This will ensure that the appropriate infection prevention and control procedures are implemented at ward level and department level.

The TB CNS will be available to give advice and education to both the patient and staff, they will also ensure close household contacts are identified that may need TB screening.

An assessment of staff close contacts will be made by the TB CNS in-conjunction with IPCT, Occupational health (OCCH) and local Public Health Officers.

- Ward/departmental manager to inform the OCCH department of any HCW known or suspected to be infected with TB.

6.1.6 Education

Education of all Trust staff is undertaken either by Infection Prevention and Control Team (IPCT) staff or using materials developed or advised by the IPCT. Blended learning, including classroom teaching, e-learning and opportunistic workplace methods will be utilised. The level of training is determined by the HCW role and is documented in the annual training manual for the Trust and:

- As a minimum, all HCW's are expected to attend IPC induction training as soon after employment as possible.
- Level 1 training focuses on precautions and procedures undertaken by those providing direct patient/service user care or working in a clinical environment.

- Level 2 training is undertaken every 2 years to ensure clinical HCW's are kept up to date with current research, guidelines, policies, and projects.
- Junior and locum doctor induction is provided per intake.
- The Infection Control Doctor (ICD) updates consultant colleagues at consultant meetings while the antimicrobial pharmacist will input into the doctor training programme.
- Additional targeted training will be provided as required for specific groups including porters, domestics, volunteers etc. and as required to respond to a new infection prevention problem or to meet a particular need.

6.2 Infection Prevention, Control and Management of a TB Case

6.2.1 Patients Admitted to a Setting Where Care Is Provided or People Who Are Immunocompromised

TB patients should not knowingly be admitted to a setting where care is provided for people who are immunocompromised.

6.2.2 Smear-positive pulmonary disease (Open TB)

All patients with TB should have a risk assessment for drug resistance and be tested for HIV (Appendix 1). In some patients smear positivity may be due to colonisation or infection with mycobacterium other than M. tuberculosis. If this is thought or known to be the case, then discuss isolation requirements and precautions with the IPCT or the clinician in charge of the patient. Unless there is a clear clinical need, people with TB at any site of disease should not routinely be admitted to Velindre Cancer Centre for diagnostic tests or care.

The TB CNS will be available to provide advice and education to both the patient and staff, they will also ensure close household contacts are identified that may need TB screening.

6.2.3 Control Measures

- The method of isolation/precautions used for patients with tuberculosis depends on the type of disease diagnosed (Appendix 2). This includes a risk assessment for Multi Drug resistant TB (MDRTB).
- Patients must be admitted to a single room (negative pressure ventilation is not available in Velindre Cancer Centre) ideally vented to the outside air as soon as they are found or suspected to have pulmonary (open) TB. On no account should they be admitted to a ward with immunosuppressed patients (e.g. neutropenic) or to an open ward or bay.
- Single room isolation should continue until a full 2-week course of continuous appropriate anti tuberculosis therapy has been completed and following liaison between the supervising physician and the IPCT.
- Standard Precautions will be sufficient in most circumstances e.g. hand hygiene, risk-based use of gloves and aprons.
- A contact/respiratory precaution sign should be placed on the door.
- Health care workers caring for patients with suspected open pulmonary disease should use fluid repellent surgical masks as part of their PPE as per respiratory precautions until the diagnosis of TB is confirmed.
- HCW's caring for people with confirmed Pulmonary TB where no other indication for respiratory isolation is present, are not required to wear masks, gowns, or barrier nursing techniques unless:
    - Multi drug resistant/extensively drug resistant (MDR/XDR) TB is suspected OR Aerosol-generating procedures are being performed (e.g. cough inducing procedures including chest physiotherapy, tracheal suctioning prolonged face to face exposure to respiratory and oral secretions e.g. during RT and planning of head/neck patients, tracheostomy care, intubation).

- Staff entering the room of a confirmed or suspected should wear an FFP3 mask or respirator and eye protection, for which they have been appropriately fit tested.
- The door of the room should be kept closed at all times unless the clinical need of the patient dictates otherwise, for which this should be clearly documented in the patient notes and risk assessed. Appropriate signage should be placed on the door to the room indicating that transmission-based precautions are required, including appropriate personal protective equipment (PPE).

- Patients undergoing anaesthesia or mechanical ventilation must have a disposable closed system for tracheal suctioning with the anaesthetic circuit protected by a single use bacterial filter. On intubation a disposable endotracheal tube or laryngeal mask and must be used. The laryngoscope blade and handle must be single use and disposed of in the clinical waste stream. Any positive end expiratory pressure must be switched off temporarily before disconnecting the patient from the machine to avoid expulsion of the organism into the air.
- Patients should receive education on respiratory hygiene measures/etiquette to ensure that they cover both the nose and mouth with a disposable tissue whenever they cough and sneeze and that they dispose of their tissues into an orange clinical waste bag.
- Limit visiting to next-of-kin or those in close-contact prior to diagnosis. They must not visit other hospital patients especially immunocompromised patients. Children are discouraged from visiting.
- Provide en-suite room, if possible, otherwise dispose of faeces/urine using usual clinical waste disposal procedures e.g. macerator.
- No special precautions for cutlery/crockery – machine-wash in central kitchen or ward dishwasher if available. Collect from infected room last.
- No special precautions for **Linen** unless contaminated with sputum or from fluid from lesions known to contain tubercle bacilli.
- Dispose of **Clinical Waste** using an orange bag.
- Daily **room cleaning** with combined detergent and chlorine releasing agent (chlorclean).
- Housekeepers cleaning the room are not at particular risk but are required to wear appropriate PPE as per transmission-based precautions, on entering the room, and should have had their BCG status established. Normal housekeeping procedures should be carried out, including enhanced terminal cleaning and curtain change (if required) on discharge of the patient, as well as ultraviolet radiation (UV-C) disinfection for rooms of patients with MDR/XDR TB.
- The person in charge of the ward will advise the housekeepers, caterers, and porters of necessary precautions.
- The TB CNS caring for the patient should be notified when a patient is **discharged** home or **transferred** between hospitals.

6.2.4 Suspected Smear-positive pulmonary disease (Open TB)

Patients with suspected pulmonary TB must be managed as smear-positive (6.1.2). Therefore, they must be admitted to a single room (with en-suite facilities), which is ideally vented to the outside air (i.e. Negative pressure/Isolation room), until their sputum status is known, and risk assessments have been carried out for infectivity and likelihood of MDRTB or XDR-TB (Appendix 2).

- Patients whose bronchial washings are smear-positive should be managed as if infectious under the following conditions:
  - The clinician regards the patient as being potentially infectious.
  - The sputum is also 'smear-positive' or becomes so after bronchoscopy.
  - The patient is on a ward with immuno-compromised patients, for example patients on high-dose steroids/chemotherapy.

- The patient is known or suspected of having MDRTB.

If the patient's bronchial washings are smear-positive, but the above conditions do not apply, the patient should be managed as if **non-infectious.**

Consideration should be given to treating the TB before chemotherapy commences in patients who are to undergo chemotherapy and are diagnosed with TB.

NB. If MDRTB is suspected the patient's management MUST be discussed with the IPCT or Consultant Microbiologist as transfer to a facility with negative pressure cubicle will be required.

6.2.5 Smear-negative pulmonary disease

The patient may be nursed on the open ward unless there are immunocompromised patients on the same ward in which case the patient should be placed in a single room. If aerosol-generating procedures are to be performed (e.g. bronchoscopy) the patient should be isolated during the procedure.

6.2.6 Non-pulmonary disease

These patients are considered **non-infectious**, although patients whose urine or other secretions contain tubercle bacilli should be isolated if performing aerosol-producing procedures e.g. wound irrigation. There would be no restrictions on visiting.

6.3 Transfer of Patients

As with other infection control matters, the Nurse-in-charge of the ward/department has the responsibility to ensure that the necessary information regarding an infectious patient is passed on to a senior member of the receiving ward/department, prior to transfer.

6.3.1 Within the hospital

Patients with sputum that is AFB smear negative pulmonary and non-pulmonary tuberculosis do not present a problem for the receiving ward. When transfers of this type take place, the receiving ward must be informed of the patient's status prior to transfer.

6.3.2 Visits to Other Departments

Visits of smear-negative pulmonary and non-pulmonary tuberculosis cases to other departments should be kept to a minimum. When there is a need, arrangements must be made with the senior staff of the department concerned prior to transfer. Patients should be seen at the end of the working session and minimum time should be spent in the department.

Patients with smear-positive pulmonary tuberculosis **must not** visit other departments unless there is an overriding clinical need. While they are infectious, patients should wear a fluid resistant surgical mask (cover tracheostomy if appropriate) when they are being **transported through public or patient areas.**
There should be no delay e.g. where a wait in corridors might occur. Ideally the patient should be last on the list or at the end of a session to allow for cleaning afterwards.

6.3.3 Transfers to Other Hospitals

Smear positive pulmonary TB patients should be transferred, whenever possible, to the Infectious Diseases Unit (Huelwen ward UHW) and should only be discharged from this unit when the consultant-in-charge of the patient is satisfied that they are no longer infectious. Prior arrangements will have to be made with the receiving ward and the ambulance service for transfer of an infectious patient. No transfer should take place unless all parties, especially in the case of MDRTB, have agreed these arrangements. The receiving ward must be informed of the status of the patient. For smear-negative or non-pulmonary tuberculosis transfer can take place much more readily; but the receiving ward must be notified of the patient's status prior to transfer.

6.3.4 Ambulance Transportation

The ambulance service must be notified prior to transfer of any patient with suspected or confirmed open pulmonary tuberculosis, especially MDRTB. Further information for the ambulance service can be obtained from the Consultant in Communicable Disease Control (CCDC 03000030032).

6.4 Discontinuation of Precautions

After 2 weeks of appropriate treatment, most patients are non-infectious and can be removed from isolation (providing this is the only reason for isolation). This should be discussed with the clinician in charge of the patient. It is preferable if patients moving out of isolation are not placed on a ward with immunosuppressed patients e.g. neutropenic. Isolated patients can only be moved out of the single room and into a ward which cares for immunocompromised patients if:

- The patient has had at least two weeks of appropriate multiple drug therapy *and*
- The patient has had three negative sputum smears *and*
- The patient is adhering to and tolerating the anti-tuberculosis medication *and*
- The patient's cough has completely resolved or there is definite improvement on treatment.

6.5 Death of a patient with known or suspected TB patient

In the event of the death of the patient, the body should be managed as 'high risk' of infection and placed in a disposable body bag. The portering, mortuary and undertaker staff must be informed that the body is high risk. Standard precautions must be advised for the portering staff e.g. gloves, apron, and hand hygiene only as they should not be opening the body bag. Mortuary and undertaker staff will follow national guidelines for the protection of mortuary workers.

6.6 Health Care Personnel

6.6.1 Pre-employment

- Employees new to the NHS who will be working with patients or clinical specimens should not start work until they have completed a TB screen or health check, or documentary evidence is provided of such screening in the last 12 months.
- Employees new to the NHS who will have contact with patients should not start work if they have signs & symptoms of TB.
- Health checks for employees new to the NHS who will have contact with patients or clinical materials should include:
  - assessment of personal or family history of TB
  - symptoms and signs enquiry/questionnaire
  - documentary evidence of TB testing and/or BCG scar check by an Occupational Health professional, not relying on the applicant's personal assessment
  - Mantoux result within the last 5 years if available.

6.6.2 TB Screening and BCG Vaccination

New employees from the UK or countries with low TB incidence:

Offer a Mantoux test to new NHS employees who will be in contact with patients or clinical materials if the employees:

- Patients or clinical materials if the employees:
- Are not new entrants from high-incidence countries **and**
- Have not had a Bacillus Calmette-Guérin (BCG) vaccination (for example they are without scar, other documentation or reliable history).

6.6.2.1 If Mantoux test is negative, refer to the Green Book for BCG immunisation guidance. An individual risk assessment for HIV infection needs to be made before BCG vaccination is given.

6.6.2.2 If the Mantoux test is positive, offer an Interferon-gamma test and inform the TB Service. If interferon gamma positive, the person should be referred to the TB service for clinical assessment for diagnosis and possible treatment of latent infection or active disease. Clinical assessment by TB service should be completed before starting work.

New employees from countries of high TB Incidence or have had contact with patients in settings with a high TB prevalence

- Offer a Mantoux test to new NHS employees who are from a high-incidence country.
- If the Mantoux test is positive (5 mm or larger, regardless of BCG history), assess for active TB; if this assessment is negative, offer them treatment for latent TB infection.
- If Mantoux testing is unavailable, offer an interferon-gamma release assay.
-
- Offer an interferon-gamma release assay to new NHS employees who have had contact with patients in settings where TB is highly prevalent:
- • If the interferon-gamma release assay is positive, assess for active TB and
- • if this assessment is negative, offer them treatment for latent TB infection
- If negative, offer BCG vaccination as 6.7.2.1 & 6.7.2.2
- If positive the person should be referred to the TB service for clinical assessment for diagnosis and possible treatment of latent infection or active disease. Clinical assessment by TB service should be completed before starting work.

If a prospective or current HCW who is Mantoux negative (less than 8mm), declines BCG vaccination, the risks should be explained, and the oral explanation supplemented by written advice. If the person still declines BCG vaccination, he or she should **not** work where there is a risk of exposure to TB.

Healthcare workers who are immunocompromised
HCW's who are immunocompromised should be screened in the same way as other people who are immunocompromised.

Clinical students, agency, and locum staff
Those that have contact with patients or clinical materials should be screened for TB to the same standard as new employees in healthcare environments as recommended before.
Documentary evidence of screening to this standard should be sought from locum agencies and contractors who carry out their own screening.

Staff Close Contact Screening
Reminders of symptoms of TB, and the need for prompt reporting of such symptoms, should be included with annual reminders about occupational health for staff who:

- Are in regular contact with TB patients or clinical materials, *or*
- Have worked in a high-risk clinical setting for four weeks or longer.

Assessment of staff contacts of smear positive pulmonary tuberculosis patients (open TB)
An assessment of staff close contacts will be made by the TB CNS in conjunction with IPCD, the OCCH Department and local Health Protection Officers.

The ward manager/nurse-in-charge will be given a letter and ward staff close-contact list to complete. (CAVUHB form Appendix 3a and 3b), which is then sent on to the OCCH department.

Close contacts are defined as members of staff who carry out:

- Exposure prone procedures e.g. mouth-to-mouth resuscitation, intubation, invasive dental procedure
- prolonged care of a high dependency patient
- repeated chest physio

One-off reminders should be given to these identified staff after a TB Incident on their ward.

Casual contacts (not identified on list) should only be assessed if they are unusually susceptible (immunosuppressed) or have no history of BCG vaccination.

Assessment of staff contacts of smear negative pulmonary or non-pulmonary TB patients (open TB)
In these cases, no action is necessary.

6.7 Contact Tracing

Contact tracing of infected patients and HCW's will be undertaken by Public Health Wales in conjunction with the TB nursing/medical team at the Health Board local to the patient/member of staff or to the hospital the patient is being cared at. In both cases in-house patient and HCW's contact tracing may require the support of OCCH and the IPCT.

If an individual on an open ward is diagnosed as being infectious, in general, patients in the same bay (rather than the ward) should be regarded as at risk, but mainly only if the index case was coughing, has smear-positive pulmonary TB and was present in the bay for more than 8 hours before isolation or the patient exposed is immunosuppressed. In this case, after discussion with the appropriate Public Health Wales professional it may be appropriate to convene an outbreak control group to enable a full risk assessment of other potentially affected patients to be made.

6.8 Audit and monitoring

Audit of compliance with the procedural document will be carried out by the Infection Prevention and Control Department as part of their procedure audit programme.

6.9 Implementation

The document will be available on the VCC intranet site and the Infection Prevention and Control clinical portal site. This policy will be maintained by the IPCT.

Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

7 REFERENCES

British HIV Association guidelines for the management of tuberculosis in adults living with HIV 2018 (2023 interim update) https://www.bhiva.org/file/5c485f3dc7c17/BHIVA-TB-guidelines.pdf

BTS Clinical Statement on the Management of Multidrug-Resistant Tuberculosis (MDRTB) https://www.brit-thoracic.org.uk/quality-improvement/clinical-statements/mdrtb/

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8 GETTING HELP

8.1 Further information and support

The IPCT have access to patient information leaflets in many languages, relating to the specific organism. In addition, there is access to Language Line in VCC which will assist is interpretation is required or further questions and queries in the patients first language.

Please see appendix 5.

8.2 Key guidance

Guidance on the management of Tuberculosis was last updated by NICE 16th February 2024. https://www.nice.org.uk/guidance/ng33 . This guidance has been used in the preparation of this procedure which also considers local circumstances.

9 RELATED POLICIES

This policy should be read in conjunction with:

- National Infection Prevention and Control Manual IPC 05.
- Transport of Specimens IPC 11.
- Control and Management of Multi Drug Resistant Bacteria IPC 15.
- Waste Management Policy PP 08.

10 INFORMATION, INSTRUCTION AND TRAINING

10.1 Training

Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Divisional Nurse, Departmental Manager, Head of Nursing and Head of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are always adhered to.
Further departmental based training is available by contacting the TB CNS's.

11 MAIN RELEVANT LEGISLATION

Legislation considered in the development of this policy includes:

Health and Safety at Work etc. Act 1974 The Stationery Office
https://www.legislation.gov.uk/ukpga/1974/37

Management of Health and Safety at Work Regulations 1999
The Stationery Office https://www.legislation.gov.uk/uksi/1999/3242/contents/made

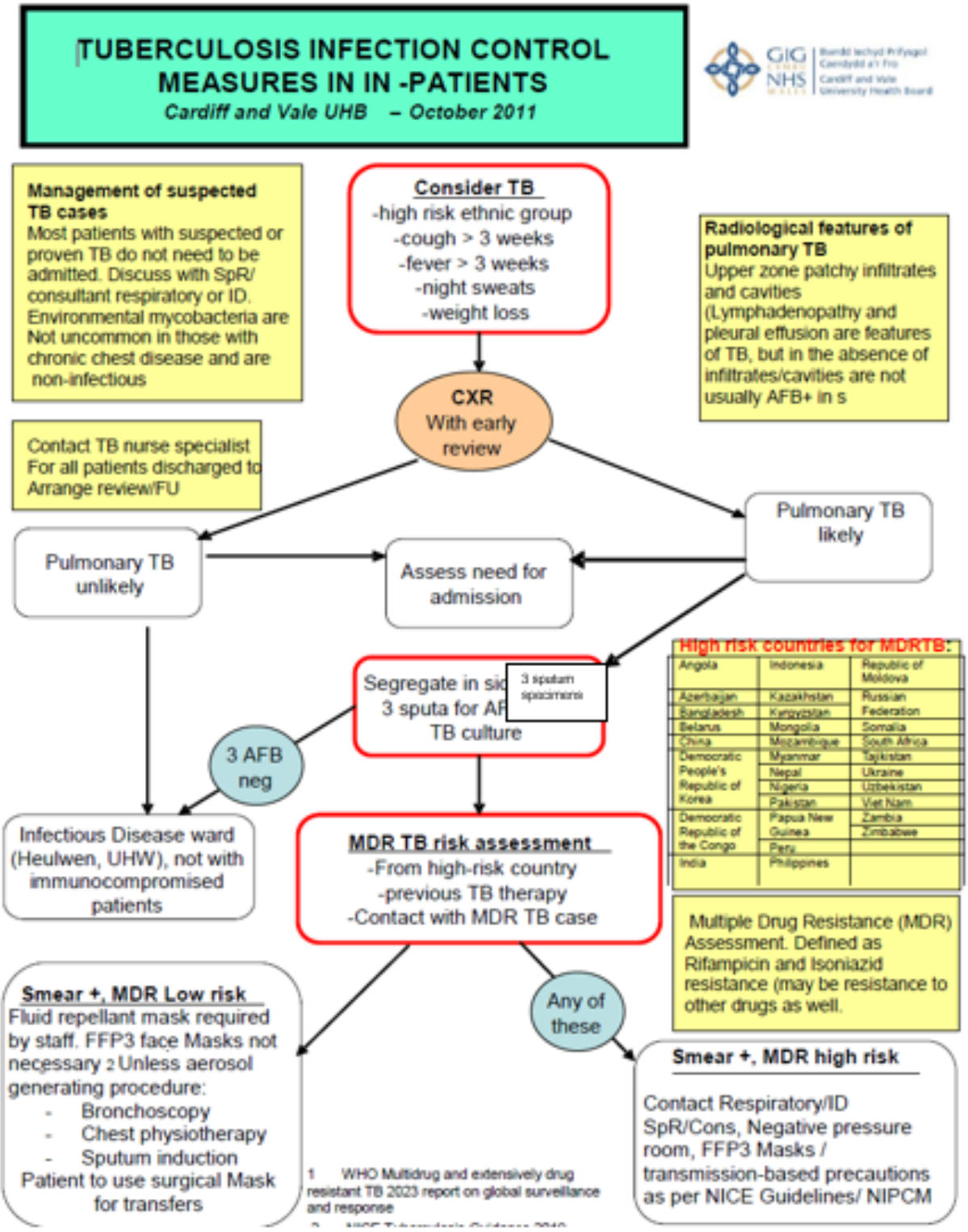
Control of Substances Hazardous to Health Regulations 2002
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Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
The Stationery Office https://www.legislation.gov.uk/uksi/2013/1471/made

Health Protection Legislation (Wales) Guidance 2010
https://gov.wales/sites/default/files/publications/2019-04/health-protection-guidance-2010.pdf

Public Health (Control of Disease) Act 1984 (amended 2020)
https://www.legislation.gov.uk/ukpga/1984/22/2020-03-25

APPENDIX 1 - Algorithm Recommended for Use by Cardiff & Vale Integrated TB Team



NB. Negative pressure rooms are not available in Velindre Hospital patients requiring these facilities must be transferred to a specialist centre.

APPENDIX 2 - MDR/XDR TB risk assessment

For people with clinically suspected TB, a TB specialist should request rapid diagnostic nucleic acid amplification tests for rifampicin resistance on primary specimens if a risk assessment for multidrug resistance identifies any of the following risk factors:

- history of previous TB drug treatment, particularly if there was known to be poor adherence to that treatment

- contact with a known case of multidrug-resistant TB

- birth or residence in a country in which the World Health Organization reports that a high proportion (5% or more) of new TB cases are multidrug-resistant.

(See "WHO high MDR burden list" below)

In cases of suspected/confirmed pulmonary TB, where a risk factor for MDR-TB is identified;

Start infection control measures as per 6.2

WHO high MDR burden list 2012 - 2025

This list represents countries which currently have the largest burden in terms of case rates per capita and account 85% of the global burden of MDR TB.

Angola	Kyrgyzstan	Russian Federation
Azerbaijan	Mongolia	Somalia
Bangladesh	Mozambique	South Africa
Belarus	Myanmar	Tajikistan
China	Nepal	Ukraine
DR Congo	Nigeria	Uzbekistan
DPR Korea	Pakistan	Vietnam
	Papua New Guinea	Zambia
India	Peru	Zimbabwe
Indonesia	Philippines	
Kazakhstan	Republic of Moldova	

APPENDIX 3A Ward staff close-contact list

TB CONTROL SERVICE & OCCUPATIONAL HEALTH SERVICE
CARDIFF AND VALE NHS TRUST

List of Staff Contacts (all disciplines) of:

NAME OF PATIENT: _____

WARD, HOSPITAL: _____

DATES OF ADMISSION: _____

To be completed and returned to Occupational Health Department within seven days. If no contacts are identified, Ward Manager to sign below.

SURNAME	FORENAME	DOB	STAFF GRADE	STAFF ADDRESS	For Occupational Health Use			
					BCG Date	Mx/IGF Date & Result	CXR Date & Result	Inform & advice

NO CLOSE CONTACTS IDENTIFIED. Signed _____ **Ward Manager**

APPENDIX 3B Ward staff close-contact list to complete

TB Nurse Specialists
TB Control Services
Primary Care Service Centre - 1st Floor
Cardiff Royal Infirmary
Glossop Road
Cardiff
CF24 0SZ
Telephone 02920 335121

University Hospital of Wales and University Hospital of Llandough

Ymddiriedolaeth CIG Ysbyty Athrofael Cymru ac Ysbyty Llandochau

Llandough Hospital
Ysbyty Llandochau
Penlan Road, Penarth, Vale of Glamorgan CF64 2XX
Tel 029 20711711

Heol Penlan, Penarth, Bro Morgannwg CF64 2XX
Ffon 029 20711711

Confidential

Date:

Dear Sister/Charge Nurse – Ward:

Re:

Ward: **From:** **To:**

The person named above has been diagnosed as suffering from smear positive (open) pulmonary TB. In order to assist with the screening and monitoring of staff that have cared for this patient, would you please complete a list of the names of all staff working on the ward/unit that were in close regular contact on the attached form.

A CLOSE REGULAR CONTACT IS DEFINED AS ANY STAFF MEMBER INVOLVED IN:-

1. PROVIDING PERSINAL CARE FOR A HIGH DEPENDENCY PATIENT
2. ADMINISTERING ACTIVE AND RECURRENT CHEST PHYSIOTHERAPY
3. MOUTH-TO-MOUTH RESUSCITATION

The completed form should be returned to the Occupation Health Department of you trust.
Most staff will only require a reminder of TB signs and symptoms from the Occupational health department.

All other staff in contact with this patient may be reassured that they are not at risk. Staff who are unsure if they are protected against TB should contact the Occupational Health Department for further advice.
If you require any further detail regarding this matter, please contact me on the above telephone number.

Yours sincerely

Yvonne Hester, Karen Baker & Martha Williams
Clinical Nurse Specialists in Tuberculosis

APPENDIX 4: Contact List

CCDC/HPT, IPCT Velindre University NHS Trust, Integrated TB Service Cardiff & Vale UHB, Occupational Health

CCDC/Health Protection Team	0300 000 30032
Email (Email notifications are only reviewed Monday to Friday 9 am- 5 pm).	AWARE@wales.nhs.uk

Velindre Infection Prevention & Control Office	02920 196129

Infection Control Doctor Velindre Trust	
Dr Rishi Dhillon	02920 745896 9am – 5pm
On call microbiologist	via UHW switchboard 02920 747747

Integrated Service for People with TB		
Lead TB Clinician	Dr Simon Barry	Tel: 02920 715024

Infectious Diseases (ID) TB Clinicians	
Dr Matthijs Backx	02920 742184
Dr Bazga Ali	
Dr Owen Seddon	
Jonathan Underwood	

Infectious Diseases Unit (IDU) UHW	
Huelwen ward , University Hospital of Wales, Heath Park, Cardiff, CF14 4XW	02920 742184 or 029 2074 6516 weekly Infectious Diseases Outpatient Clinic is held every Tuesday morning. Two ward-based clinics each week in which we see urgent referrals.

TB Clinical Nurse Specialists	
Yvonne Hester (Lead)	Office: 02920 335124
Karen Baker	02920 335125
Martha Williams	02929 335121

TB Office - Referrals & appointments	Office & Answerphone: 02920 335121

Occupational Health Department	029 2074 3264 (43264 from an internal phone)

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: IPC01

VIRAL GASTRO-ENTERITIS (INCLUDING NOROVIRUS)

Executive Sponsor & Function	Executive Director of Nursing, AHP's and Health Sciences
Document Author:	Infection Prevention and Control Team
Approved by:	Infection Prevention and Control Management Group
Approval Date:	
Date of Equality Impact Assessment:	December 2024
Equality Impact Assessment Outcome:	
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1. Policy Statement

Managing cases of gastroenteritis is a common event in hospitals, especially during the winter months. An outbreak is two or more patients with diarrhoea and / or vomiting, or more than the expected number, within 48 hours. The early detection and appropriate management of episodes is therefore essential to minimise service disruption.

This policy is based on the principle of minimising disruption to essential services and maximising the ability of the Trust to deliver appropriate care to patients safely and effectively.

2. Scope of Policy

This policy covers infection prevention and control management issues and applies to all healthcare workers employed by the Trust that undertake patient care, or who may encounter affected patients. This is to:

- prevent and minimise the risk of transmission of viral gastroenteritis.
- ensure that each patient with viral gastroenteritis is cared for effectively and appropriately.
- outline the roles and responsibilities of staff involved in the care of a patient with viral gastroenteritis.
- prompt and effective measures are essential in controlling the spread of infection between patients, staff, and visitors.

3. Aims and Objectives

The aim of this policy is to ensure that staff have sufficient information to enable early detection of possible cases of Norovirus (NV). This will help staff to:

- Identify possible cases
- Manage cases correctly
- Manage and cascade information effectively
- Reduce incidents
- Contain any incidents of Norovirus
- Detect outbreaks quickly and initiate outbreak measures promptly.
- Report to managers when symptoms have ceased

4. Roles and Responsibilities

4.1 Chief Executive

The Trust Board, via the Chief Executive, is ultimately responsible for ensuring that systems are in place that effectively manage the risks associated with Infection Control. Their role is to support a zero-tolerance approach to healthcare-associated infections.

4.2 Directors and Senior Managers

Directors and senior managers must ensure that all relevant staff are informed of the policy and trained on the use of Personal Protective Precautions and the management of infected patients.

4.3 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) is responsible for providing expert advice following this policy, for supporting staff in its implementation and assisting with risk assessment where complex decisions are made.

4.4 Healthcare Workers

All relevant clinical staff are responsible for keeping their up to date with policies and procedures. Reporting any signs of gastroenteritis infection to their line manager.

The policy is intended to ensure that all members of clinical and non-clinical staff including non-permanent members of staff working within the Trust adhere to and follow this policy.

5. Gastroenteritis

Viral gastroenteritis can spread very quickly within a hospital/healthcare environment causing ward closures in some cases. The most common cause of diarrhoea and vomiting outbreaks in hospitals is from small round structured viruses (SRSVs) such as Norovirus. These viruses are more common during the winter months and affect both patients and staff.
Symptoms can be acute but self-limiting and recovery normally takes place within 72 hours.

5.1 Clinical Features

There is an incubation period of 12-48 hours and the symptoms may last 24-72 hours on average. Symptomatic individuals are infectious for up to 48 hours after the last episode of diarrhoea and/or vomiting. Other symptoms may include abdominal cramps and/or nausea, headaches, muscle aches and fever. Recovery is usually rapid.
A note should be made of any members of the family who have had any of these symptoms, or if a service user has been transferred from another healthcare setting that may be experiencing an outbreak.

5.2 Routes of Transmission

- Airborne – inhalation or ingestion of virus particles when a patient vomits.
- Contact via the hands.
- Person to person via faecal-oral route.
- Ingestion of contaminated food and drink.
- Environmental contamination from faeces or vomit.

6. Management of Patients with Gastroenteritis

A patient with symptoms of gastroenteritis should be isolated in a single room (preferably ensuite) with appropriate infection control measures until at least 48 hours symptom free. Refer to IPC 05 - National Infection Prevention and Control Manual (NIPCM).

In an outbreak situation the numbers of affected individuals may be high. If an outbreak is suspected, it is essential to implement appropriate infection control measures immediately to prevent the spread of infection. During the outbreak you must regard all patients, staff and visitors who present with symptoms as infectious.

7 Outbreak control measures – key points

7.1 In patient departments

- Inform a member of the IPCT as soon as possible. During office hours, contact IPCT or out of hours contact the on-call Consultant Microbiologist (via switchboard), who will carry out a risk assessment and advise the ward of further infection control measures to be implemented.

- **Isolate patients as soon as they become symptomatic**. All patients admitted with or who develop diarrhoea and/or vomiting, should be nursed in a single room and remain isolated until asymptomatic for 48 hours.
- Strict Transmission based precautions should be adhered to including hand washing with soap and water as per World Health Organisation (WHO) 5 moments of hand hygiene (*Appendix 1*), the use of Personal Protective Equipment (PPE). (Facemasks may be considered if there is a risk of droplets or aerosol contamination).
- Where the number of symptomatic patients exceeds the number of single rooms, the IPCT will provide advice.
- In some cases, bays or the entire ward will need to be closed to new admissions. This will only occur after consultation with the IPCT and discussion with other relevant personnel.
- Close affected bay(s) to admissions and transfers.
- Keep doors to single room(s) and bay(s) closed.
- Place signage at ward entrance informing all visitors of the closed status and restricting visits to essential staff.
- Daily assessment will take place to ascertain earliest date for terminal clean and reopening.
- Seek advice from IPCT if a patient needs to leave the ward for investigations in other departments. A patient's treatment must not be compromised whilst the ward is closed, but risk assessments must take place to reduce the risk of cross infection. **Communication with the receiving department is essential**. The IPCT can be consulted to advise to minimise the risk of spread of infection.

7.2 Healthcare Workers

- Ensure all staff are aware of the outbreak situation and how viral gastroenteritis is transmitted.
- Staff are often affected during an outbreak of viral gastroenteritis. Affected staff should be immediately excluded from work if they are experiencing symptoms of diarrhoea and/or vomiting until 48 hours symptom free.
- Unless unavoidable wherever possible allocate staff to duties in either affected or non-affected areas of the ward.
- Visiting staff such as Physiotherapists, Occupational Therapists and Phlebotomists should if possible, visit the affected ward(s) last or allocated an individual to visit affected wards. Only essential procedures should be carried out on symptomatic patients.

7.3 Patient and Visitors Information

- Provide all affected patients with information on the outbreak and control measures they should adopt.
- Patients'/visitors information leaflets on relevant organisms are available from the IPCT. Copies of these will be issued to ward staff which is then the responsibility of the nurse in charge to make sure these are distributed to patients and visitors.
- Visitors may contribute to an outbreak of viral gastroenteritis and should be advised to refrain from visiting if they are symptomatic or have not been free of symptoms for 48 hours.
- People with protected characteristics may be more susceptible to infection and should be advised to refrain from visiting during the outbreak.
- Visitors should be encouraged to decontaminate their hands prior to, and after visiting their relative/friend using the ward facilities.
- Visitors should be discouraged from sitting on beds, nor should they use patient toilets.

7.4 Clinical Practice

Hand Hygiene

- Hand hygiene is essential in the prevention of cross infection and hand decontamination is compulsory before and after contact with all patients and their immediate environment. The

use of antiviral alcohol hand gel should be encouraged on physically clean hands between patients.

- Patient hand washing should not be forgotten. All patients should be reminded about good hand washing practices and help should be offered if their physical or mental condition makes it difficult for them to wash their hands. Non ambulant patients must be offered means of decontaminating their hands before eating and after using bedpans/commodes, for example.

Personal Protective Equipment (PPE)

- Personal protective equipment must be used when handling faeces and/or vomit, other body fluids and for direct patient contact. Disposable aprons and gloves must be removed before leaving the patients room and disposed of as clinical waste. Hands should be decontaminated immediately using soap and water.

Environment

- It is essential that environmental cleaning is performed to a high standard and cleanliness is maintained. The operational services department should be notified at the earliest point when an outbreak occurs (*Appendix 2*).
- Supervisors & Housekeeping staff responsible for undertaking the cleaning must liaise with the ward manager & the IPCT.
- Cleaning procedures should be undertaken twice daily to reduce the buildup of bacteria in the environment. Special attention must be paid to toilet and bathroom areas, commodes, all high touch surfaces such as door handles, flush handles, sinks, taps and nurse call systems.
- Remove exposed foods e.g. fresh fruit in bowls on lockers.
- Staff should not consume food or drink at the nurses' station during an outbreak of viral gastroenteritis. Any exposed food and drink are likely to have been contaminated.

Equipment

- Use single-patient use equipment wherever possible
- Decontaminate equipment immediately after use i.e. commodes
- Dispose of soiled bedpans/vomit bowls immediately

Linen

- While clinical area is closed, discard all linen in a water soluble (alginate) bag and then a secondary bag
- Leave empty beds unmade

Spillages

- Excreta/vomit must be covered immediately, removed and the area decontaminated. Decontamination of all vomit or faecal spillage is vital to ensure viral particles are destroyed.

Reducing the risk of spread of infection to other areas

- It is the responsibility of the nurse-in-charge to make sure that a ward closure notice is placed at the entrance/exits to the ward and that patients and visitors are kept informed of the situation.
- Alcohol hand sanitiser should be accessible at point of care and visitors encouraged to perform hand decontamination prior to entering the ward and on leaving.
- An IPC Practitioner will visit the ward every weekday to review and reassess the situation. Out of hours the ward will be reviewed by telephone by the on-call Consultant Microbiologist who can be contacted via switchboard.
- Do not accept admissions while the ward is closed unless approved by the IPCT or medical director.

- Do not transfer symptomatic to other hospitals or care institutions (nursing, residential homes etc.) whilst they are symptomatic or exposed to symptomatic patients.
- If there is a clinical necessity for a patient to be transferred to another ward or hospital (e.g. to ICU or theatre) advice must be sought from a member of the IPCT prior to transfer. A risk assessment will be performed, and the receiving unit can then be informed, and appropriate precautions taken.
- A patient's treatment must not be compromised whilst the ward is closed, but risk assessments must take place to reduce the risk of cross infection. Communication with the receiving department is essential. The IPCT can be consulted to give advice to minimise the risk of spread of infection.
- During the working shift, where possible do not transfer staff to other wards if they are working on an affected ward. Agency staff must not work on other wards once exposed to an outbreak ward situation.
- Leaflets are available for patients with Norovirus from the IPCT. The leaflets give details of the action that is being taken and why.

When is the patient/ward clear of infection?

- Patients are usually but not always deemed non-infectious 48 hours after their last episode of diarrhoea or vomiting. In the elderly or immunocompromised patient, they may continue to excrete the virus for a longer duration.
- Further stool specimens are not required once a confirmed positive sample has been detected or to check if an agent has cleared.
- Usually, the ward can be opened when the last patient with symptoms has had no diarrhoea or vomiting for 48 hours. A thorough terminal clean of the ward (environment and equipment) must take place prior to beds being re-opened.
- The Infection Prevention and Control Practitioner will issue the ward with a cleaning check list which is the responsibility of the nurse in charge to make sure this is completed prior to the ward re-opening and undertaken to a satisfactory level (*Appendix 3*).
- Following each outbreak a multidisciplinary evaluation should take place to review the outbreak and learn lessons to strengthen future plans.

What happens if symptoms recur?

- Contact a member of the IPCT immediately for a further risk assessment.

8. Patients Discharge

Patients discharge to their own home

This can take place as long as they are medically fit for discharge and do not require nursing or social care at home. It is not necessary to delay the discharge of symptomatic patients or those who may be incubating gastroenteritis. Advise them to inform the admitting Doctor/ Nurse if they are readmitted within 48 hours of discharge. Patients from closed wards should be discharged directly from the ward. **Please note:** if a patient is being 'fast tracked' home for palliative care contact the IPCT for advice.

Patients discharge to nursing or residential homes

Discharge to a home known not to be affected by an outbreak of diarrhoea and or vomiting should not occur until the patient has been asymptomatic for more than 48 hours. However, discharge to a home known to be affected by an outbreak at the time of discharge should not be delayed providing the home can safely meet the individual's care needs. Those who have been exposed but asymptomatic patients may be discharged only on the advice of the IPCT.

Please note: if a patient is being 'fast tracked' to a care home for palliative care contact the IPCT for advice.

9. Equality

- 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 and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

- The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

10. Training

- Staff will receive instructions and direction regarding infection prevention and control practice and information from a number of sources: -
- Trust Induction
- Trust Policies and Procedures available on the intranet
- Infection Prevention & Control pages on the intranet
- Ward/departmental/line managers
- As part of the mandatory infection control education sessions that Trust staff attend
- Infection Prevention and Control Educational displays/ posters
- Trust Infection Prevention and Control Team

11. Review

The IPCT will review the operation of the policy as necessary and at least every 3 years.

12. Legislation

Health and safety at Work Act (1974)

The Management of Health and Safety at work Regulations (1999)

Control of Substances Hazardous to Health (COSHH) Regulations (2002) (as amended 2003 & 2004)

Management of Health and safety at Work regulations (1999)

Personal Protective Equipment (PPE) at Work Regulations 1992 (as amended 2002)

13. Getting Help

Further information and support is available from the Infection Prevention & Control Team on Tel No/ ffion: 02920 196129.

14. References

- IPC 05 – National Infection Prevention and Control Manual

- Immunotherapy Guidelines for the Management of Immunotherapy Induced Diarrhoea
- Management of Systemic Anti-cancer Therapy or Clostridioides difficile – Induced Diarrhoea in Adult Patients

- The Communicable Disease Outbreak Plan for Wales

Appendix 1

Five Moments for Hand Hygiene



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

World Health Organization | Patient Safety | SAVE LIVES Clean Your Hands

May 2009

Appendix 2

Environmental Cleaning Recommendations during an Outbreak

Environmental decontamination during an outbreak
• Increase frequency of cleaning using dedicated domestic staff where possible and avoiding transfer of domestic staff to other areas, as directed by the Infection control team. • Clean from unaffected to affected areas, and within affected areas from least likely contaminated areas to most highly contaminated areas • Use disposable cleaning materials including mops and cloths • Where reusable microfibre cloths suitable for use with chlorine releasing disinfectants are in use, the system must be supported by a robust laundry service and adherence to manufacturer's instructions • Dedicate reusable cleaning equipment to affected areas and thoroughly decontaminate between uses e.g. mop handles and buckets • After cleaning, disinfect with 0.1% sodium hypochlorite (1000ppm available chlorine - Chlorclean) • Pay particular attention to frequently touched surfaces such as bed tables, door handles, toilet flush handles and taps • Cleaning staff and other staff who undertake cleaning tasks should follow standard infection control precautions and wear appropriate personal protective equipment (PPE) including disposable gloves and apron • National and local colour coding for PPE and cleaning equipment should be adhered to, in order to avoid cross contamination

Appendix 3

Deep Cleaning Following Discharge of Patient or Completion of Outbreak

Deep Cleaning following Discharge of Patients or Completion of Outbreak
1. Discard unused disposable patient-care items 2. If items cannot be appropriately cleaned, consider discarding these items 3. Remove window and privacy curtains avoiding unnecessary agitation and send for laundering 4. Change disposable curtains place into orange bags. 5. Remove bed linen and unused linen and send for laundering as per Velindre policy. 6. Place all waste into an orange bag. 7. Decontaminate all equipment in accordance with manufacturer's instructions 8. Thoroughly clean all surfaces with a neutral detergent. 9. Cleaning of furniture & bed mattresses present in rooms upon patient discharge is suggested. Check mattress on discharge for integrity & strikethrough. 10. After cleaning, disinfect with 0.1% sodium hypochlorite (1000 ppm available chlorine*). 11. Liaise with Operational Services to decontaminate cubicles with Ultraviolet/ Hydrogen Peroxide Vapour Technology as per manufacture guidance.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: IPC 15

CONTROL & MANAGEMENT OF MULTI-DRUG RESISTANT BACTERIA

DRAFT

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Sciences
Document Author:	Infection Prevention and Control Team
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	
Equality Impact Assessment Outcome:	*This policy has been screened for relevance to equality. No potential negative impact has been identified.*
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ABBREVIATIONS

CRA	Clinical Risk Assessment
CPO	Carbapenemase Producing Organisms
CRO	Carbapenem Resistant Organisms
IPC	Infection Prevention & Control
IPCT	Infection Prevention & Control Team
HCWs	Healthcare Workers
MDRO	Multi Drug Resistant Organism
MRSA	Meticillin Resistant Staphylococcus Aureus
PPE	Personal Protective Equipment
VRE	Vancomycin Resistant Enterococcus

DRAFT

1 INTRODUCTION

Multi-Drug Resistant Organisms (MDRO) are bacteria that are resistant to representatives of at least three classes of antimicrobials, to which the bacterial species involved are usually susceptible. In some cases, this can significantly limit therapeutic options, such as the safety and efficacy of available treatment options are reduced or uncertain. Although most infections with MDRO are not more severe than those with susceptible organisms, in some cases there is evidence that clinical outcomes are worse.

MDROs can develop through naturally occurring genetic changes. MDROs can then opportunistically colonise and infect humans, with secondary transmission between patients, particularly between vulnerable individuals in close proximity to one another in healthcare environments. Antimicrobial use can preferentially select for MDROs encouraging infection/ colonisation with these organisms and secondary spread.

Successful prevention and control of MDROs require a high level of organisational leadership and commitment that can be visualised by all healthcare professionals. Financial and human resources commitment is necessary. This includes:

- investment in infection prevention and control teams (IPCTs)
- prudent and effective antimicrobial stewardship to prevent overuse of antibiotics and the development of resistance
- efficient and effective healthcare cleaning service
- access to expert Microbiology consultation
- laboratory provision and specialist support for a resistant organism
- National and local surveillance of organisms alongside monitoring, data analysis and reporting.

2 POLICY STATEMENT

2.1 This policy is intended to provide guidance across the Trust with practical advice in the identification and subsequent management of patients with MDRO) including meticillin resistant *staphylococcus aureus* (MRSA), this includes key requirements for Clinical Risk Assessments (CRA), patient placement and management. This will not address diagnosis and/ or treatment of infection related to MDRO.

3 SCOPE OF POLICY

3.1 The Policy applies to the care of all patients and applies to all staff working in any care setting across Velindre University NHS Trust.

4 AIMS AND OBJECTIVES

4.1 The Trust aims is providing optimum treatment for patients with known or suspected MDRO such as Multi-Drug Resistant Gram-Negative Bacilli (MDR-GNB) infection and ensure staff are aware of the required infection control procedures. The Organisation's policy for control of MDRO will be continually monitored and updated in line with current professional guidelines.

4.2 The policy objectives are to outline:

- To provide an outline of the clinical significance and risk factors associated with MDRO
- To provide an outline of establishment requirements to enable early identification and subsequent management of patients suspected or confirmed with MDRO
- To provide individual staff groups with an outline of their expected roles and responsibilities in the identification, prevention, and management of MDRO
- To adopt the all-Wales template with minimum requirements for screening patients for MDRO, including MRSA

- To provide a toolkit of templates within the appendices to support MDRO clinical risk assessment, screening, and subsequent patient management and placement

5 RESPONSIBILITIES

The Role of Trust Executive Team

- Chief Executive has overall responsibility for ensuring effective procedures and resources are in place to enable appropriate screening and management of MDRO as per local and Welsh Government recommendations.
- The Executive director for Director of Nursing, Allied Health Professionals & Health Science has strategic responsibility within the Trust for the implementation of local MDRO policy and guidelines.
- MDRO prevention and control must be an organisational priority.
- Robust systems must be in place to communicate information appropriately when a patient with MDRO is identified and prior to patient transfer within or outside the organisation.
- Promote provision of appropriate isolation facilities to safely manage patients with MDRO.
- Executive support to integrate MDRO into education programmes in relation to infection prevention for all healthcare staff disciplines, ensuring all front-line staff are mandated to attend, and/ or completed equivalent E-learning.
- A multi-disciplinary process should be in place such as 'root cause analysis' or 'post incident review' process to investigate each patient case individually, sharing good practice and lessons learnt locally and across Wales, with leadership from the Executive Team.
- Have systems in place to support clinicians to use appropriate treatment plans to manage MDRO and prevent transmission.
- Provide feedback to clinicians in respect of antimicrobial susceptibility and current trend analysis.

5.1 The role of Clinicians, Head of Nursing and Ward Managers

- Have responsibility for ensuring a robust process is in place so the Executive Team can be provided with assurance that all their staff are aware of and receive training in MDRO screening and subsequent patient management.
- Responsible for monitoring, through audit and surveillance, compliance with infection prevention standards to reduce the risk of cross contamination from patient to patient and their environment and compliance with local and all-Wales screening protocol. Where non-compliances are identified prompt action plans must be instigated to improve compliance.

5.2 The role of the Infection & Prevention Control Team (IPCT)

- Robust and current local infection prevention and control policies in place to support infection prevention standards including specific policy for MDRO and MRSA detection and management.
- Clear guidelines to be easily accessible to the workforce regarding patient screening and management on admission, based on all-Wales recommendations and local policy.
- MDRO and MRSA management training should be integrated into annual Infection Prevention mandatory training programmes.
- Local annual IPC audit programme should include compliance with MDRO and MRSA patient screening and subsequent placement and management in line with local policy.
- Promote healthcare staff to access local policy and guidelines via Health Board/Trust local intranet and Public Health Wales intranet to access further information to support MDRO management.

5.3 The role of Operational Services

- Appropriate cleaning, disinfection, and decontamination methods available to eradicate MDROs from the clinical environment following current all-Wales recommendations and current evidence base.
- New and innovative methods for eradicating environmental contamination are given due consideration.
- Local domestic service team managers must provide a training programme for their staff to ensure high standards of cleaning and decontamination methods and a good baseline knowledge is provided to all facility staff in respect of infection prevention risks of cross contamination within the environment.

5.4 The role of Healthcare Workers (HCWs) – All Healthcare Staff with Direct Patient Contact

- All Trust employees have a responsibility to ensure they adhere to the advice and guidelines provided within their local MDRO and MRSA policy.
- All HCWs to be compliant with infection prevention and control standard precautions.
- All HCWs with direct patient contact must attend annual infection prevention mandatory training (level 2) or complete the equivalent e-learning.
- All HCWs to comply with their local patient screening protocol, CRA and subsequent patient placement and management.
- Any deviations from local guidelines must be discussed with a member of the IPCT and/or Consultant Microbiologist and a risk assessment undertaken.

5.5 The role of Estates

- Estates department has a responsibility to ensure all new builds and refurbishments within the Trust conform to current Welsh Health Building Notes (WHBN), Health Building Notes (HBN) and Welsh Health Technical Memorandum (WHTM) in respect of recommendations for the provision of appropriate isolation facilities and compliance with infection prevention standards.
  https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment
  http://www.wales.nhs.uk/sites3/page.cfm?orgid=254&pid=64096
  https://nwssp.nhs.wales/ourservices/specialist-estates-services/publications-and-information/welsh-health-technical-memoranda-whtms-health-technical-memoranda-htms/
- IPCTs must be engaged early in the process of any planned works the Trust that may impact on patient management and placement.
- Consideration must be given within the Estates budget to support safe management of patients with MDRO.
- Where ward and isolation facilities are identified as sub-optimal priority should be given to improve such areas as per IPCT advice and recommendations.

5.6 Distribution

The policy will be available via the Trust intranet site, Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

6 DEFINITIONS

Infections associated with MDROs are increasing worldwide, with some of the most common causing healthcare-associated infections (HCAIs) being:

MDRO	Multidrug resistant organisms (MDRO) are defined as bacteria that have become resistant to more than one class of antimicrobial agents and usually are resistant to all but one or two commercially available antimicrobial agents, complicating treatment of illnesses they cause.

CRO	Carbapenem-resistant organisms (CRO) - Gram negative bacteria including Enterobacteriaceae (such as *Klebsiella pneumonia* and *Escherichia coli*) and non-fermenters (such as *Acinetobacter baumannii*, *Pseudomonas aeruginosa* and *Stenotrophomonas maltophilia*).
CPO	Carbapenemase Producing Organisms (CPO) - with resistance resulting from production of enzymes that breakdown carbapenem antibiotics – this makes the bacteria resistant to the carbapenem group of antibiotics, which includes Meropenem.
CRE	Carbapenem-resistant Enterobacteriaceae (CRE) – Enterobacteriaceae that are resistant to carbapenems by any mechanism, including the production of an acquired carbapenemase or the production of an ESBL combined with porin loss.
CPE	Carbapenemase Producing Enterobacteriaceae (CPE) – resistance resulting from production of enzymes that breakdown carbapenem antibiotics in the group of organisms that includes *E. coli* and *Klebsiella* spp.
ESBL	Extended Spectrum Beta-Lactamase are enzymes produced by certain bacteria that destroy, and so confer resistance to, a wide range of antibiotics. ESBL enzymes are most commonly produced by two types of bacteria – *E.coli* and *Klebsiella*.
MR-GNB	Multi Resistant Gram-negative bacteria are a type of Gram-negative bacteria with resistance to multiple antibiotics. .
MRAB	Multi-resistant Acinetobacter baumannii – environmental organisms widespread in & outside healthcare settings. Prevalent in static water & found within hospital environment.
CRAB	Carbapenem Resistant Acinetobacter - resistance resulting from production of enzymes that breakdown carbapenem antibiotics in Acinetobacter sp.
MRSA	Meticillin Resistant *Staphylococcus aureus* is a gram-positive bacterium that is highly resistant to meticillin, penicillin, and certain other antibiotics. MRSA is any strain of *Staphylococcus aureus* that has developed, through horizontal gene transfer and natural selection, multiple drug resistance to beta-lactam antibiotics.
GRE	Glycopeptide Resistant Enterococci – resistance to the Glycopeptide antibiotics Vancomycin & Teicoplanin. Often found as commensals of the gastrointestinal tract, lower urethra, and female genital tract. Commonly cause urinary tract infections, in compromised patients may cause more invasive disease such as bacteraemia, endocarditis, wound infection, cholangitis and meningitis.
VRE	Vancomycin Resistant Enterococci may also be called GRE. Enterococci resistant to Vancomycin.
C. auris	*Candida auris* is an emerging fungus that presents a serious global health threat. Healthcare facilities in several countries have reported that *C. auris* has caused severe illness in hospitalised patients. Some strains of *C. auris* are resistant to all three major classes of antifungal drugs. This type of multidrug resistance has not been seen before in other species of *Candida*. *C. auris* can persist on surfaces in healthcare environments and spread between patients in healthcare facilities.

7 IMPLEMENTATION/POLICY COMPLIANCE

7.1 Clinical significance of MRDO's

Once MDROs are introduced into a healthcare setting, transmission and persistence of the resistant strain is determined by the availability of vulnerable patients, selective pressure exerted by antimicrobial use, increased potential for transmission from larger numbers of colonised or infected patients and the impact of implementation of infection prevention and environmental cleaning measures. It is important to recognise that:

- MDROs are resistant to many first line antibiotics used in hospitals.
- Treatment may necessitate second- or third line antibiotics which may be less effective or have increased side effects.
- Some MDROs can colonise the environment for long time periods.
- Once a patient is colonised, it may not be possible to eradicate.
- Strains exist that are resistant to all known antibiotics and so can lead to life threatening infection.
- Colonisation will often precede infection; therefore, interventions must target transmission prevention from colonised patients to other patients.
- Delay in identifying MDRO as the causative organism may result in significant morbidity and mortality.

Patient risk factors

- Multiple hospital admissions
- Transfer from a hospital outside of the United Kingdom
- Transfer from hospitals within the United Kingdom
- Recent history of close contact with a person who has been with and MDRO Previous history of an MDRO
- Prolonged in-patient stays
- Prolonged stay in long term care facility
- Indwelling devices, e.g. urinary catheter, or central venous catheter
- Severe disease and multiple co-morbidities
- Admission to critical care unit
- Open wounds
- Dialysis
- Structural lung disease/bronchiectasis
- Conditions that cause skin breakdown
- Multiple courses of broad-spectrum antibiotics

7.2 Clinical risk assessment & identification of patients who require screening and/ or isolation on admission

7.2.1 A Clinical Risk Assessment MUST be conducted on admission to establish whether a patient has risk factors for carriage / infection with a MDRO.

7.2.2 An Admission CRA tool (***appendix 1)***, – T must be filled in when a patient is admitted to the Trust to assess the infection risks and aid with appropriate decision-making regarding isolation and screening of patients. It helps staff to identify patients who require screening +/- isolation on admission.

CLINCAL RISK ASSESSMENT	
Has the patient been transferred in from a hospital abroad?	
Has the patient been transferred from a hospital /healthcare setting in the UK in known high prevalence areas?	

Has the patient received healthcare abroad within the last 12 months? - Healthcare abroad includes the whole range of in-patient care, also dental care, cosmetic surgery, elective surgery, fertility treatment and out-patient wound care.	
Patients transferred in from other hospitals or who have been in-patients within the last 12 months in hospitals outside the Trust and who are admitted onto high-risk units: Critical Care, Cardiac Surgery, Neurosurgery, Renal, Haematology, should be **isolated if possible and screened** for CPO and MRSA	
Is the patient known to be infected / colonised with a CPO / MDRO? Had known epidemiological link to a known carrier of CPE?	
If the patient is considered to meet one or more of the criteria above for being colonised or infected with a suspected MDRO, Isolation and contact precautions and screening are required according to the table below. Please also refer to Appendices 3 & 4 for Public Health Guidance for CPE.	

7.3 Addressing Carbapenemase-Producing Enterobacteriaceae

PATIENT HISTORY / CARE ENVIRONMENT		Known to be infected or colonised with a Carbapenemase Producing Organism (CPO)	Direct medical transfer from abroad or from a UK care setting with *known high prevalence of CPO*	Has received healthcare abroad (e.g. in-patient care, dental care, cosmetic surgery, fertility treatment) in last 12 months	Medical transfer from hospitals outside Velindre NHS Trust.	Identified as contact of positive case (colonisation or infection)	History of hospitalisation in last 12 months in a UK care setting outside Velindre Trust	No risk factors identified on admission
		HIGH			MEDIUM		LOW	
Admission to or receiving care in specialist / augmented care unit	HIGH							
Admission to or receiving care in acute general ward	DIUM							
Day care	DIUM	**	**	**	**	**		NA
Outpatient clinic	LOW	**	**	**			NA	NA

Key:

High risk	Isolate immediately in a side room with en suite facilities (or dedicated commode) and retain in isolation as follows: Suspected case – isolate until 3 consecutive NEGATIVE screens (if still in hospital). *Should any sample screen positive treat as a confirmed case* Known case or case confirmed via clinical / screening sample (further screening not required) – *isolate throughout hospital stay*
Medium risk	Isolate in side room with en suite facilities (or dedicated commode) if possible (see increased transmission risks) until first screening result demonstrates NEGATIVE. If not possible to continue isolation then: EITHER cohort patient (Please discuss with the IP&C team) OR, if not possible to cohort, nurse with *strict emphasis* on maintaining compliance with standard precautions and optimal environmental cleaning (without fail) AND submit further 2 samples to achieve 3 consecutive NEGATIVE screens if still in hospital. *Should any sample test positive treat as a confirmed case.* **For outpatients and day cases: provide appointment timed for end of clinic or list; consider caring for day case in single room depending on facilities and on degree of contact with body fluids (see below: increased transmission risks). Maintain compliance with standard precautions and optimal environmental cleaning (without fail).
Low risk	No action, other than be alert to change in risk-level in light of any further information relating to patient status. Maintain compliance with standard precautions and optimal environmental cleaning (without exception).

(Please refer Appendix 3 & 4 for further information on clinical risk assessment & isolation of individuals who may be colonised / have an infection with carbapenamase-producing *Enterobacteriaceae)*

Screening

All patients admitted to Velindre NHS Trust must be risk assessed for the presence of infections or colonisation with MDRO. This is to enable early identification of risk factors and appropriate isolation and screening.

Healthcare abroad includes the whole range of in-patient care, also dental care, cosmetic surgery, elective surgery, and fertility treatments.

- Screening of patients may be recommended during outbreaks or clusters of MDROs, on the advice of the IPCT in conjunction with Microbiology and Executive Leads.
- In some circumstances patients may be screened who have been in close proximity to MDRO colonised or infected patients. Microbiology/ IPC advice should be sought prior to undertaking any such MDRO screening or refer to local policy.
- Cohort of contacts may be considered if there are a number of contact cases and will require expert advice from Microbiology and IPCT.
- Contact cases within a specialist unit/ augmented care should be high priority for isolation while awaiting screen results.
- Screening of household contacts and healthcare staff is not necessary unless this is discussed and agreed at a multi-disciplinary meeting in response to an MDRO or MRSA incident or event.

Environmental screening

Environmental screening is rarely of value as the sensitivity is low and the potential risk of a given site acting as a reservoir is unpredictable. It can sometimes be useful to determine the dynamics of environmental spread or as part of outbreak control.

Staff carriage

There have been no published reports implicating staff carriage as a source of patient colonisation or infection within an outbreak setting. Screening of staff for carriage during an outbreak or as part of an investigation may be considered but might be of limited use and may cause considerable stress.

Screening samples

The type of sample required to detect MDROs reflects the nature of the organism that is of interest.

Screening samples required for CPO and VRE are:

- a rectal swab (with visible material) or faecal sample,
- a urine sample if the patient is catheterised and
- if Carbapenem Resistant Acinetobacter is suspected skin sites should also be sampled and if a catheter or endotracheal tube is present, urine and respiratory secretions should be sampled. Please discuss with IPC.

A rectal/ faecal swab should be obtained within 48 hours of admission (*appendix 7).*

In some circumstances, other screening samples may be requested by medical microbiology or the IPCT.

Screening samples required for MRSA are:

A routine screen consists of:

- nasal swab
- perineal swab (or groin if perineum not accessible)
- swabs of any breaks in skin, including wounds, vascular access devices and drain exit sites.

Surveillance

The purpose of effective surveillance is to:

- determine antimicrobial susceptibilities of targeted and emerging MDROs.

- use ICNet (clinical surveillance software) tracking, so that early identification of MDRO increase or clusters can be monitored locally and on an all-Wales basis and reported promptly via PHW enterprise monitor.
- provide prompt notification to (IPCT, Executive Team and Medical Directorate when a novel resistance pattern for that facility is detected.
- provide incident tracking and management.
- understand facility-specific colonisation rates of MDROs to define the local colonisation pressures.
- maintain a bacteriology database for individual facility/ ward, including as a minimum, the date of identification, organism and antibiotic sensitivity and resistance.
- provide record of CRA and subsequent actions taken.

7.4 Safe management of patients

Spread of MDRO is usually via direct patient contact and most commonly can be transmitted on the hands of HCWs or via objects and devices within the patients' environment. All healthcare staff have a responsibility to comply with Infection Prevention Standards for all patient and take the necessary environmental interventions within the healthcare setting, all the time. The Trust must provide the appropriate facilities, equipment, and tools to enable compliance with Infection Prevention Standard Precautions. Please refer to ***appendix 2*** for management of patient.

- Patients should be informed of their status for colonisation or infection with MDRO upon laboratory confirmation. The patient should be provided with an information leaflet (***appendix 5***).
- The responsibility for informing patients of their MDRO status and documenting this in the healthcare record lies with the clinical team caring for the patient. Healthcare records should be flagged to highlight the positive MDRO status as per local policy.
- If a patient is found to be infected or colonised with a CPO, they should be issued with a copy of a patient card (***appendix 6***) to assist with informing others offering healthcare to the patient of their status.

7.5 Prevention and control management

7.5.1 Antimicrobial Stewardship

The emergence and spread of MDRO has been driven by the use of broad-spectrum antimicrobials Antibiotics should be prescribed and administered as per Trust antimicrobial policy in conjunction with the antibiotic stewardship programme to monitor compliance with local policy which will promote optimal and safe use of antibiotics to minimise acquisition and spread of resistance.

7.5.2 Clinical Presentation

This depends on the causative organism. There is no presentation that rules out infection by a MDRO. Where there is increased prevalence or first line therapy has failed MDRO's should be suspected.

7.5.3 Treatment

These guidelines do not provide recommendations for treatment, however, the important factor in successfully treating MDRO and MRSA is prompt diagnosis and recognition that the bacteria causing infection are resistant to antibiotics, so that the most appropriate treatment can be prescribed without unnecessary delay.
Treatment options for MDRO's should be discussed with a microbiologist as soon as possible. Delayed commencement of appropriate therapy is the biggest cause of patient harm when a patient is infected with a MDRO.

7.5.4 Last Offices

No special precautions are required.

7.6 Audit and monitoring

The IPC Annual Programme of work contains audit programme which incorporates audits of clinical practices to ensure compliance with screening, correct use of PPE, hand hygiene etc.

7.7 Implementation

This policy will be implemented and maintained by the Infection Prevention and Control Team (IPCT).

8 REFERENCES

Standards for the Identification, Management, and Treatment of Clinically Significant Antimicrobial Resistant Organisms (CSARO)
NHS Wales Guidance Management of Clinically Significant Antimicrobial Resistant Organisms
https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/infection-prevention-control/resources-for-healthcare-professionals/csaro/

The UK's 5 year vision for antimicrobial resistance (2019)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/773065/uk-20-year-vision-for-antimicrobial-resistance.pdf

Welsh Heath Circular 2023/031. AMR and HCAI Improvement Goals for 2023-24
https://www.gov.wales/sites/default/files/publications/2023-08/amr-hcai-improvement-goals-for-2023-24.pdf

Loveday, H.P., Wilson, J., Pratt, R.J., Golsorkhi, M., Tingle, A., Bak, A., Browne, J., Prieto, J. and Wilcox, M., 2014. epic3: national evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England. *Journal of Hospital Infection*, *86*, pp.S1-S70.

Antimicrobial resistance in animals and the environment: implementation plan (2023). https://www.gov.wales/antimicrobial-resistance-animals-and-environment-implementation-plan

National Infection Prevention and Control Manual
https://phw.nhs.wales/services-and-teams/antibiotics-and-infections/nipcm/

9 GETTING HELP

9.1 Further information and support

IPCT: 02920 196129 or bleep 205.

Microbiology at UHW on 02920 744825

The IPCT have access to patient information leaflets in many languages, relating to the specific organism. In addition, there is access to Language Line in VCC which will assist is interpretation is required or further questions and queries in the patients first language.

10 MAIN RELEVANT LEGISLATION

Legislation considered in the development of this policy includes:

- Health safety at Work Act etc. (1974).
- Health and Safety at work Regulations (1999).
- Control of Substances Hazardous to Health (COSHH) Regulations (2002).
- Management of Health and safety at Work regulations (2002)
- Personal Protective Equipment (PPE) at Work Regulations (2002)
- Health and Care Quality Standards 2023

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Appendix 1

Adapted with permission from Cardiff & Vale University Health Boards' MDRO procedure (Updated November 2017).

Infection Prevention and Control (IP&C) Admission Risk Assessment	**NO**	**YES**	If '**YES**' to any question action the following immediately	Initial
Carbapenemase Producing Organism (CPO)				
In the last 12 months has the patient had any healthcare contact outside of the U.K.? Healthcare abroad includes the whole range of in-patient care, also dental care, cosmetic surgery, elective surgery (including day surgery) and fertility treatments			Isolate (High priority) and contact precautions Seek advice from IP&C / Microbiology out of hours. Screen for CRO & MRSA	
In the last 12 months has the patient been an in-patient or transferred from a hospital /healthcare setting in the UK?			Screen for CRO & MRSA Discuss with IP&C	
Does the patient have any IP&C flags (on CANISC/ ICNet) for any multi-drug resistant organisms?				
Does the patient have a history of MDRO infection/colonisation (Inc. *Candida auris*)?			Discuss with IP&C	
MRSA				
Is patient screened for MRSA routinely on admission?			Screen for MRSA: Nose Groin Invasive device site(s) Wound(s) ...../...../..... (Screen sent date / time / initial) Refer to local MRSA Procedure / Clinical Risk Assessment	
Does the patient have a previous history of MRSA?				
On admission does the patient have a wound or invasive device?				
Has the patient been transferred from a hospital outside of the Health Board/Trust?				
Has the patient been admitted from a Nursing Home or Long-term care facility?				
Diarrhoea and Vomiting				
Does the patient have a history of diarrhoea / vomiting within the last 48 hours that may be infectious?			Isolate / cohort (High priority) Contact Precautions Send two separate diarrhoea samples for Microbiology and Virology Refer to local Viral Gastroenteritis Procedure	

Any contact with someone with symptoms of D&V in the last 72 hours? (e.g. from a care home with an outbreak of D&V)			Isolate if possible. Commence Stool chart. Monitor closely.	
Clostridium difficile				
Current diagnosis or suspected of having *C difficile* infection?			Isolate (High Priority) Refer to local *Clostridium difficile* Algorithm / Procedure	
Does the patient have a history of *C difficile* infection? (Check workstation flags)			Recurrence possible, isolate if diarrhoea develops.	
Other infections				
Suspected or confirmed acute viral respiratory infection? e.g. flu (Check Admission notes)			Isolate or cohort Respiratory precautions Refer to Transmission Based Precautions	
Suspected or confirmed open TB?			Isolate (high priority) & Respiratory precautions Refer to local TB Procedure	
High risk rash of infectious or unknown origin e.g. Chicken Pox, disseminated or exposed Shingles? (refer to Admission Notes)			Isolate (high priority) & Respiratory precautions Refer to Transmission Based Precautions Seek advice from IP&C	
If patient due to have surgery / endoscopy, has the patient ever been suspected or confirmed CJD or vCJD?			Refer to CJD Procedure	
For Assessment Unit *(if applicable)*: Travel or clinical history consistent with very high risk infection e.g. Ebola or Middle East Respiratory Syndrome? (Refer to Admission Notes)			Isolate (high priority) in a negative pressure isolation facility according to agreed pathway. Inform IP&C / Microbiology	
Person completing assessment: Sign / Print:			Date:	

Appendix 2
Management of a patient with suspected or confirmed MDRO
Key Aspects of management

Further information can be found in the National Infection Prevention and Control Manual

INFECTION PREVENTION MEASURE	RATIONALE
Single room isolation	• All patients with MDRO (colonised or infected) should be isolated in single rooms with en-suite facilities and should continue for the duration of the patient's stay. • All patients repatriated from a healthcare facility abroad or a high-risk department in a UK hospital should be isolated and screening commenced. • Patients with a possible drug resistant Tuberculosis will require isolation and preferably negative pressure isolation.
Hand Hygiene	• Hand hygiene is the **single most important practice** in reducing the transmission of infectious agents. • Patients should be encouraged to perform hand hygiene after using the toilet and before meals.
Personal Protective Equipment (PPE)	• PPE should be worn when there is a possibility of direct contact with blood or body fluids or contact with items in the environment that may be contaminated.
Environmental Cleanliness	• Thorough and regular cleaning is the most effective way of preventing transmission. • On patient discharge the room must receive a terminal clean followed by Ultra-Violet Clean (UVC).
Equipment cleanliness	• It is best practice to dedicate equipment to an isolated patient. • Where possible equipment should be single use or single patient use, or should be cleaned in accordance with local policy.
Patient movement	• Patient transfer should be kept to a minimum, but this should not compromise the patient's care. • Arrangements should be put in place to minimise contact with other patients and expedite their journey through that department.
Surgical/ invasive procedures	• If the procedure is carried out in an operating theatre which provides the recommended minimum air exchanges and cleaning and disinfection can be carried out effectively there is no reason to place these patients at the end of the list during a procedure list.
Communication	• All staff should check with the Nursing team regarding instructions prior to entering the room. • Patient and family should be given advice by the medical team and an information leaflet given to the patient.

Isolation Precautions

- All patients confirmed with MDRO are high priority for prompt single room isolation.
- If a patient is undergoing contact screening a CRA must be undertaken to determine if isolation room is required (See example in ***appendix 1***)
- If a patient is colonised with MDRO a CRA must be undertaken.
- A single room should be en-suite with appropriate hand hygiene facilities and easy access to personal protective equipment (PPE).

- The door of the isolation room should be kept closed unless the patients' clinical requirements dictate. Otherwise, and a local risk assessment is undertaken.
- Enhanced or negative pressure ventilation is not usually necessary but will require risk assessment in respect of identified organism.
- The Trust should consider the provision of an 'isolation ward' or the availability of a designated cohort ward/ area which could be promptly adapted should a potential MDRO outbreak occur.

Environmental Management

- Enhanced environmental cleaning programme should be introduced for the duration of the patients' stay.
- On patient vacation of a single room or cohort area the area should receive an enhanced clean. A hypochlorite is currently recommended for cleaning of the environment at 1000 ppm of available chlorine. Following environmental cleaning consideration should be given to an environmental decontamination process such as hydrogen peroxide vapour decontamination process or ultra-violet decontamination process if these systems are available.
- An annual 'deep clean' and curtain change rolling programme must be in place.
- All Trust employees have a responsibility for maintaining high standards of cleanliness within the environment.

Standard Infection Prevention and Control Precaution (SICPs)

It is essential to control the emergence and spread of MDRO due to the limited therapeutic alternatives, the increasingly compromised in-patient population, and the potential for transfer of resistance to other pathogenic bacteria and development of further resistance. Once colonisation of the patient or the environment has been identified, control is complex[3, 8].

The Trust must provide adequate and safe provision for staff to comply with SIPCPs, epic 3 (2014) divide these into five categories:

- Hospital environmental hygiene
- Hand hygiene
- Use of personal protective equipment
- Safe use and disposal of sharps
- Principles of asepsis

None of the above can be regarded as optional.

Other important considerations are:

- Safe handling and disposal of waste
- Safe management of linen

The policy is intended to ensure that all members of clinical and non-clinical staff including non-permanent members of staff working within the Trust adhere to and follow this policy.

The purpose and overall aim of this policy is to provide and ensure a safe environment for patients, other staff groups and visitors in the interests of preventing and controlling the spread of infection.

epic3 evidence-based guidelines can be accessed following this link:
https://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf

Appendix 3
Early recognition of individuals who may be colonised / have an infection with carbapenemase-producing Enterobacteriaceae

Adapted from Public Health England's CPE toolkit (2014/2015)

KEY MESSAGE: Include this risk assessment as part of the routine admission procedure to identify suspected cases of colonisation or infection with carbapenemase-producing Enterobacteriaceae
Assess each patient on admission, readmission *OR* on transfer from another healthcare facility
NOTE: if the patient is a recent laboratory confirmed case of carbapenemase-producing Enterobacteriaceae infection/ colonisation (i.e. during this admission episode or confirmed at a transferring healthcare facility [UK facility only]) bypass this step, isolate the patient immediately and treat as a positive case. IN THE LAST 12 MONTHS HAS THE PATIENT: Been an inpatient in a hospital abroad *OR* Been an inpatient in a UK hospital known to have had problems with spread of carbapenemase-producing Enterobacteriaceae *OR* Previously been colonised or had an infection with carbapenemase-producing Enterobacteriaceae or close contact with a person who has, if known
If one or more of above applies then:
The patient is considered to meet the criteria for being a suspected case of carbapenemase-producing Enterobacteriaceae colonisation or infection (as applicable). AND REQUIRES IMMEDIATE ISOLATION PLUS • instigation of *strict standard precautions* to prevent possible spread (as per local policy) • screening to assess current status for colonisation or infection (as per local policy) • assessment for appropriate treatment (applies to infection only) (as per local policy)
Acute setting management advice
ENSURE THAT assessment takes place and it is effective by: • including risk assessment in routine admission and transfer documentation • providing training for all relevant staff in: ➢ taking an effective admission history ➢ recognising patients who meet the criteria for a recent laboratory confirmed case or suspected case (as per local MDRO policy) ➢ the need to act promptly if a recent laboratory confirmed or suspected case presents

Appendix 4
Early isolation of suspected and laboratory-confirmed CPE

Adapted from Public Health England's CPE toolkit (2014/2015)

KEY MESSAGE: If you have a suspected case or laboratory confirmed case this step is needed to prevent spread within your organisation
If the patient already has laboratory-confirmed infection or colonisation with carbapenemase-producing Enterobacteriaceae *OR* meets the criteria for a suspected case (following risk assessment) then:
Advise the patient (and relatives if appropriate) of the positive result or your suspicions (whichever applies) and your management plan – provide patient information leaflet (***appendix 5***) *AND* Immediately place the patient into a single room with en suite facilities and send screening samples *AND* Apply strict standard precautions in all settings
Acute setting management advice
The patient is considered to meet the criteria for being a suspected case of carbapenemase-producing Enterobacteriaceae colonisation or infection (as applicable) AND REQUIRES IMMEDIATE ISOLATION PLUS • instigation of *strict standard precautions* to prevent possible spread (as per local policy) • screening to assess current status for colonisation or infection (as per local policy) • assessment for appropriate treatment (applies to infection only) (as per local policy)
Acute setting management advice
All suspected (including previously positive) patients should be isolated until screening results are known. If the patient is POSITIVE on screening for carbapenemase-producing Enterobacteriaceae or is a laboratory-confirmed case (colonisation or infection): • they should remain in isolation for the duration of their hospital stay • comprehensive awareness raising of the plan should take place amongst staff including doctors, nurses, physiotherapists, domestics and others with patient contact Strict standard precautions must be practiced (whether the patient has infection or colonisation) including: • good hand hygiene • where any part of a staff uniform, not protected by an ordinary apron, is expected to come into contact with the patient, a long-sleeved disposable gown should be used e.g. when assisting movement for a dependent patient • use of personal protective equipment (PPE) in line with standard precautions environmental cleaning and decontamination, with an enhanced focus on frequent cleaning of hand contact areas (follow local policy) If NEGATIVE a further two negative samples need to be achieved and a risk assessment undertaken before removing from isolation

Appendix 5
Advice for Patients
Multi-Drug Resistant Organisms (MDRO) including Carbapenem Resistant Organisms (CRO) and Carbapenemase-producing *Enterobacteriaceae* (CPE)

What are Multi-Drug Resistant Organisms?
MDRO are bacteria (or germs) that are resistant to at least three different antibiotics. MRSA (Meticillin resistant *Staphylococcus aureus*) is a multi-drug resistant organism, but there are many other organisms that can become resistant and this information covers common organisms such as *Escherichia coli*, *Acinetobacter baumanii*, *Pseudomonas aeruginosa* and other organisms **that have** become resistant to three or more antibiotics. You may see these organisms referred to as Carbapenem Resistant Organisms (CRO), Carbapenem Resistant *Acinetobacter baumanii* (CRAB), Carbapenemase Producing Enterobacteriaceae (CPE) or simply MDRO.

Why does Multi resistance to antibiotics matter?
Some antibiotics e.g. Carbapenem antibiotics can only be given in hospital directly into the bloodstream. Until now, doctors have relied on certain antibiotics to successfully treat particularly 'difficult' infections when other antibiotics have failed to do so. When organisms become resistant to these "last resort" antibiotics there are few treatment options left. In a hospital, where there are many vulnerable patients, spread of resistant bacteria can cause problems. If the bacteria get into the wrong place, such as the bladder, bloodstream or open wound they can cause infection which may be difficult to treat.

Does carriage of or infection with an MDRO need to be treated?
If a person is a carrier of an MDRO such as Carbapenem Resistant Organisms (CROs), they do not need to be treated. However, if the bacteria have caused an infection then antibiotics will be required as advised by a Consultant Microbiologist.

How might I 'pick up' an MDRO?
These bacteria can sometimes be found, living harmlessly, in the gut and on the skin of humans and this is called 'colonisation'. It can be difficult to say when or where you picked it up. However, there is an increased chance of picking up these bacteria if you have been a patient in a hospital abroad **or** in a UK hospital that has had patients carrying the bacteria, **or** if you have been in close contact with a carrier in hospital **or** in the community **or** you have had repeated courses of antibiotics. If any of these apply to you, and you need to be admitted to hospital, screening will be arranged and you may be accommodated in a single room at least until the results of the tests are known.

How will I be cared for while in hospital?
You may be accommodated in a single room whilst you are in hospital and on any subsequent admissions. You may be asked to provide a number of samples to send to the laboratory to check if you are carrying or have an infection with the bacteria. These will probably be taken on a weekly basis during your stay. The samples might include swabs e.g. the site an intravenous drip enters the skin, a rectal swab i.e. a sample taken by inserting a swab briefly just inside your rectum (bottom), and/or a sample of faeces. You may also be tested if you have been in close contact with a patient during your hospital stay who has later been found to have a resistant organism. You will normally be informed of the results within two to three days but none of these measures will hinder your care in any way.

How can the spread of MDRO's be prevented?
If a patient in hospital is carrying these bacteria they can get into the ward environment and be passed on by direct contact to another patient. For that reason, you may be accommodated in a single room to help prevent spread. Healthcare workers must wash and clean their hands regularly. They will use gloves and aprons (or gown) when caring for you. The most important measure for you to take is to wash your hands well with soap and water, especially after going to the toilet. You should avoid touching your medical devices (if you have any) such as your urinary catheter tube, any wound and your intravenous drip, particularly at the point where it is inserted into the body or skin. Visitors will be asked to clean their hands on entering and leaving the room

and may be asked to wear gloves and apron (or gown) especially if they are assisting in your care.
Effective environmental cleaning and good hand hygiene by all, staff, patients and visitors, can reduce the risk of spread significantly.

What about when I go home?
While there is a chance that you may still be a carrier when you go home quite often this will go away with time. No special measures or treatment are required; any infection will have been treated prior to your discharge. You should carry on as normal, maintaining good hand hygiene especially after using the toilet. If you have any concerns you may wish to contact your GP for advice.

Before you leave hospital, ask the doctor or nurse to give you a letter or card advising that you have had an infection or have been/are colonised with an MDRO and which MDRO you have had. This will be useful for your future care and it is important that you make health and social care staff aware of it e.g. when attending an outpatient appointment or being visited by the community nursing team. Should you or a member of your household be admitted to hospital, you should let the hospital staff know that you are, or have been a carrier and show them the letter/card.

Where can I find more information?
Do ask your doctor or nurse to explain this to you in more detail. They may also contact the Infection Prevention and Control Team for you if you need further information about the management of MDRO and CRO.

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Appendix 6
Patient card

If a patient is found to be infected or colonised with a Carbapenem Resistant Organism, they should be issued with a copy of the card below to assist with informing others offering healthcare to the patient of their status. This card can be cut out and folded in half to fit in a standard wallet.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales Important information about: Carbapenem-Resistant Organism (**CRO**) Please show this card to health and social care staff	**For the Attention of Health and Social care staff** This patient is known to be colonised with **CRO**. Please follow your local infection control guidelines. For further advice please contact your local infection prevention and control team. Date Issued: _____ Organisation: _____ https://www.gov.uk/government/publications/carbapenemase-producing-enterobacteriaceae-early-detection-management-and-control-toolkit-for-acute-trusts

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales Important information about Carbapenem-producing Enterobacteriaceae (**CPE**) Please show this card to health and social care staff	**For the Attention of Health and Social care staff** This patient is known to be colonised with **CPE**. Please follow your local infection control guidelines. For further advice please contact your local infection prevention and control team. Date Issued: _____ Organisation: _____ https://www.gov.uk/government/publications/carbapenemase-producing-enterobacteriaceae-early-detection-management-and-control-toolkit-for-acute-trusts

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales Important information about Multi-Drug Resistant Organism (**MDRO**) Please show this card to health and social care staff	**For the Attention of Health and Social Care staff** This patient is known to be colonised with MDRO. Please follow your local infection control guidelines. For further advice please contact your local infection prevention and control team. Date Issued: _____ Organisation: _____ https://www.gov.uk/government/publications/carbapenemase-producing-enterobacteriaceae-early-detection-management-and-control-toolkit-for-acute-trusts

Appendix 7

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust	**CPE SCREENING CULTURE** (CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE) **TEST:** CULTURE AND SENSITIVITY (C&S) **Refer to : MDRO policy IPC 15**

Specimen type	Rectal swab / Faeces
Container	**Swabs:** Sterile, individually wrapped rayon tipped swab with a charcoal transport medium. All swabs used should be CE marked and meet the Clinical Laboratory Standard Institute approved standard M40-A2 (2014). **Faeces:** Sterile, CE marked, leak-proof universal container, preferably with an integral spoon.  
Optimal time and method of collection	• Ensure there is obvious faecal material on rectal swabs • Faecal specimens may be passed into a clean, dry, disposable bed pan*, or similar, then transferred to a suitable container (see above)
Transportation	• Place the labelled swab inside a sealed plastic bag attached to the microbiology request form. • Specimen to be collected from ward and transported to UHW labs like other specimens
Special considerations and limitations	Specimens sent for CPE screening are selectively cultured for these organisms only: if clinically infected with other potential pathogens please send the appropriate specimen for general culture.
Consent information	Healthcare professionals: follow local procedures for obtaining consent from patients.
Biological reference intervals and clinical decision values	Positive CPE screening swabs will be reported with a culture and sensitivity results and an appropriate comment stating 'This isolate is a CPE (Carbapenemase producing Enterobacteriaceae)' Negative screening swabs will be reported as 'No significant growth: Carbapenemase producing Enterobacteriaceae not isolated'
Availability of testing	Swabs are processed 7 days a week during routine laboratory hours. Urgent requests are not applicable for this investigation.
Information for patients	Information on this page is intended for clinical staff. Please contact the Infection Prevention and Control team if you have any queries. Ext: 6129. Email: VCC.InfectionPreventionControl@wales.nhs.uk

Date of issue December 2022

Ref: RD01

INTELLECTUAL PROPERTY (IP) POLICY

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1. INTRODUCTION

Intellectual Property (IP) is the term used to describe new ideas that result in the generation of some output such as a new device, diagnostic or therapeutic product document, design, or an improved way of working.

The core principles of the Policy relating to Intellectual Property is under pinned by the following three fundamental principles:

1. The management and exploitation of intellectual property must deliver benefits to patients and service users.
2. That industry has an important role to play in developing innovations.
3. That individuals who contribute intellectually to new ideas that generate an income to the Trust should be rewarded for their contributions.

2. POLICY STATEMENT

Velindre University NHS Trust recognises the importance of innovation and creativity as essential elements in the process of continual improvement. The UK Policy Framework for Health and Social Care Research https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/ places a duty on the Trust to have in place a mechanism for the exploitation of IP arising from its employees. Innovation in the NHS also occurs in the delivery of patient care and in the education and training of employees. The purpose of this document is to detail a policy for the effective management of IP within the Trust taking into account the principles referred to above and also arrangements with the Trust's academic and commercial partners.

3. SCOPE OF POLICY

This Policy applies to IP opportunities arising from activity involving:

- All staff that are full or part-time employees of the Trust where employment activity results in the generation of any form of IP either within the course of a working day or outside normal working hours and/or away from the place of work, where IP relates to their area of employment by the Trust. This includes IP generated in the course of education or training which is funded by the Trust, especially if the Trust also contributes towards creation of IP by, for example, acting as sponsor of the research in accordance with the UK Policy Framework for Health and Social care research.
- Staff with Trust contracts of employment whose payroll costs are partially or fully funded by another party (e.g. Academic Institution, Medical Charity and Government Department) unless the contract between the Trust and that party assigns ownership of the IP to that party.
- Academic staff of associated universities with honorary clinical contracts.
- Trainee professionals and students hosted by the Trust who are not also employees of the Trust who generate IP during the course of their training (IP

generated by students engaging in research for the Trust may be owned by the student, the institution with whom they are enrolled or the Trust, depending on the agreements between the student, the institution and the Trust.
- Independent providers of services who generate IP from research funded by the NHS are required to inform the appropriate party and share the benefits of its commercialisation. Where IP is assigned to the Trust, the Independent Provider of Services will benefit under the revenue sharing scheme of the Trust.

For individuals who hold an Honorary Contract with the Trust, the IP Policy of their substantive employer will take precedence over the Trust's policy unless circumstances (such as the Trust's or the Velindre University NHS Trust Charity's contribution to the creation of the IP for example where the honorary employee has utilised Velindre Charity funding, Trust equipment, consumables or the time during Trust funded sessions or of Trust-funded staff to create the IP) require negotiation to the contrary to ensure the Trust's contribution is fairly rewarded.

Trust staff seconded to another organisation or employees of another organisation hosted by the Trust under contract are subject to the terms defined in the contract between the Trust and that organisation.

Please note that the applicability of this IP Policy may be subject to a person's employment contract or any other terms upon which a person is engaged by the Trust.

4. AIMS & OBJECTIVES

In order to achieve its core objectives this Policy aims to ensure that:

- There is a good awareness and understanding of IP issues throughout the Trust.
- There is a process in place for disclosure, evaluation, management and exploitation of any IP generated by Trust employees which is timely, transparent and supportive.
- The responsibilities of staff and management are clear.
- The support role of the RD&I Service is clear.
- The ownership of IP related to the disclosure of an idea is established clearly at the outset by the RD&I Service.
- The ownership and management of IP arising from collaborative projects with other organisations, e.g. universities, is clear and supports innovation.
- There is a clear framework governing the ownership and management of the results and associated IP arising from collaborative research projects.
- The apportioning of revenue from any profits of commercialisation is clear and there is a process to implement revenue sharing.
- Potentially exploitable IP is protected appropriately.
- There is a transparent process to resolve any disputes.
- Income from IP owned by the Trust is used to improve patient care and service delivery.

5. ROLES AND RESPONSIBILITIES

5.1 Staff Responsibilities It is the responsibility of all Trust employees involved in the creation of IP to report any IP developments to the Trust's R&D Office in line with divisional policy and procedure and prior to any public disclosure outside the Trust (whether verbal or written)

Should employees fail to report any IP development to the Trust's R&D Office the key principles of this policy will apply retrospectively, unless public disclosure has invalidated the opportunity to protect IP. Potentially protectable IP should only be discussed outside the Trust within the strict confines of a reciprocal non-disclosure agreement which should be negotiated between the R&D Office and will be generally be between the Trust and the part to whom the IP, or idea which may generate IP, is to be disclosed.

5.2 The Executive Medical Director has the responsibility for IP Management and will keep the Trust's Board informed of all significant issues via the Research, Development & Innovation (RD&I) Sub-Committee or the Executive Management Board**.**

5.3 The Trust RD&I Sub-Committee undertakes the role of exploitation panel and is responsible for assessing newly identified IP and determining which exploitation route, if any, should be pursued. Recommendations from the exploitation panel will be passed to the Trust Board for approval.

5.4 The Trust Board has the final decision on which IP should be exploited based on the recommendations of the Trust RD&I Sub-Committee.

5.5 The Head of Research & Development is the nominated Trust IP manager. The post holder will be responsible for overseeing all IP projects and will act as the point of liaison between the Trust and any advisors engaged by the Trust and other stakeholders.

5.6 The Trust RD&I Service and R&D Office will provide advice and where appropriate signpost staff to other sources of information and support.

The role of the RD&I Service will be to:

- Maintain the Trust's IP policy.
- Ensure that new IP is recognised and treated appropriately with regard to confidentiality.
- Provide a contact point for Trust personnel seeking advice on IP.
- Increase the profile of IP and educate staff appropriately in the Trust, for example by facilitating awareness raising and training sessions for staff.
- Coordination with partners and national bodies in relation to IP management.
- Market and manage funding calls relating to innovation and IP.
- Where the RD&I Committee has identified an exploitation route the R&D Department will endeavour to secure the relevant resources to enable staff to develop their ideas and associated IP.

The role of the R&D Office will be to:

- Identify the most appropriate means of protecting the IP, determine the appropriate path to take advantage of the IP & raise awareness.
- Negotiate agreements where appropriate with third parties.

6. DEFINITION OF INTELLECTUAL PROPERTY (IP) AND INTELLECTUAL PROPERTY RIGHTS (IPR)

IP is intangible. It can be defined as the products of intellectual or creative activity in the form of novel ideas, innovation or research and development that can be given legal recognition of ownership. This ownership is a tradable commodity known as the intellectual property right (IPR). This can be a patent, copyright, database right, design rights, trademarks, know-how, as well as medical marketing authorisations and regulatory certifications (see Appendix 1). IPR can be assigned or licensed exclusively or non-exclusively. IP can be generated where R&D, innovation, delivery or management of care or other creative work is being undertaken.

During the application process for a patent, it is imperative that the invention documentation remains confidential. Prior disclosure of this information will render the invention non-patentable in almost all regions of the world.

While IP can and often does arise from formal research projects, it is not limited to the outputs of research studies and can be generated in many other ways. For example, IP may arise as a result of staff trying to find a solution to a problem, developing innovative teaching or training materials or designing a new device based on their experience while working with other staff and patients.

It should be noted that IP legislation is complicated and the scope of IP rights (what can be protected and what cannot be protected) is often a grey area. Members of staff are advised to contact the Trust RD&I Service at the earliest opportunity to discuss in more detail the relevance of IP protection to their ideas and any expression of those ideas. In order to ensure protection of the IP in your idea the idea must be recorded in permanent form.

More information about IP is available on the Intellectual Property Office website (www.ipo.gov.uk).

7. IMPLEMENTATION

This policy will be maintained by the R&D Office.

Please refer to section 5 further information in relation to the responsibilities in connection with this policy.

The policy will be available via the Trust Intranet Site and from the R&D Office. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

The RD&I Sub-Committee will review the operation of this policy as required and at least every three years as set out in the Trust policy of Policies (GC01) https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Governance-&-Communications.aspx.

8. POLICY COMPLIANCE

8.1 Identifying and Protecting IP

Staff at all levels need to be aware of the possibility that they may generate new IP during the course of their employment. The following are examples of activities where IP needs to be considered:

- A novel treatment
- A new diagnostic technique
- A new device
- A new drug or the new use of a drug
- Data, software, training material
- A treatment protocol
- New management system
- Research ideas
- A research protocol
- Guidelines, process maps and flowcharts, standard operating procedures and checklist

8.2 Ideas Disclosure

Velindre University NHS Trust RD&I Service has developed an “Ideas Disclosure Form” to be used by Velindre employees if they have an innovation that, as far as is known, is not in place elsewhere. A completed form should be submitted to the R&D Office for consideration by the RD&I Sub-Committee. The RD&I Sub-Committee will evaluate the potential of the IP and if appropriate create a plan for its management and exploitation.

The ideas disclosure form is attached in Appendix 2 and the general process for the disclosure of ideas in Appendix 3.

The Ideas Disclosure Form asks Velindre employees to provide information on their idea, explaining its originality/inventiveness, and how it can benefit the NHS and patients, either directly or indirectly.

In seeking to establish the originality/inventiveness of an idea, employees should review the overview of types of IP protection in Appendix 1 and, if the idea seems to fall into the category of a patentable invention, investigate current patents online before completing the Idea Disclosure Form. The following link will allow Velindre employees to do a preliminary patent search https://worldwide.espacenet.com/

Please note the RD&I Service is an official function of Velindre University NHS Trust. Therefore, any disclosure made to the RD&I Service including to its staff, e.g. through the Ideas Disclosure Form, is deemed as a confidential disclosure and will be kept confidential by the RD&I Service.

The Trust emphasises that staff should not disclose their idea to anyone apart from research collaborators with whom they are bound by a legally enforceable contract which includes provisions for confidentiality, as this might jeopardise subsequent IP protection.

Employees are urged to consult the Trust's R&D Office at the earliest possible stage if they have any questions about this and especially if they are uncertain about the implications of disclosing an idea to others.

8.3 Due diligence

When an idea or potential invention is notified to the RD&I Service, a process of due diligence will be carried out to identify all of the contributors, their employment status and their contribution to the idea/invention. Staff are asked to provide all records as necessary to facilitate this process. Incorrect identification of inventors may in some cases invalidate a patent, so it is important that all inventors are correctly identified.

8.4 Partnering with Universities or other organisations to develop IP

The Trust may partner with neighbouring universities' IP/commercialisation facilities to utilise their infrastructure and expertise. In this event both the inventor and the Trust will agree in clear terms the nature of the relationship with the partner university or other organisation. This agreement should be underpinned by three clear criteria:

- Where possible, Trust costs incurred in the development of the IP should be recovered before the benefits of commercialisation are shared with the inventor or other parties;
- That the development and commercialisation of the IP delivers benefits to patients/donors and the Trust;
- That the inventor(s) retain the rights to receive an appropriate level of income in the event that commercialisation of the IP generates downstream revenue..

8.5 Partnering with IP specialists

The Trust may also make use of external IP specialist's for advice on matters such as licensing, funding, legal, technical, spin-out to maximise new knowledge creation.

In the above circumstances, benefits to the licencing partner organisation will need to be agreed, for example a percentage of revenue in the event that the IP generates future revenues and/or profits. To achieve this a formal licensee partnership agreement will be put in place with the external specialist organisation if the Trust intends to use or commercialise the IP in partnership.

This can be useful in helping to build long-term, productive strategic relationships between the organisations concerned.

8.6 Ownership of IP

The Trust has right of ownership to all IP produced by Trust employees in the course of their normal duties. Employees have an obligation to inform the Trust about IP generated as a result of their activities and must not sell, assign or otherwise trade IP without Trust agreement.

Where the potential for new IP can be identified in advance, steps will be taken by the Trust to ensure that contracts/agreements contain appropriate terms and conditions to clearly indicate the assignment of intellectual property rights (IPR) and the distribution of benefits arising from the IP.

Where such agreements are not in place, or where organisations have differing agreements, the Trust will negotiate an appropriate share of benefit in accordance with the Trust procedure.

Where Velindre University NHS Trust chooses not to exploit IP arising from the work of its employees, it will, in most cases (subject to no outstanding claims such as from a funding body), assign the IP back to the inventor(s) who may wish to pursue its further development. In return for the assignment, the inventor(s) may be asked to share a small percentage of any income generated with the Trust. Additionally, the Trust will retain the right to use the work at no cost for its own non-commercial purposes.

Where IP is generated by students of higher education institutions the IP will be owned by the student or, if the student and the institution have agreed to this, by the institution. This agreement may occur, for example, by provision in the university regulations accepted by the student, or the terms of a particular funding scheme. Where Velindre University NHS Trust provides support for such research, and there is an opportunity to seek cost recovery or an appropriate share of benefit the Trust will do so. Where appropriate, any such agreement should be negotiated by the relevant parties at the outset.

8.7 Staff Rewards Policy

Velindre University NHS Trust wish to encourage full participation by our employees in the creation and commercial exploitation of IP when it has not been generated as part of their normal duties. This policy therefore lays out a set of conditions under which staff can receive tangible rewards as a result of the intellectual contributions to the generation of IP which is commercialised. This can be done in two ways:

1. To share revenue where the Trust receives any profits from IP exploitation.
2. To allow staff to participate in and hold equity in spin-out companies.

8.7.1 Revenue Sharing from IP Exploitation

In all cases the shared revenue will be the net income attributed [by the Trust] to an IP

right minus any costs incurred by the Trust in bringing the product to market. The Trust, exercising probity, will put robust systems in place to administer and calculate income arising from IP commercialisation. Revenue will be shared between the Trust and the inventor(s) according to the revenue sharing formula. In cases where several staff have been involved in generating the IP, the proportion of revenue allocated to inventors will be divided between them evenly unless it can be demonstrated and agreed that the contribution of individuals varies significantly.

The Trust will ensure that any profits arising from the exploitation of IP, which have been disclosed by and generated by a member of staff identified to the R&D Department, are shared on the following terms:

- In all cases the shared revenue will be the net of any remaining monies after reasonable protection and exploitation costs have been deducted e.g. the costs incurred by the researcher, the clinical directorate within which the research work took place, patenting fees or other legal costs, or marketing costs.
- Where the employee produces more than one item of IP, the income from subsequent IP - unless the subsequent IP is unrelated - will be aggregated with that from the first IP for the purpose of determining the employee's share according to the sliding scale of net revenue.
- Where there is a contracted agreement with a funding sponsor to share revenue from successful exploitation of IP arising from research funded by that sponsor, the cumulative net revenue to the Trust is the income from exploitation remaining after deduction of the sponsor's share and other costs as above.

8.7.2 Velindre University NHS Trust Revenue Sharing

Consideration has been given to the revenue sharing policies of University Health Boards/Trusts and Universities in Wales and is reflected in the following revenue sharing schedule:

Cumulative net income	Inventor	Department	R&D	Trust
First £10K	100%	0%	0%	0%
£10K-£20K	60%	20%	10%	10%
£20K-£100K	50%	20%	15%	15%
£100K-£250K	40%	20%	20%	20%
Over £250K	35%	20%	15%	30%

9. COLLABORATIVE RESEARCH PROJECTS

The Trust actively encourages its staff to work collaboratively with other organisations to promote research and innovation. It is widely recognised that the issue of IP in

collaborative research/innovation can be complex. The Trust aims to provide a framework whereby those that generate ideas are able to use them and are rewarded for their efforts whilst ensuring that the appropriate level of control is in place to ensure that any IP arising from collaborative research always benefits patients and donors and facilitates the collaborative process.

It is therefore important before embarking on a collaborative venture that all parties, the researchers, contract managers and funders, agree the principles of the collaboration. Researchers should engage with the R&D Office at the earliest opportunity to ensure that fair and reasonable IP arrangement which accord with this policy are negotiated.

10. SHARED MATERIALS

Materials are defined as biological materials, most often clinical biological samples derived from patients participating in research studies and donor blood and blood components. When such materials (whether or not they are “relevant material” as defined in the Human Tissue Act 2004) are distributed outside the Trust to researchers or for use in a research project they should be subject to a Material Transfer Agreement (MTA) which will be managed via the Trust’s R&D Office.

This agreement should define the limitations of use of the material and recognises the interest in the IP that may arise from its use. This agreement must be in place prior to distribution and use of the material. The use of trademarks and design rights associated with the aforementioned materials should also be the subject of this agreement. If the materials are intended to be used in a collaborative research project, including projects which require research approval via the Integrated Research Application System and consequently use the model agreements developed for use in such projects, material transfer clauses are likely to be incorporated into wider collaboration agreements.

11. RESOLUTION OF DISPUTES

Where there is dispute about the inventor(s) of IP, dated written records associated with the generation of the IP will be used to establish the inventor(s) of the IP and to determine their level of contribution/remuneration. In the absence of documentary evidence, the Chief Executive of the Trust shall decide, taking such professional advice as appropriate and this decision will be final.

12. NON COMPLIANCE

If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate workforce and organisational development policies.

13. TRAINING

Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director/Divisional Director and General/Departmental Manager must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are adhered to at all times.

14. EQUALITY

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 and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation

15. GETTING HELP

For further information on this Policy all Velindre University NHS Trust staff should contact the Velindre University NHS Trust R&D Department using the email address Velindre.R&DOffice@wales.nhs.uk.

16. REFERENCES

- Welsh Assembly Government, 'Intellectual Property and Innovation in Health care in Wales' – A Framework and Guidance on the Management of Intellectual Property in the NHS in Wales, February 2005
- The UK Policy Framework for Health and Social Care Research https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/
- GC01 Policy and Procedure for the Management of Trust Wide Policies and Other Trust Wide Written Control Documents
- https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Governance-&-Communications.aspx

17. ACKNOWLEDGEMENTS

- Abertawe Bro Morgannwg University Health Board R&D Department

APPENDIX 1 - INTELLECTUAL PROPERTY (IP) PROTECTION

This appendix includes a very brief overview on some aspects of IP protection. For more detail please consult the Intellectual Property Office website "types of IP" section www.ipo.gov.uk/types.htm.

This information is provided for guidance purposes only and is not intended to constitute a definitive or complete statement of the law on IP, nor is any part of it intended to constitute legal advice for any specific situation.

Know-how

“Know how” rights arise automatically and do not require registration. Know-how (also known as a "trade secret") is any information that is not in the public domain which has an assumed value. Know-how is often the most valuable of all IP assets and rights arise automatically with no need for registration. For example, it can be the knowledge about how to perform a procedure or to create a product or process. Know-how can be identified and protected by a Non-Disclosure Agreement (NDA) agreement (also known as Confidential Disclosure Agreements, CDA). When working with other parties, NDAs can be reciprocal agreements whereby the boundaries of confidential information that is disclosed and received is identified and obligations on both receiving and disclosing parties are detailed. A template NDA may be obtained from the Trust R&D Department. Know-how and confidential information are not capable of assignment as property rights but a formal information transfer coupled with a non-use and secrecy agreement can have the same effect. They persist indefinitely, as long as they remain covered by the terms of a NDA.

Copyright

Copyright rights arise automatically and do not require registration. Copyright covers a wide range of works including written and graphical information such as leaflets, articles, assessment tools, training packs, databases, computer software, “Apps” and films/videos, drawings and the 2-D representation of 3-D structures. Copyright is an automatic unregistered right that subsists if the work is "original". The requirements for originality are low. Therefore it is best to assume that copyright will subsist in all written, graphic or photographic works generated by staff.

It is advisable to attach a statement to any works such as: Copyright Velindre University NHS Trust Date XX. All rights reserved. Not to be reproduced in whole or in part without the permission of the copyright owner. However, you may decide to designate certain areas of activity for which permission does not have to be obtained. For example "non-for-profit organisations such as NHS Health Boards and Trusts, may reproduce this work solely for the purposes of teaching or further non-commercial research. In all other circumstances the permission of the Trust must be obtained".

Patents

Patents need to be registered to attract protection. Patents can be used to protect "technical" inventions that are new and have a utility. The vast majority of ideas will have potential utility. In Europe and the majority of countries in the world "new" means that all of the features of the invention must not have been made available to the public in a single disclosure anywhere in the world prior to the patent filing date. A public disclosure can be written, verbal or by any other means (e.g. journals, internet, meetings, posters, etc) and could merely be the result of a conversation between friends. To qualify as a patentable invention the idea must also not be obvious. The assessment of what is obvious is a complex area of patent law and in the first instance staff are advised against concerning themselves with this criterion. In the UK, some inventions are specifically excluded from patenting where those inventions consist entirely of methods of treatment by surgery or therapy or diagnostic methods. However, these inventions are patentable in other countries, notably the USA.
Excluded inventions are also a complex area of patent law and staff are advised that if they think they have an invention which lies in an excluded category to please consult the Trust R&D Department in the first instance. However, it is best not to assume an invention is excluded in the first instance.

Design Rights

Design rights arise automatically and do not require registration. Design Rights protect against the copying of the shape or configuration of an article. Design Rights may exist in addition to other forms of protection offered by patents or copyright.

The "Design Right"

The "unregistered" Design Right as it is known, similar to copyright, is an automatic right and can last up to fifteen years. It can protect the 3D features of an article, internal and external features, but there are a number of exclusions for example where the article is dependent on another article the so-called “must-fit, must match" exclusion. A surgical instrument could be protected by this right. However, unregistered design rights are generally considered to be weak IP rights and often stronger rights such as patents are sought, at least to improve levels of protection. Given the particular requirement of this “niche” aspect of IP law it is best in the first instance not to assume that the design right will protect a given article.

Registered Design Rights

Both UK and European law provide for registered design rights which last up to 25 years. Registration is required to attract protection. Registered design rights protect the appearance of a product, for example its shape, colour or texture of materials. For example, a new design of surgical gown or a patient's pillow could be the subject of a registered design right.

Trade marks

A trademark is a sign or symbol that is used to distinguish a product or service of one undertaking (e.g. a company or organisation, such as an NHS organisation) from another undertaking. Trademarks need to be registered to attract protection. Trademarks can protect words, logos, shapes, colours and even smells (e.g. the name “Coca Cola” and also the shape of the Coca Cola bottle are registered trademarks). Trademarks are the IP right that protect brands. They can last forever, providing renewal fees are paid.

Database right

A database means a collection of independent works, data or other materials which are arranged in a systematic or methodical way and are individually accessible by electronic or other means. There are two types of intellectual property protection for databases: database right and copyright. Both are automatic, unregistered rights that allow the owner to control certain uses of their databases.

Copyright protects the selection or arrangement of material in a database where this is original (i.e. creative). Database right protects the contents of a database. A database does not have to be original for it to qualify for database right, but there needs to have been a substantial investment in obtaining, verifying or presenting the contents of the database.

Database right is based on the European Community Directive 96/9 on the legal protection of databases. This was implemented in the UK by the Copyright and Rights in Databases Regulations 1997, which remain in force as ‘retained EU law’ with amendments following the UK’s departure from the EU. The maker of a database must have a connection with the UK (or the European Economic Area if the right arose before 31 December 2020). Databases created from 2021 onwards are only protected under UK law.

Database right lasts for 15 years from the end of the calendar year in which the making of the database was completed. Any substantial change to the contents of a database which can be considered to be a substantial new investment qualifies the database resulting from that investment for its own term of protection.

Appendix 2 – Innovative Ideas Disclosure Form



INNOVATIVE IDEAS DISCLOSURE FORM

Full Name	
Role	
Department	
Status of Employment	
The name of any collaborating individuals or parties	
Title of the project (max 60 characters)	
Idea Summary (Maximum 200 words)	
Summary of potential benefits to patients/health service (Maximum 200 words)	
What were the results of your preliminary patent	

search? A free patent search can be undertaken using the following link https://worldwide.espacenet.com/	
Any other relevant information (max 200 words)	

If applicable please include separately any supporting drawings or schematics to this application.

Appendix 3 - General Process for the Disclosure of Ideas

