# Public Trust Board

*Thu 30 January 2025, 10:00 - 13:00*

**Velindre University NHS Trust Headquarters / Microsoft Teams**

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 28th November 2024

*Professor Donna Mead OBE, Chair*

1.4.0 FINAL Public Trust Board Minutes 28.11.2024(v3)_SH.pdf (13 pages)

### 1.5. Public Action Log

*Professor Donna Mead OBE, Chair*

1.5.0 PUBLIC TRUST BOARD ACTION LOG - JAN25(1).pdf (1 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 30.01.2025.pdf (7 pages)

### 2.2. Chief Executive's Report

*David Donegan, CEO*

2.2.0 CEO's Update Trust Board 30.01.2025.pdf (6 pages)

**10:25 - 10:25**
0 min

## 3. INTEGRATED GOVERNANCE

**There are no items for discussion*

**10:25 - 11:50**
85 min

# 4. QUALITY, SAFETY & PERFORMANCE

## 4.1. VUNHST Risk Register

*Non Gwilym, Interim Director of Corporate Governance*

- 4.1.0 TRR - TB PUBLIC COVER PAPER - 30.01.2025 - V06.pdf (7 pages)
- 4.1.0a TRR PUBLIC TRUST BOARD v10.pdf (9 pages)

## 4.2. Trust Assurance Framework

*Non Gwilym, Interim Director of Corporate Governance*

- 4.2.0 TAF Cover Paper - TB - 30.01.2025 V01.pdf (14 pages)
- 4.2.0a TAF - TB 30.01.2025 - V01 - TAF DASHBOARD (4).pdf (30 pages)

## 4.3. Performance Management Framework (November 2024)

*Anne Carey, Interim Chief Operating Officer, Lauren Fear, Interim Director of Transformation, Matthew Bunce, Executive Medical Director and Sarah Morley, Executive Director of Organisational Development & Workforce*

- 4.3.0 November PMF 2024 - Trust Board 30th January version - Final v2.pdf (38 pages)

## 4.4. Financial Report (November 2024)

*Matthew Bunce, Executive Director of Finance*

- 4.4.0 Month 9 Finance Report Cover Paper - TRUST BOARD 30.01.2025.pdf (12 pages)
- 4.4.0a Appendix 1 - M9 VELINDRE NHS TRUST FINANCIAL POSITION TO DECEMBER 2024 - TRUST BOARD 30.01.2025.pdf (29 pages)
- 4.4.0b Appendix 2 - TCS Programme Finance Paper (December 2024) - Main Report.pdf (15 pages)

## 4.5. Public Quality, Safety & Performance Committee Highlight Report (16/01/2025)

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

- 4.5.0 Public QSP Highlight Report 16th January 2025 v3.pdf (6 pages)

## 4.6. Annual Presentation of Nurse Staffing Levels

*Nicola Williams, Executive Director of Nursing, Allied Health Professionals*

- 4.6.0 NSLWActNov2024TrustBoardFinal.pdf (11 pages)

## 4.7. Health Technology Wales Annual Report

*Peter Groves, Chair HTW and Lisa King, Senior Programme Manager HTW*

- 4.7.0 HTW presentation to Velindre Public Board Meeting January 2025 - DM.pdf (11 pages)
- 4.7.0a HEALTH-TECHNOLOGY-WALES_ANNUAL-REPORT-2024_AW-1 (1).pdf (34 pages)

**11:50 - 12:00**
10 min

# *BREAK 11:50-12:00*

**12:00 - 12:05**
5 min

# 5. PLANNING AND STRATEGIC DEVELOPMENT

## 5.1. Strategic Planning Update

*Lauren Fear, Interim Director of Transformation*

- 5.1.0 Strategic Planning Update - Jan 2025.pdf (5 pages)

5.1.0a Appendix 1 - Strategic Planning Update - Jan Board.pdf (5 pages)

12:05 - 12:40
35 min

# 6. CONSENT ITEMS

## 6.1. CONSENT FOR APPROVAL

*Professor Donna Mead OBE, Chair*

### 6.1.1. Chair's Urgent Actions Report

*Non Gwilym, Interim Director of Corporate Governance*

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

### 6.1.2. Commitment of Expenditure Exceeding the CEO Limit

*Matthew Bunce, Executive Director of Finance*

6.1.2 PUBLIC Commitment of Expenditure Cover Paper_Trust Board_JAN 2025.pdf (4 pages)
6.1.2a APPENDIX 1 Commitment of Expenditure Over Chief Exec Limit - International Courier WBS FINAL1.pdf (8 pages)

### 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*

6.1.3 Budgetary Control - Proposed Amendment to the Trust Delegated Financial Limits - Trust Board 30.01.2025.pdf (8 pages)

### 6.1.4. Trust Policies for Approval

*Sarah Morley, Executive Director of Organisational Development & Workforce*

- Reviewed – Employing Ex-Offenders and People with a Criminal Record Policy
- 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

6.1.4 People and OD Polices and Processes Jan 25.pdf (7 pages)
6.1.4a Employing Ex Offenders and People with a Criminal Record Policy .pdf (24 pages)
6.1.4b Annual Leave and Bank Holiday Policy and Procedure Medical V7.pdf (16 pages)
6.1.4c 2024_12_05 Job Evaluation Policy and Procedure FINAL.pdf (19 pages)
6.1.4d 2024_07_24 All Wales Pregnancy Loss Support Policy FINAL English.pdf (9 pages)
6.1.4e All Wales Recovery of Overpayments Procedure.pdf (25 pages)

## 6.2. CONSENT FOR NOTING

*Professor Donna Mead OBE, Chair*

### 6.2.1. Public Audit Committee Highlight Reports (17/09/2024 & 12/12/2024)

*Gareth Jones, Independent Member and Chair of the Audit Committee*

6.2.1a Audit Committee Part A Public Highlight Report 17 September 2024(GJ) v2.0.pdf (4 pages)
6.2.1b Audit Committee Highlight Report (Dec) for January Board Meeting (GJ).pdf (5 pages)

### 6.2.2. Public Strategic Development Committee Highlight Report (22/10/2024)

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

6.2.2 Highlight Report SDC 22.10.2024 v2_SH LF.pdf (4 pages)

### 6.2.3. Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports (25/09/2024 & 21/11/2024)

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

6.2.3a TRUST BOARD PUBLIC TCS HIGHLIGHT REPORT 25.09.2024 v2.pdf (4 pages)
6.2.3b TRUST BOARD PUBLIC TCS HIGHLIGHT REPORT 21.11.2024 v2.pdf (4 pages)

### 6.2.4. Local Partnership Forum Highlight Report (12/12/2024)

*Sarah Morley, Executive Director of Organisational Development & Workforce*

6.2.4 LPF Highlight Report V01.pdf (4 pages)

### 6.2.5. Remuneration Committee Highlight Report (20/11/2024)

*Professor Donna Mead OBE, Chair of Remuneration Committee*

6.2.5 Highlight Report REMCOM 20.11..2024-V01_.pdf (2 pages)

### 6.2.6. Trust Seal Report

*Non Gwilym, Interim Director of Corporate Governance*

6.2.6 Trust Seal Report 28.11.2024-29.02.2025.pdf (3 pages)

### 6.2.7. Health & Wellbeing Champion Annual Report

*Stephen Harries, Vice Chair*

6.2.7 HWB Champion Report 2024.pdf (7 pages)

### 6.2.8. Academic Partnership Board Annual Report

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

6.2.8 Academic Partnerships.pdf (10 pages)

**12:40 - 12:40**
0 min

## 7. ANY OTHER BUSINESS

*Professor Donna Mead OBE, Chair*

*Prior approval required by Chair

**12:40 - 12:40**
0 min

## 8. DATE OF NEXT MEETING

*Professor Donna Mead OBE, Chair*

Thursday, 27th March 2025

**12:40 - 12:40**
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).

**12:40 - 12:40**
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
- Electronic Prescribing and Medicines Administration
- Private Committee Highlight Reports

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**12:40 - 12:40**
0 min

## 11.

**MINUTES PUBLIC TRUST BOARD MEETING – PART A**
**VELINDRE UNIVERSITY NHS TRUST LIVE STREAMED**
**28th NOVEMBER 2024 AT 10:00AM**

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| **PRESENT** | |
| Stephen Harries (SH) | Acting Chair |
| Professor Andrew Westwell (AW) | Independent Member |
| Vicky Morris (VM) | Independent Member *(remotely)* |
| Gareth Jones (GJ) | Independent Member *(remotely)* |
| Lindsay Foyster (LLF) | Independent Member |
| Hilary Jones (HJ) | Independent Member *(remotely) (in part)* |
| Carl James (CJ) | Interim Chief Executive Officer |
| Nicola Williams (NW) | Executive Director of Nursing, Allied Health Professionals & Health Science |
| Dr Jacinta Abraham (JA) | Executive Medical Director |
| Matthew Bunce (MB) | Executive Director of Finance |
| Lauren Fear (LF) | Interim Executive Director of Strategic Transformation, Planning & Digital |
| **ATTENDEES** | |
| Anne Carey (AC) | Interim Chief Operating Officer |
| Carl Taylor (CT) | Chief Digital Officer |
| Non Gwilym (NG) | Interim Director of Corporate Governance |
| Kyle Page (Secretariat) | Business Support Manager *(remotely)* |

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| **1.0.0** | **STANDARD BUSINESS** | |
| **1.1.0** | **Welcome and Apologies**<br><br>The Chair welcomed attendees to the meeting, noting the following apologies:<br><br>• Professor Donna Mead OBE, Trust Chair<br>• Sarah Morley, Executive Director of Organisational Development & Workforce<br>• Emma Rees, Deputy Head of Internal Audit, NHS Wales Shared Services Partnership<br>• Alan Prosser, Director of Welsh Blood Service<br>• Katrina Febry, Audit Lead, Audit Wales *(not noted at the meeting)* | |
| **1.2.0** | **In Attendance**<br><br>The Chair extended a warm welcome to the following additional attendees:<br><br>• Bethan Davis, Simultaneous Welsh Interpretation Service<br>• Rachel Hennessy, Interim Director of Velindre Cancer Service *(remotely)*<br>• Amanda Jenkins, Acting Assistant Director of Workforce *(deputising for Sarah Morley)*<br>• Tina Jenkins, Head of Quality, Safety & Assurance *(for item 4.6.0)*<br>• David Cogan, Patient Representative | |

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| | • Sian James, Head of Research, Development & Innovation Services *(for item 5.2.0)*<br>• Andrew Nash, Surveyor, NHS Wales Shared Services Partnership *(for items in the approvals section)* | |
| **1.3.0** | **Declarations of Interest**<br><br>There were no declarations of interest pertinent to today's agenda. | |
| **1.4.0** | **Minutes of the Public Session held on 26th September 2024**<br><br>The Trust Board confirmed that the minutes of the meeting held on the 26th September 2024 were an accurate reflection of proceedings. | |
| **1.5.0** | **Action Log**<br><br>The Trust Board was content that all actions marked as closed was an accurate reflection.<br><br>It was clarified that overdue open actions had been marked as red and those within their target date had been marked as green. The status of open actions was reviewed as follows:<br><br>• ***4.1.0 (26/03/2024)*** **Action 1** – It was agreed that the action should remain open with a revised target date.<br>• ***5.1.0 (23/05/2024)*** **Action 2** – It was agreed that the action should remain open with a revised target date.<br>• ***7.***1.4 ***(23/05/2024)*** **Action 3** – It was agreed that the action should remain open with a revised target date.<br>• **4.1.0** ***(26/09/2024)*** **Action 8** – As this had been included in the governance section of the cover paper for the Trust Risk Register, it was proposed to close the action once this item had been considered later in the agenda.<br>• **4.3.0** ***(26/09/2024)*** **Action 9** – Anne Carey confirmed that the wording had been updated as requested and it was agreed to close the action.<br><br>The Trust Board **NOTED** the status of open actions and Gareth Jones requested that target dates that had passed be revised and circulated to Board members (with the action marked allocated a red rating). | **RH**<br><br>**NG**<br><br>**NG**<br><br>**Secretariat**<br><br>**Secretariat** |
| **1.6.0** | **Matters Arising**<br><br>Due to its significance, it was agreed that one substantive matter arising would be considered via the main agenda (under item 4.6.0). | |
| **2.0.0** | **KEY REPORTS** | |
| **2.1.0** | **Chair's Report**<br>Professor Donna Mead OBE, Chair<br><br>The report provided an overview of the Chair's activity since the previous meeting of the Trust Board. The Acting Chair added the following item:<br><br>• Colonel Simon Lawrence (a member of the Trust's Radiology department) had been presented with the King's Coronation medal. As a serving soldier at the time of the coronation, he was until recently the Commanding Officer of 293 Wales Medical Reserve Regiment. The Chair had wished to express her personal congratulations and it was | **NG** |

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| | agreed that communication would be sent on behalf of the Board to congratulate Simon.<br>• Next week the Trust will welcome the new Chief Executive Officer, David Donegan. The Acting Chair and the Board expressed thanks to Carl James for the exemplary way the role of Interim Chief Executive Officer had been carried out over the past five months.<br>• Thanks were also expressed to other Board members who had undertaken interim roles as a result, (Jacinta Abraham, Lauren Fear and Non Gwilym).<br><br>The Trust Board **NOTED** the content of the Chair's Update Report. | |
| **2.2.0** | **Vice Chair's Report**<br>Stephen Harries, Vice Chair<br><br>The report provided an overview of the Vice Chair's activity since the previous meeting of the Trust Board.<br><br>No questions were raised, and the Trust Board **NOTED** the content of the Vice Chair's Update Report. | |
| **2.3.0** | **Chief Executive's Report**<br>Carl James, Interim Chief Executive Officer<br><br>The report provided information to the Board regarding a number of matters and activity since the previous meeting of the Trust Board. Carl James highlighted the following:<br><br>• Attendance at the Employee Excellence Awards during October, which recognised and celebrated the achievements of inspirational colleagues across the Trust and the difference made to patients and donors as a result.<br>• Thanks to the Board for the opportunity and privilege of assuming the role of Chief Executive Officer for the past 5 months. Carl James thanked the Executive Team for their support and welcomed David Donegan's appointment, marking the next chapter in the growth of the organisation.<br><br>Lindsay Foyster queried the outcome of the meeting with the Senedd's Public Accounts and Public Administration Committee regarding the procurement process supporting the development of the new Velindre Cancer Centre. Carl James advised that discussions had included an explanation of the process (procurement, chronology). Feedback had been positive due to the transparent nature of the meeting and had provided the Trust with a welcome opportunity to outline the actions it had taken. Stephen Harries advised that a recording of the meeting was available for public view on the Senedd's website.<br><br>Lauren Fear added that the robust process / due diligence undertaken by the Board and Transforming Cancer Services Programme Scrutiny Sub-Committee, had been outlined.<br><br>Lauren Fear also advised that the BBC had reached out to the Trust, Sacyr, DLA Piper and Kajima directly, providing the opportunity to comment prior to the imminent television coverage of the matters under review.<br><br>The Trust Board **NOTED** the content of the Chief Executive's Update Report and the continued celebration of the achievements of staff was welcomed. | |

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| **3.0.0** | **INTEGRATED GOVERNANCE** | |
| | There were no items for discussion. | |
| **4.0.0** | **QUALITY, SAFETY AND PERFORMANCE** | |
| **4.1.0** | **VUNHST Risk Register**<br>Non Gwilym, Interim Director of Corporate Governance<br><br>The report summarised the current position of risks scoring 12 and above for Quality / Safety and 15 and above for all other domains, whilst also referencing discussions in respect of the register that have been held over the reporting period. The paper referred (for the first time) to a summary of two risk categories which had been the focus over the period (Systemic Anti-Cancer Treatment (SACT) and Medical Staffing), including discussions of risks at a more strategic level.<br><br>Vicky Morris added that detailed discussion had been undertaken at November's meeting of the Quality, Safety & Performance, noting the succinct articulation of this in the cover paper for Board assurance, and the triangulation with the information detailed in the Committee highlight report.<br><br>Gareth Jones referenced narrative on page 7 regarding the use of Datix Web / Datix Cymru, querying which of these would be used by the Trust. Non Gwilym advised that a decision had not yet been reached and further internal consideration was required before presenting the pros, cons, benefits and challenges of using a new system and how risk would continue to be managed within the organisation.<br><br>Gareth Jones queried the timeline for the planned review of all risks under the risk appetite level (as instructed by the Audit Committee). Non Gwilym indicated that it was intention to undertake this at the end of January and that an understanding of what the Audit Committee requires from this substantial piece of work is required in the first instance.<br><br>Andrew Westwell suggested that it would be helpful to have a timescale by when the 'target rating' may be reached. Non Gwilym agreed to discuss this with the Executive Team.<br><br>Gareth Jones noted that a more recent update than detailed in the register should be received by the Board (referencing the date of the 12th September for risk 3338). Anne Carey confirmed that while actions had been subject to a more recent update, this had not been included. However, it was advised that the cover paper had referred to this particular risk (among other SACT risks), in addition to referencing the SACT improvement plan. The plan includes a number of initiatives and actions which will influence the management of this risk. However, the issue of the date was noted, and it was agreed that this section would be reviewed. It was also agreed that the most recent updates would be noted in red for ease of reading.<br><br>As a recent update on the current position of risks scoring 16+ had been included in the cover paper and can be retained going forward, Stephen Harries queried whether action 8 on the log could now be closed as the narrative also provided assurance that conversations are being held.<br><br>In order to satisfy the action of providing an update on the current position a week prior to Board, Anne Carey suggested that both divisional Operation and Senior Leadership Teams separate out risks scoring 16+ for specific discussion and incorporate narrative regarding the current position into the cover paper for Board assurance purposes (given that Board papers are published a week prior to Board as a matter of course). | **NG**<br><br>**AC**<br><br>**NG**<br><br>**AC** |

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| | It was also agreed to make the Board aware of matters for escalation in relation to risks scoring 16+, as opposed to reporting on risks in steady state.<br><br>The Trust Board **NOTED:**<br>• 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;<br>• The ongoing development of the Trust's Risk Framework;<br>• The work underway to improve organisational management of risk reporting.<br><br>It was **AGREED** that action 8 on the action log would remain open until the next meeting of the Trust Board, while proceeding with the above agreement in the interim. | |
| **4.2.0** | **Trust Assurance Framework (TAF)**<br>Non Gwilym, Interim Director of Corporate Governance<br><br>The report summarised the latest position of the Trust Assurance Framework, which provided the Board with the opportunity to review updates and actions planned for the coming period. Non Gwilym highlighted the following:<br><br>• Substantial work on the Framework had been undertaken since the previous meeting, which had been noted in red in the appended document. The cover paper also summarised the main changes in the dashboard.<br>• Discussions at October's Strategic Development Committee had been summarised in the governance section of the cover paper.<br><br>Vicky Morris added that detailed discussions had also been undertaken at the Quality, Safety & Performance Committee (noted in the summary section) and significant work had been carried out to achieve the current version. Vicky Morris advised that whilst significant amendments had been made to TAF07 since the previous meeting, the controls did not currently reflect the closed actions.<br><br>Lindsay Foyster queried the wording of the title of TAF03, which read "there is a strategic risk of an optimised workforce……..". It was agreed that this should include "***lack of*** optimised workforce" for accuracy.<br><br>Lindsay Foyster also questioned whether Executive Management Board had agreed an update on the risk score trend. Non Gwilym advised that this had not yet been achieved, as the main focus had been the update of risks against the Integrated Medium Term Plan objectives. It was agreed that this would be re-visited, and a date confirmed.<br><br>Gareth Jones noted that an action on page 4 of the dashboard had been due for implementation by April/May 2024, however the most recent update was October. Non Gwilym agreed to review this.<br><br>While it was appreciated that the governance process dictates how dates are noted, it was recognised that identification of a mechanism to assure the public audience that action had been undertaken since the previous update was required. It was also agreed that it would be appropriate to update the Board (post Quality, Safety & Performance Committee) by exception if required. | **SM**<br><br>**NG**<br><br>**NG** |

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| | Non Gwilym also agreed to review the dashboard to ensure that all information is visible.<br><br>The Trust Board **NOTED** the current status and ongoing development of the Trust Assurance Framework. | **NG** |
| **4.3.0** | **Performance Management Framework (September 2024)**<br>Anne Carey, Interim Chief Operating Officer, Lauren Fear, interim Executive Director of Strategic Transformation, Planning and Digital, Matthew Bunce, Executive Director of Finance and Amanda Jenkins, Acting Assistant Director of Workforce<br><br>The Framework provided an update and supporting analysis on the performance of the Trust for the month of September 2024 against a number of targets, which had been robustly discussed at the November meeting of the Quality, Safety & Performance Committee. Lauren fear advised the following:<br><br>• A significant amount of detail in relation to previous discussions had been provided in the governance section.<br>• Following discussion regarding the format of the document at the Quality, Safety & Performance Committee, two changes had been made to the report; (1) a snapshot across core services had now been provided in the cover paper in place of divisional reports (2) exception reporting – the report had been condensed wherever possible based on feedback from the relevant Committee receiving the overall dashboard, however, more detail had been included for areas not meeting the required standards.<br>• An overall rating for the report, plus an assurance rating for each of the core service areas would be present in the next report.<br>• Inclusion of progress regarding the 7 packages of work presented to the September meeting of the Trust Board.<br><br>Amanda Jenkins noted that sickness data had been subject to significant scrutiny and confirmed a downward trend over the last 12 months. A request for more detailed analysis of the Trust's PADR compliance had also been requested for scrutiny at the Quality, Safety & Performance Committee.<br><br>Vicky Morris added that the Committee had spent a significant amount of time ensuring that the Workforce team is bringing forward action plans supporting the Strategy, noting that it would also be necessary to demonstrate outcomes. Therefore, the level of assurance had been reduced in some areas, which will increase as outcomes are evidenced.<br><br>The Trust Board**:**<br><br>• **DISCUSSED** and **NOTED** the September 2024 Performance Management Framework. | |
| **4.4.0** | **Financial Report (September 2024)**<br>Matthew Bunce, Executive Director of Finance<br><br>The report provided an update on the financial position and performance for the period to the end of September 2024. Matthew Bunce advised the following:<br><br>• **LTA Contract Rebase** – Commissioners had discussed responses from all Commissioning Bodies and there was a unanimous agreement | |

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| | to move to rebasing with a neutral impact across Commissioners. It was re-iterated that this item would be discussed in further detail at December's Board Development Session.<br>• **New financial risk** – A new financial risk had emerged, involving ensuring that income activity captured by the Trust's clinical systems is correctly mapped and flows into the Data Warehouse. The planned additional income of £1.3m had not materialised as expected, therefore presenting a potential risk of £700k not being delivered (based on data noted at Month 6). Work is urgently being undertaken to resolve process issues and it was confirmed that TAF08 of the Trust Assurance Framework would be updated accordingly in addition to recording the risk on Datix.<br>• **KPIs** – Capital Funding is showing amber status, as funding had not yet been secured from Welsh Government for a number of schemes, including the nVCC, Enabling Works and Whitchurch Hospital and land matters. The necessary funding has, however, been secured since the time of writing.<br><br>Carl James assured the Board that the sustainable long term position of the organisation would be worked through via a Task & Finish Group. Confidence remained that financial balance would be achieved by year end and it was advised that progress would be reported at the next meeting of the Trust Board.<br><br>The Trust Board **NOTED** the content of the September 2024 financial report, in particular:<br><br>• The year to date and forecast revenue out turn position and PSPP performance.<br>• The agreed position on LTA income for 2024-25 from our Commissioners.<br>• The position with Commissioners on the contract rebase agreement.<br>• The latest position on the LTA activity performance for 2024-25.<br>• That at the time of writing the Trust was still waiting to secure Capital funding from Welsh Government in relation to the nVCC, Enabling Works and Whitchurch Hospital and Land Matter for 2024-25<br>, but that the necessary funding has since been secured.<br><br>The Trust Board also **NOTED** the new financial risk and associated assurance. | **MB** |
| **4.5.0** | **Public Quality, Safety & Performance Committee Highlight Report (14/11/2024)**<br>Vicky Morris, Independent Member and Chair of Quality, Safety & Performance Committee<br><br>The report provided the Board with detail of the key issues and risks considered at the November meeting of the Quality, Safety & Performance Committee for escalation to the Board, in addition to the Trust's Quarter 2 Quality & Safety Report. Vicky Morris highlighted the following:<br><br>• **Triangulated themes** – Key triangulated issues / themes considered by the Committee based on papers received which provide any emerging pictures had been noted at the beginning of the report.<br>• **Trust Risk Register** – While this had been included under items for alert/escalation, the Risk Register was not discussed in detail under this item following detailed discussion earlier in the meeting. | |

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| | Nicola Williams wished for the Board to receive sight of quarterly Quality & Safety reports; the second quarterly report brought to the meeting distilled information from (previously) 6 separate reports from differing areas of the Trust, produced through the relevant leads, along with the three established quality hubs. Nicola Williams referenced section 2 of the report, which provided an overview of quality and safety indicators and improvements evidenced by implementation of enhanced processes. The following was also noted:<br><br>• The Trust continues to note nil complaints referred to the Public Service Ombudsman.<br>• Implementation of the Audit Management and Tracking (AMaT) quality assurance system has provided a mechanism to enable significant oversight of whether appropriate action has been undertaken following an inspection, investigation following a serious incident, a review, or an audit.<br>• Delays to quality metric work had resulted from allocation of resource to the SACT improvement work. However, the development of the dashboard is in progress and overseen by the Integrated Quality & Safety Group.<br><br>The Trust Board **NOTED**:<br><br>• The key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on 14th November 2024.<br>• The Quarter 2 Quality & Safety Report. | |
| **4.6.0** | **Process for capture of patient / donor feedback**<br>Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science and Tina Jenkins, Head of Quality, Safety & Assurance<br><br>Following an action raised at the July meeting of the Trust Board, the report provided an update on work undertaken (and planned) to ensure that all patient and donor feedback is captured and used to provide an overarching picture of the Patient and Donor experience across the Trust. A Trust-wide exercise had been undertaken to identify potential missed opportunities to do so (including triangulation of data capture with Quality & Safety reporting). Tina Jenkins advised the following:<br><br>• To date, the Trust has been dependent on CIVICA feedback surveys as a quantitative measure of Trust performance, which generally provide a low return. Additional mechanisms currently used for the capture of feedback were outlined within the document.<br>• A recent refresh of the NHS Wales People's Experience Framework had been undertaken (currently embargoed) and permission had been granted to use the 'local self-assessment tool' for the work required going forward.<br>• Individuals across the Trust had been identified to take part in the self-assessment tool and it is the intention to work collaboratively with the Patient and Carer Partnership Board. Nicola Williams advised that it had been agreed with David Cogan (patient representative) that a similar gap analysis would be undertaken in conjunction with the Patient and Carer Partnership Board within the coming months.<br>• In addition to providing the national document once published, a Trust work plan will be completed and presented to the March meeting of the Trust Board. | |

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| | David Cogan welcomed the inclusion of the Patient and Carer Partnership Board (previously Patient Liaison Group) and hoped that the new Framework would create organised, structured involvement of the patient voice. All Board members were invited to attend future meetings and it was suggested that a schedule of meetings be circulated to Board members.<br><br>Nicola Williams agreed to address how the patient voice could regularly be presented to the Board going forward (and mapping of this through the appropriate governance route) outside the Board.<br><br>Lindsay Foyster requested further information on potential actions taken by the Trust based on feedback received, whether there was evidence of improvements and how this could be communicated to the Board. Tina Jenkins indicated that the self-assessment requires the individual to evidence how patients / donors are heard and how their feedback is used. Tina Jenkins also advised that the involvement of the Dementia Lead Nurse and Safeguarding Lead would ensure that feedback is obtained from hard to reach cohorts of patients.<br><br>Nicola Williams also recognised that ineffective communication is a recurring theme in feedback received from patients, donors, families and carers and that this must be prioritised over the coming year. David Cogan emphasised that the Trust would benefit from allowing resolution of such issues to be patient, family and carer led, as these are often not considered through the lens of the service user.<br><br>The Trust Board **NOTED** the current position and plans in respect of capturing all patient and donor feedback. | **DC**<br><br>**NW / NG**<br><br>**NW** |
| **5.0.0** | **PLANNING AND STRATEGIC DEVELOPMENT** | |
| **5.1.0** | **Strategic Planning Update**<br>Lauren Fear, Interim Executive Director of Strategic Development, Planning & Digital<br><br>The update provided an overview across strategic planning matters for the Executive Management Board, Strategic Development Committee and Trust Board. The report outlined the following:<br><br>• The next substantive discussion in relation to the Integrated Medium Term Planning (IMTP) Framework is to take place in next week's Strategic Development Committee.<br>• An update regarding the newly established Regional Cancer Board for South East Wales, the second meeting of which took place last week. Lauren Fear advised that the Director of Planning for each of the 4 Trusts / Health Boards involved provides a strategic planning paper to their respective Board, in addition to sharing the attached update. It was noted that the Cancer programme was now allocated amber / red status as this is still in development.<br>• An update regarding recent partnership Board meetings between the Trust, Cardiff & Vale University Health Board and Aneurin Bevan University Health Board.<br><br>The Trust Board **NOTED** the update for assurance purposes. | |
| **5.2.0** | **Welsh Blood Service's Research, Development & Innovation Strategy**<br>Dr Jacinta Abraham, Executive Medical Director, supported by Sian James, Head of Research, Development & Innovation Services | |

Unconfirmed

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| | The purpose of the paper was to seek Trust Board approval of the Strategy, which had been designed to guide the Welsh Blood Service's research activities and partnerships with academia, NHS organisations, funders, industry partners and educational leaders, to improve the lives of people in Wales. It was acknowledged that this had previously been endorsed by the September RD&I Sub-Committee and October Strategic Development Committee prior to Trust Board.<br><br>Jacinta Abraham praised the transformation of Research, Development and Innovation within the Welsh Blood Service over recent years, noting the expansion of the workforce, content of activity and 100+ projects now in train.<br><br>The development of the Strategy had been well-coordinated and had included robust engagement with a large number of both internal and external stakeholders and alignment with the existing Trust and Welsh Blood Service Strategies.<br><br>Signoff of the associated Quality Impact Assessment and Equality Impact Assessment Plan was confirmed.<br><br>Anne Carey expressed thanks to Sian James on Alan Prosser's behalf for the support and effort in achieving this position and the Trust Board **APPROVED** the Welsh Blood Service's Research, Development & Innovation Strategy and the team was commended for the significant amount of work involved. | |
| **5.3.0** | **Welsh Blood Service: Fleet Replacement Business Justification Case**<br>Anne Carey, Interim Chief Operating Officer<br><br>The Business Case had been presented to the Board prior to submission to Welsh Government, to enable a three-year phased replacement programme of the Vehicle Fleet. Signoff of the Quality Impact Assessment was confirmed, in addition to endorsement of the Business Case by October's Strategic Development Committee.<br><br>Anne Carey advised that significant work had gone into preparation of this detailed case and noted that discussions with Welsh Government Colleagues indicated that the case had been considered business critical.<br><br>Nicola Williams indicated overwhelming support for the replacement of the fleet, to avoid adverse incidents which may occur as a result of ageing vehicles.<br><br>The Trust Board **APPROVED** the Business Justification Case. | |
| **6.0.0** | ***CONSENT ITEMS***<br><br>*Gareth Jones requested the removal of item 6.1.2 to allow for further discussion.*<br>*Stephen Harries requested the removal of item 6.1.3 to allow for further discussion.* | |
| **6.1.0** | **CONSENT FOR APPROVAL** | |
| **6.1.1** | **Chair's Urgent Actions Report**<br>Non Gwilym, Interim Director of Corporate Governance | |

Unconfirmed

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| | The Trust Board **CONSIDERED** and **ENDORSED** the Chair's Urgent Action taken between 20th September 2024 and 21st November 2024. | |
| **6.1.2** | **Commitment of Expenditure Exceeding the CEO Limit**<br>Non Gwilym, Interim Director of Corporate Governance<br><br>One item of expenditure had been included for Trust Board approval (Renewal of Contract for HLA Typing by Next Generation Sequencing (NGS)).<br><br>As a number of queries were raised in relation to inconsistencies regarding the dates noted within the paper, it was accepted that an oral response was insufficient and that the paper would be updated with correct details outside the meeting.<br><br>**The paper was withdrawn** and the Trust Board:<br><br>• **Did not AUTHORISE** the Chief Executive to **APPROVE** the award of the contracts summarised within this report and supporting appendix.<br>• **Did not AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements. | **MB** |
| **6.1.3** | **Alder House Increase of Rent (NWSSP)**<br>Andrew Nash, NWSSP Surveyor<br><br>Stephen Harries queried the date of the increase in annual rent noted in the paper (**effective from the 10th December 2023**) and delay in the paper being presented to the Board.<br><br>Andrew Nash advised that the rent review had been undertaken for December 2023, based on the application of RPI uplifts for the previous 5 years. As notification of the uplift was not received from the Landlord until several months later, payment of the new rent commenced (backdated to December 2023). The paper was being presented to the Trust Board at the first available opportunity following the NHS Wales Shared Services Partnership Committee.<br><br>Shared Services Finance colleagues were content that the calculations to agree the RPI had been calculated and applied correctly, prior to issue of the Rent Review Memorandum.<br><br>Andrew Nash confirmed that the building is the main Shared Services office in North Wales and therefore serves an administrative function.<br><br>The Trust Board **APPROVED** the increase in annual rent for lease contract at NWSSP Alder House, St Asaph. | |
| **6.1.4** | **Extension of Charnwood Court Lease (NWSSP)**<br>Andrew Nash, NWSSP Surveyor<br><br>Gareth Jones raised a minor point of accuracy; while the cover paper referenced a 'Heads of Terms' as the appendix, a Counterpart Lease had been attached. This, however, did not affect the approval of the lease.<br><br>The Trust Board formally **APPROVED** the lease extension and signing and sealing thereof on behalf of NWSSP. | |

Unconfirmed

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| **6.1.5** | **Trust Policies for approval**<br>Non Gwilym, Interim Director of Corporate Governance<br><br>The Trust Board **APPROVED** the following amended / new policies for adoption within the organisation:<br>• WF01 NHS Wales Respect and Resolution Policy<br>• WF08 NHS Wales Managing Attendance at Work Policy<br>• WF16 Welsh Language Policy<br>• WF57 Flexible Pension Policy | |
| **6.1.6** | **Amendment to Standing Orders – Schedule 3 Annual Review Committee Terms of Reference**<br>Non Gwilym, Interim Director of Corporate Governance<br><br>The Trust Board **APPROVED** the revisions to the Terms of Reference and Operating Arrangements in respect of the Transforming Cancer Services Programme Scrutiny Sub-Committee. | |
| **6.2.0** | **CONSENT FOR NOTING** | |
| **6.2.1** | **Approved Policies Update**<br><br>The Trust Board **NOTED** that policy IG10 VUNHST Mobile Phone Policy had been approved by the Quality, Safety and Performance Committee at its meeting held on 14th November 2024. | |
| **6.2.2** | **Public Audit Committee Highlight Report (17/09/2024)**<br><br>The Trust Board **NOTED** that the paper had not been received and would be brought to the next Trust Board meeting. | |
| **6.2.3** | **Public Strategic Development Committee Highlight Report (22/10/2024)**<br><br>The Trust Board **NOTED** that the paper had not been received and would be brought to the next Trust Board meeting. | |
| **6.2.4** | **Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports (25/09/2024 & 17/10/2024)**<br><br>The Trust Board **NOTED** that the papers had not been received and would be brought to the next Trust Board meeting. | |
| **6.2.5** | **Joint Commissioning Committee (JCC) Summary Report (15/10/2024)**<br><br>The Trust Board is requested to **NOTED** the content of the report. | |
| **6.2.6** | **NHS Wales Shared Services Partnership Committee Assurance Report (19/09/2024)**<br><br>The Trust Board **NOTED** the content of the report. | |
| **6.2.7** | **NHS Wales Shared Services Partnership Audit Committee Assurance Report (15/10/2024)**<br><br>The Trust Board **NOTED** the content of the report. | |

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| **6.2.8** | **Trust Seal Report**<br><br>The Trust Board **NOTED** the content of the Trust Board Seal Register for the period 26th September 2024 – 27th November 2024. | |
| **7.0.0** | **Date of the next meeting**<br><br>The next public meeting of the Trust Board will take place on Thursday 30th 2025 at 10:00am. | |
| **8.0.0** | **CLOSE** | |
| **9.0.0** | **It was noted that the following items would be addressed at the Private / Part B Session of the Trust Board:**<br><br>• Minutes of previous Trust Board meetings in Private<br>• nVCC Major Capital Scheme of Delegation<br>• nVCC and Enabling Works Contract Approval<br>• COVID-19 Inquiry update<br>• Health Technology Wales Scope<br>• Infected Blood Inquiry update<br>• Chair's Urgent Actions Report<br>• Commitment of Expenditure Exceeding Chief Executive's Limit<br>• Private Committee Highlight Reports | |

Unconfirmed

# ACTION LOG

| MEETING DATE | AGENDA ITEM | Action number | ACTION | LEAD | DEADLINE DATE | UPDATE (including date) | STATUS | IF CLOSED WHAT ACTION WAS TAKEN |
|---|---|---|---|---|---|---|---|---|
| **26.03.2024** | | | **VUNHST RISK REGISTER** | | | | | |
| | **4.1.0** | **1** | Detail for each phase of recruitment programme for Radiotherapy Physics Department to be provided via Vicky Morris / Quality, Safety & Performance Committee. | Interim Director of Velindre Cancer Service | **30/07/2024** | Agreed at September Trust Board that a high level update would be provided, to include number of posts required, number recruited to date, number remaining, also for consideration at the next Independent Members' meeting.<br><br>Update for September Trust Board: Recruitment on track. Detailed updates on the relevant issues are reported and monitored through IRS Project Board. Areas of concern escalated to Velindre Futures Board and where appropriate managed through Divisional Risk process. Phased plan to be shared with QSP Chair. | **PROPOSE TO CLOSE** | **Actioned 16/01/2025.** |
| **23.05.2024** | | | **VUNHST RISK REGISTER** | | | | | |
| | **5.1.0** | **2** | Re development point 12 (Trust Risk Register) – action from QSP/Audit joint extraordinary Committee in relation to further input required by IMs to be facilitated. | Interim Director of Corporate Governance | **26/09/2024** | 18 December 2024<br>Propose to close this action on the basis of the increase in the number of Independent Members included in the membership of the Governance, Assurance and Risk group and the newly established meeting schedule for the group. | **PROPOSE TO CLOSE** | **GAR group reconvened. Phase 2 plan of GAR programme under review for Audit Committee consideration in December 2024.** |
| **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** | 16 January 2025<br>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**<br>**(until adoption of Corporate Governance Manual, proposed for March 2025)** | |
| **26.09.2024** | | | **VUNHST RISK REGISTER** | | | | | |
| | **4.1.0** | **8** | Provide update on current position of risks over 16 a week prior to Board. | Interim Director of Corporate Governance | **30/01/2025** | Updated position included in January papers for Board. | **PROPOSE TO CLOSE** | |
| **28.11.2024** | | | **CHAIR'S REPORT** | | | | | |
| | **2.1.0** | **18** | Communication to be sent to Colonel Simon Lawrence (Radiology) on behalf of the Board, congratulating him on receipt of the King's Coronation Medal. | Interim Director of Corporate Governance | **30/01/2025** | Actioned 28 January 2025. | **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** | 16 January 2025<br>Target date for target rating to be reviewed at next EMB discussion of risk on 10 February. | **OPEN** | |
| **28.11.2024** | | | **VUNHST RISK REGISTER** | | | | | |
| | **4.1.0** | **20** | Review update dates (example given is risk 3338). | Interim Director of Corporate Governance | **30/01/2025** | 20 January 2025<br>Update on dates for actions conducted by Director of VCS and WBS in advance of January meeting.<br>New emphasis on management of SMART actions as part of Risk Management Training. | **OPEN** | |
| **28.11.2024** | | | **VUNHST RISK REGISTER** | | | | | |
| | **4.1.0** | **21** | To note most recent updates in the dashboard in red for ease of reading. | Interim Director of Corporate Governance | **30/01/2025** | January register includes most recent updates, as requested in Action 8. | **PROPOSE TO CLOSE** | |
| **28.11.2024** | | | **VUNHST RISK REGISTER** | | | | | |
| | **4.1.0** | **22** | Liaise with Operation and Senior Leadership Teams within both divisions to discuss risks scoring 16+ to enable inclusion of narrative regarding an up to date position within the cover paper. | Interim Chief Operating Officer | **30/01/2025** | January register includes most recent updates, as requested in Action 8. | **PROPOSE TO CLOSE** | |
| **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** | 16 January 2025<br>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. | **OPEN** | |
| **28.11.2024** | | | **TRUST ASSURANCE FRAMEWORK** | | | | | |
| | **4.2.0** | **24** | Review inconsistencies between anticipated delivery dates and update dates (page 4 of dashboard). | Director of Transformation (Interim) | **30/01/2025** | Completed. | **PROPOSE TO CLOSE** | |
| **28.11.2024** | | | **TRUST ASSURANCE FRAMEWORK** | | | | | |
| | **4.2.0** | **25** | Review presentation of dashboard to ensure that all information is visible. | Interim Director of Corporate Governance | **30/01/2025** | 22January<br>Completed. | **PROPOSE TO CLOSE** | |
| **28.11.2024** | | | **TRUST ASSURANCE FRAMEWORK** | | | | | |
| | **4.4.0** | **26** | Review wording of the Strategic Risk title of TAF03 to clarify sentence "there is a strategic risk of an optimised workforce……..". | Executive Director of Workforce and Organisational Development | **30/01/2025** | December 2024<br>Completed. | **PROPOSE TO CLOSE** | |
| **28.11.2024** | | | **PROCESS FOR CAPTURE OF PATIENT/DONOR FEEDBACK** | | | | | |
| | **4.6.0** | **27** | Circulate schedule of Patient and Carer Partnership Board meetings to Board members. | Secretariat | **30/01/2025** | Actioned. | **PROPOSE TO CLOSE** | |
| **28.11.2024** | | | **PROCESS FOR CAPTURE OF PATIENT/DONOR FEEDBACK** | | | | | |
| | **4.6.0** | **28** | Discuss mechanism for regular presentation of the patient voice at Trust Board. | Executive Director of Nursing / Interim Director of Corporate Governance | **30/01/2025** | Process confirmed to be aligned to Quality & Safety Reporting. To consider implementation of patient / donor stories at Board. | **PROPOSE TO CLOSE** | |
| **28.11.2024** | | | **PROCESS FOR CAPTURE OF PATIENT/DONOR FEEDBACK** | | | | | |
| | **4.6.0** | **29** | Confirm process for communicating to the Board actions taken by the Trust based on patient feedback. | Executive Director of Nursing | **30/01/2025** | The process is via the Quarterly Quality & Safety Reports and Annual report which will reported in full to Board from November 2024. The voice of the Patient Engagement Group to be incorporated going forward, included themes from | **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** | Updated Documentation to be circulated to IMs indepenently. | **OPEN** | |

# TRUST BOARD

## CHAIR'S UPDATE REPORT

| | |
|---|---|
| **DATE OF MEETING** | 30 January 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 (17th December 2024)
- Private Trust Board meeting (28th November 2024)
- Volunteer Christmas Party (11th December 2024)
- Christmas Message
- Meetings with Fundraisers (7th January 2025)
- Delivery Plan for Advanced Therapies in Wales Launch Event (9th January 2025)
- Chairs' meeting with the Chair of the Ministerial Advisory Group for Performance and Productivity (15th January 2025)
- Health and Care Research Wales Advisory Board Meeting (20th January 2025)
- King's New Year's Honours

## 3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

### 3.1 Board Development Sessions

One Board Development Session took place during the period (17th December 2024), to discuss the following:

- An introduction – David Donegan, Chief Executive Officer
- Key Employment Law Updates
- Learning from Reviews and Inquiries
- Long Term Agreements / Contract Rebasing

### 3.2 Private Trust Board meetings:

**28th November 2024 (regular)** - Discussions at this private meeting of the Trust Board addressed the following items:

- nVCC Major Capital Scheme of Delegation
- nVCC and Enabling Works Contract Approval
- COVID-19 Inquiry
- Health Technology Wales Scope
- Infected Blood Inquiry
- Commitment of Expenditure exceeding Chief Executive's Limit
- Band 2/3 Health Care Support Workers
- Private Committee Highlight Reports

### 3.3 Volunteer Christmas Party (11th December 2024)

The Volunteers Christmas party took place at Whitchurch Golf Club and was attended by the Chair, Chief Executive, Executive Director of Strategy & Planning and Interim Director of Corporate Governance.

The evening celebrated our new and returning Velindre Volunteers, alongside members of the newly formed Patient and Carer Partnership Board.

### 3.4 Christmas Message

The Chair shared an end of year Christmas message for everyone throughout the Trust, praising the extraordinary dedication, compassion and resilience shown by every member of the organisation and reassuring staff that their work doesn't go unnoticed or unrecognised. The opportunity was taken to wish our nurses from Kerela, India, a happy first Christmas in Wales and to welcome the return of our volunteers to the Trust. This year marks a new beginning for the Trust as we welcome our new Chief executive, David Donegan.

### 3.5 Meetings with Fundraisers (7th January 2025)

The Chair met with crafting fundraiser volunteers at the cancer centre recently. The fundraising stall is now in place two days per week in the Velindre cancer centre and, as always, is very popular with staff, patients and visitors. Plans are being developed to enable crafters to store products on site which will streamline the process and make things lot easier for our volunteers.

### 3.6 Delivery Plan for Advanced Therapies in Wales Launch Event (9th January 2025)

The Chair, along with several other members of staff, attended the Launch Event of the Delivery Plan for Advanced Therapies in Wales, which is part pf the precision medicine portfolio. Advanced Therapies Wales is hosted by the Welsh Blood Service and has an all Wales remit, whilst also linking in at a UK and international level for these important new therapies for cancer and other conditions.

The launch event marked a significant milestone in shaping the future of Advanced Therapies in Wales. The delivery plan sets out the vision, approach, organisation and priorities to enable a successful shared endeavour and to bring the benefits to improve the health, wellbeing and prosperity of the people of Wales and beyond.

### 3.7 Chairs' meeting with the Chair of the Ministerial Advisory Group for Performance and Productivity (15th January 2025)

Alongside chairs of NHS organisations in Wales, the Chair met with the Ministerial Advisory Group for Performance and Productivity. The brief of the MAG is "how do we improve productivity and performance in the areas of planned care, urgent care, diagnostics and cancer?" Given the importance of cancer performance in the work of the MAG, a meeting will be held with MAG panel members, the Chair and Chief Executive shortly.

### 3.8 Health and Care Research Wales Advisory Board Meeting (20th January 2025)

The Chair attended the January meeting of the Health and Care Research Wales Advisory Board, the main focus of which was to outline how strategic communications and engagement has raised the profile and visibility of research against the key aims of the Health and Care Research Wales Three Year Plan. Discussions also helped inform the development of a refreshed communications strategy in 2025.

A key item for discussion was the draft Genomics research strategy for Wales. This is timely because of the close association between advanced therapies and genomics in patient treatments. The strategy highlights the scientific capabilities and research strengths we have in Wales and Velindre is considered an important part of this endeavour.

### 3.9 King's New Year's Honours

Lee Wong's long and distinguished career in the Welsh Blood Service was recognised in the King's New Year's Honours with an MBE and we couldn't be more proud.

Lee has worked for the Welsh Blood Service for more than 40 years, beginning as a trainee Medical Laboratory Scientific Officer in 1980, eventually becoming Chief Medical Laboratory Scientific Officer.

Following a period of study Lee became a Fellow of the Institute of Biomedical Science and went on to head up the Reagents Laboratory. Lee has always enjoyed teaching and supporting others. She gained a post-graduate certificate in education as well as coaching and mentoring qualifications and developed National Vocational Qualifications (NVQs) for support workers, which enabled them to progress to study and become biomedical scientists.

More recently, Lee has been the National Blood Health Advisory Team Lead. Lee's contribution to the Welsh Blood Service has been immense and the Board offers its heartiest congratulations on the honour.

Velindre Cancer Charity Ambassador, Craig Maxwell, also received an OBE for his remarkable dedication to fundraising. His passion and determination to create a meaningful impact for cancer patients and their families in Wales have been truly inspiring and we are immensely proud to celebrate this well-earned honour with him. Craig, together with hundreds of dedicated fundraisers, have raised over £1.5 million in essential funds to support the cancer pathway in Wales.

## 4 IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:<br>NO | |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety and experience ☐<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐<br>• A beacon for research, development and innovation in our stated areas of priority ☐<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐<br>• A sustainable organisation that plays its part in creating a better future for people across the globe ☐ | |
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)**<br>*For more information: STRATEGIC RISK DESCRIPTIONS* | **Choose an item** |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | **Select all relevant domains below** |
| | Safe ☐<br>Timely ☐<br>Effective ☐<br>Equitable ☐<br>Efficient ☐<br>Patient Centred ☐ |
| | |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:**<br>*For more information: https://www.gov.wales/socio-economic-duty-overview* | Not required |
| | **Click or tap here to enter text** |
| **TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT** | N/A |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| | **Click or tap here to enter text** |

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

## 5 RISKS

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|---|---|
| **ARE THERE RELATED RISK(S) FOR THIS MATTER** | No |

| TRUST BOARD | |
|---|---|
| **CEO'S UPDATE REPORT** | |
| **DATE OF MEETING** | 30 January 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 CEO |
| **PRESENTED BY** | David Donegan, VUNHST CEO |
| **APPROVED BY** | Non Gwilym, Interim Director of Governance and Chief of Staff |
| **EXECUTIVE SUMMARY** | This report provides information to the Board regarding the CEO's activity since the previous meeting of the Trust Board. |
| **RECOMMENDATION / ACTIONS** | The Trust Board is asked to **NOTE** the content of the CEO'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 CEO's activity since commencing in post in December 2024.

## 2. UPDATE

2.1 I was delighted to commence in post as the new CEO of Velindre University NHS Trust at the start of December 2024. I would like to thank Carl James, our Director of Strategy & Transformation for having held the fort so well over the last 6 months, following the retirement of Steve Ham in June last year.

2.2 I also want to thank everyone across the NHS System in Wales who have made me feel so welcome, and to the Trust's Chair, Professor Mead, for putting together such a comprehensive induction and supporting me in the role.

2.3 Prior to commencing formally, I was delighted to spend time in November celebrating our wonderful blood and stem cell donors who have achieved particularly impressive milestones in saving lives across Wales. I was impressed by the altruism and commitment on show from these members of our community, and their sense of partnership with our staff. I was also struck by the contribution employers can make in making donation more accessible to their staff. I was privileged to experience becoming a donor for WBS myself in December.

2.4 Also in November, I was lucky enough to join our Charity's patron and some of those who donate their time and get others to donate their money to support us via our Charity, celebrating the major milestone of having raised 50 million pounds for the trust to-date. We heard many touching stories from patients, staff and the families of our patients and it was clear to me how much public support our services receive and the esteem that Velindre is held in by the people of Wales. It was also clear to me how this money is contributing to Velindre leading the way in many new research innovations and supporting better patient outcomes.

2.5 It is a matter of great pride for me to join and lead this impressive organisation.

2.6 As one might expect, much of my time in my first few months are being spent meeting staff, patients, donors, and colleagues within the Trust and across the NHS in Wales. These are proving very useful in understanding our services, what our stakeholders need and want from us, and identifying priorities for working together in 2025.

2.7 I have joined the Welsh NHS Leadership Board, and CEO Peer Group and held a number of meetings with senior colleagues from across the system and Welsh Government.

2.8 I attended our bi-annual JET performance meeting in December, and was pleased to receive a very favourable summary of our overall performance across most domains from Welsh Government in reviewing the last 6 months.

2.9 It was a delight to visit the nVCC construction site and see how far advanced the construction is now for our new Cancer Centre with the Full Business Case having been approved by the Cabinet Secretary in November 2024. While undoubtedly a

complex and challenging project, confidence is high that we will deliver on time, on budget, and on specification by 2027.

2.10 It was also exciting to visit Neville Hall and see the new Radiotherapy Unit progressing on time (in partnership with AB Health Board), to open to patients this summer.

2.11 We held a very valuable Exec to Exec meeting with DHCW in January, building closer links and supporting joint delivery of important improvements while understanding further risk and opportunity.

2.12 We are actively engaging with the Ministerial Advisory Group on Performance & Productivity, and reflecting with system colleagues on next steps with regards to the sobering observations outlined in the recent Audit Wales report on Cancer. I am keen to ensure that Velindre, as the provider of the national and specialist cancer centre for Wales, leads and supports others within the NHS and wider system to come together more effectively.

2.13 I have held a number of sessions connecting our teams with peers in the home nations, including with the CEO of the Northern Ireland Blood Service, Norther Ireland Cancer Centre, the Christie NHS FT, Clatterbridge NHS FT and the Deputy CEO of the Royal Marsden as part of ensuring we are looking out and collaborating with international best practice. Our WBS is already very active on an international scale, and leads on a UK basis in a number of areas.

2.14 Joining other new members of staff, I attended my Croeso induction and given the season, I had the pleasure of thanking staff and volunteers at a number of social events in the run up to Christmas.

2.15 Along with our chair, it was very pleasing also to attend the launch of the Advancing Therapies plan, under Suzanne Rankin's leadership, supported on an all Wales by a team at Velindre, given the synergies with our Blood and Cancer services.

2.16 It has been a very busy period, and I'd ask those colleagues and departments that I have not yet been to, to bear with me and by all means reach out. I really look forward to touring each of the sites where we delivery care from across Wales.

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

| | |
|---|---|
| The first Celebration Panel formally ratified Jodie Treble as an Advanced Practitioner and assessed her as meeting all the requirements of the NHS Wales Professional Framework for Enhanced, | Jodie Treble, Velindre Cancer Service |

| | |
|---|---|
| Advanced, and Consultant Clinical Practice (2023) | |
| Tessa Jowell Centre of Excellence status extended - The South Wales Neuro-oncology Centre, which includes Velindre Cancer Centre, was granted the status following an extensive process consisting of expert-led assessments, patient feedback and a virtual site visit. | Velindre Cancer Service neuro-oncology team |
| WBS Hits Stem Cell Donor Target - the Welsh Blood Service surpassed its target of recruiting 4,000 new volunteers to the Welsh Bone Marrow Donor Registry in just eight months | Welsh Bone Marrow Donor Registry |
| Our Value Based Health Care analytics work has been shortlisted for an HSJ Partnership Award in the category "Most Impactful Use of Technology on Clinical Practice". We have been named a finalist alongside The PSC. Winners announced on March 20th. | The Value Intelligence Centre, the Data & Insights Team and all cancer service members who provided valuable feedback during the design of the tool |
| Two research initiatives involving the Trust were Highly Commended in the MediWales Innovation Awards 2024 | Haemair's collaboration with the Welsh Blood Service was runner up in the Partnership with the NHS Award<br><br>BioNTech All Wales Research Collaboration was a runner up in the Health and Social Care Research Partnership Award with Industry |
| Welsh Blood Service Supports Casualty Christmas Special - The Welsh Blood Service helped producers of Casualty with their research for a special Christmas episode, and filming took place on a WBS mobile donation vehicles for the opening sequence of the episode. | Welsh Blood Service |
| New Year Honours - Hywel Peterson, the Vice-President of Velindre Cancer Charity, received an MBE in the 2025 New Years Honours.<br>Velindre Cancer Charity Ambassador Craig Maxwell was awarded an OBE for his remarkable dedication to fundraising. | Hywel Peterson and Craig Maxwell |

| | |
|---|---|
| Study Published in Clinical Oncology Journal - Dr Annabel Borley and Dr Sophie Harding have had their research on the Phesgo project published in the 'Clinical Oncology' journal. | Dr Annabel Borley and Dr Sophie Harding |

## 4 IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:<br>NO | |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety and experience ☐<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐<br>• A beacon for research, development and innovation in our stated areas of priority ☐<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐<br>• 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**<br>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

## TRUST RISK REGISTER UPDATE

| | |
|---|---|
| **DATE OF MEETING** | 30 January 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:<br>• Highlights the current extract of risk registers for risks scoring 12 and above for Quality/Safety and 15 above for all other domains;<br>• allows the Trust Board to have effective oversight and assurance of the way in which risks are being managed across the Trust;<br>• 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:<br>• **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 | 05.12.2024 |
| WBS SLT | 11.12.2024 |
| Executive Management Board | 08.01.2025 |
| Quality, Safety and Performance Committee (QSP) | 16.01.2025 |

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

*Summary of EMB discussion:*
The overall level of assurance for the risk register was maintained at 2, indicating that while progress has been made, there is still work to be done to improve the position, especially in terms of the operational management of Datix. Urgent awareness and understanding training should be implemented.

Emphasis was placed on the need for the inclusion of target dates to deliver all actions and for target dates for achieving a reduction in the risk scores.

*Summary of QSP discussion:*
The overall level of assurance was agreed as appropriate at Level 2.

Committee members emphasised the need for SMART actions, mirroring discussion around training in terms of operational management on Datix.

A discussion point was a review of the TRR risks that appear to be a duplication. Since the meeting, risks have been reviewed, and closures made, for transparency this risk has been marked in red on Appendix 1, for ease of reference.

Independent Members requested the inclusion of information, specifically likelihood and impact scores, to support risk scores to enable assessment of changes in risk scoring and the effectiveness of mitigations and actions in place. This information is included in the report.

The Interim Director of Velindre Cancer Service reviewed the risks, as per the request of the Board on w/c 20 January and the documentation has been revised with changes noted in this cover paper and Section 2 of Appendix 1.

| | |
|---|---|
| **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 of 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) prior to monthly consideration by the Executive Management Board.

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 December) a total of 25 risks report onto the Trust Risk Register in line with the Trust's risk appetite.

- Nine risks with a score of 12 or above reported in the safety/quality domain.
    - eight on the VCS register
    - one on the WBS register.
- Sixteen risks with a score over 15 or above reported in other domains.
    - fourteen on the VCS register
    - two on WBS register.

As requested by the Trust Board in November, Appendix 1 has been reviewed by the Interim Director of Velindre Cancer Service w/c 20 January to provide the Board with the latest position at the end of the reporting period.

Following further review, it was confirmed that:

Risk 4 – was closed as of 6 January 2025 due to duplication.

Risk 5 – was reduced to 9 during reporting period as a result of further actions being complete.

Risk 6 - was closed following confirmation of restricted access to MRI Controlled Access Area, Communications to be shared with staff.

Risk 7 – was reduced due to volume of MR compatible equipment. Monitor with anticipated closure end of January 2025.

Risk 8 – was reduced during the reporting period due to numbers reducing month on month, maintaining less than 30.

Risk 9 – was reduced during the reporting period. Current risk rating reduced from 16 to 12 due to completed actions.

Risk 16 – was reduced to 8 as a result of actions completed and service able to deliver full expansion plan.

Risk 17 – was reduced during the reporting period following Finance colleagues' discussions with WG.

Risk 20 – was closed on 20 January 2025 following confirmation that the CEX will attend as the Executive representative in line with other NHS Wales organisations.

Risk 21 – was reduced during the reporting period.

Following review, 15 risks remain on the public Trust Risk Register:

- Four risks with a score of 12 or above reported in the safety/quality domain.
  - three on the VCS register
  - one on the WBS register.
- Eleven risks with a score over 15 or above reported in other domains.
  - nine on the VCS register
  - two on WBS register.

Section 2 of Appendix 1 (public Trust Risk Register) notes the closed and reduced risks during the reporting period.

### 2.3 Risk Themes

During the reporting period, three areas of work reported multiple risks.

Some of the individual risks in these groups were reduced/closed during the reporting period.

#### a. Systemic Anti-Cancer Treatment

Significant work was undertaken during 2024 to enhance SACT delivery and develop a clear SACT improvement plan. This transformation work includes all aspects of the SACT pathways, from pre-SACT clinics to delivery - including Pharmacy capacity. Although the position has improved and performance has been more consistent across recent months, delivery of the 21-day treatment standard remains fragile.

Given the improving picture and the infrastructure in place to ensure focus and oversight, it was agreed that Business Continuity arrangements could be stood down from December 2024. The oversight of SACT has now moved into enhanced monitoring arrangements (SACT Steering Group) with a plan to transition to business-as-usual arrangements once improvement against the plan is robust and sustainable.

In addition, the Executive Management Board approved the implementation of the Chemocare Upgrade which will mitigate against some of the related risks.

Some of the relevant SACT risks remain highly scored on the VCS risk register. It is anticipated that the planned additional capacity and the revised SACT pre-assessment processes will further reduce risk and the individual risks will continue be reviewed as the work progresses.

**b. Medical Staffing**

Work is underway to move from the current consultant-delivered model to a consultant-led SACT model. 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.

Some SST specific work is underway with teams e.g. skin/melanoma to understand their local speciality needs.

**c. Transforming Access to Medicines (TrAMS)**
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.

**2.4 Welsh Blood Service, based on November 2024 data and analysis by the WBS Senior Leadership Team on 11 December 2024**

All WBS risks on the Trust Risk Register are scoring consistently with the scores reported in the November cycle.

## 2 KEY MATTERS - Summary of Actions Taken/ In Plan from Recent Governance Cycle

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

A workshop took place on 05 December 2024 to review risk process for the Major Programme team, with particular attention paid to the alignment of programme risk reporting with the Trust Policy and use of Datix. The Risk and Assurance Manager is working with the Project Team to ensure all risks reportable to Trust Board are on Datix.

**3.4 Reviewing the Trust's Risk Management Policy**
Work to review the Trust's Risk Management Policy and Procedure is ongoing.

Consultation has taken place with the following stakeholders:
- The VCS Senior Leadership Team and members of the VCS Trust Quality Hub
- The VCS Senior Leadership Team meeting
- A meeting of members of the Trust, WBS and VCS Quality Hubs
- Chief Operating Officer, Director of VCS and Director of WBS

The Risk and Assurance Manager is undertaking a review of all risks under the risk appetite level as instructed by the Audit Committee for completion by the March 2025 Audit Committee meeting.

The Manager is also undertaking a benchmarking exercise comparing current and historic Trust risk reports against those compiled by other NHS Wales/England 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.

## 5. IMPACT ASSESSMENT

| **RELATED TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please tick all relevant goals:<br>. Outstanding for quality, safety and experience ☒ | |
| **RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK** | 06 - QUALITY & SAFETY06 - QUALITY & SAFETY |

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>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**

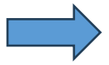
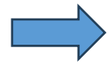
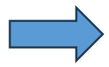
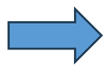
Trust Board January 2025

Please not, risk scores are calculated by multiplying the likelihood of the risk by the impact of the risk.

| 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<br>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**<br>(4 x 4) | **12**<br>(3 x 4) | **4**<br>(2x2) | → | 1. T&F group to be established<br>2. Action plan developed for outstanding actions –<br>3. Audit to be reviewed<br>4. Email guidelines and protocol to be produced for Trust. | 07.01.2025<br>Action plan in place. T&F group progressing actions. Key actions due to be complete April 2025. |
| 2 | 2187<br>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**<br>(5x5) | **12**<br>(3x4) | **8**<br>(2x4) | → | 1. Complete comprehensive 5 year workforce plan to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite Service and the transfer of services to nVCC.<br>2. Re-advertise IRS implementation lead for the development of novel techniques<br>3. Work with new the Head of Engineering to develop scrutiny business case for engineering, pending retirements. 16/10/2024 | 28.11.2024<br>1. Benchmarking taken place. Workforce plan completed Q3 but currently on hold.<br>2.Advertised x3, unsuccessful this round. New recruitment campaign to commence from 24.01.25.<br>3.Complete. |

**TRUST RISK REGISTER**

Trust Board January 2025

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | 3431<br>24.07.2024 | Medical | Quality | Consultant | 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**<br>(5 x 4) | **16**<br>(4 x 4) | **4**<br>(2x2) |  | 1. Align risk with SACT prioritisation work.<br>2. Establish recruitment plan.<br>3. patients prioritised for VAP | 16.01.2025<br>1. Risk actions now included as part of SACT prioritisation work. Work undertaken to understand the capacity gap working with SACT improvement lead<br>2. New SCP pre-SACT assessment advanced practice roles – job out to advert, closing end of month. Applications have been received.<br>3. Patients transitioned to VAP. |
| | **15+ Risks in other domains** | | | | | | | | | | |
| 10 | 3270<br>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**<br>(4x4) | **16**<br>(4x4) | **4**<br>(2x2) |  | Ongoing conversations about a workforce transformation.<br>Posts are being recruited to. Risk will be reviewed when posts in place. | 05.11.2024<br>Following review, inherent risk has increased from 12 to 16 due to inability to recruit to SAS doctors.<br><br>Agreed to go back to advert January 2025. |
| 11 | 3332<br>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**<br>(4x4) | **16**<br>(4x4) | **4**<br>(1x4) |  | 1. Recruitment of x2 SAS doctors and support structure to provide additional clinics.<br>2. Recruitment of Independent prescribers to support wider outpatient workforce model as identified within the pre-SACT assessment and business case. | 28.11.2024<br>1. recruitment of SAS doctors unsuccessful. To go back out to advert<br>2.IP recruitment process being undertaken. Shortlisting to commence. Interviews planned 31/01/2025 |
| 12 | 3392<br>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**<br>(5x4) | **20**<br>(5x4) | **6**<br>(2 x3) |  | 1. Proactive recruitment into vacant posts.<br>2. Timetable review to ensure appropriate skill mix.<br>3. Delayed launch of future service expansion until workforce has stabilised – specifically HPB/Pancreatic clinic cover. | 09.01.2025<br>1. Locum appointed<br>2. Agreement to actively recruit to key posts.<br>- Band 8a Professional Lead - interviews 21st January 2025<br>- Band 7 H&N Specialist - appointed - estimated start date 10th February 2025<br>- Band 7 UGI Specialist - out to advert<br>- Band 6 Specialist - Will advertise next week to align with recruitment into band 8a post. |

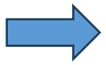
**TRUST RISK REGISTER**

Trust Board January 2025

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 13 | 3448<br>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**<br>(4x4) | **16**<br>(4x4) | **4**<br>(1x4) | → | 1. Baseline review to be undertaken benchmarking against other cancer Services to be complete.<br>2. Conversation to take place with Clinical Director, Palliative Care and Clinical Director, Acute.<br>3. meeting with current palliative care team and SLT to discuss CAT and contact to be made with regional CAT lead 7th February | 05.12.2024<br>1. o/s<br>2. Meeting with Clinical Director Palliative Medicine held November 2024<br>3. meeting with current palliative care team and SLT to discuss CAT and contact to be made with regional CAT lead 7th February |
| 14 | 3461<br>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**<br>(3x5) | **12**<br>(4x3) | **5**<br>(1x5) | → | Pharmacy Led pre-upgrade work:<br>1.Development of User Defined Worksheets and Labels:<br>by the end of October 2024. | 16.01.2025<br>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.<br>In terms of ChemoCare Upgrade Project Start, the date has not been confirmed.<br><br>26.11.2024<br>Nov 12th 2024 discussion between EMB/SLT/Digital colleagues agreeing requirement for ChemoCare Upgrade to commence as soon as viable. Digital Project Manager has been identified and process of beginning PID etc with system supplier to commence shortly. Aim to begin project Jan/Feb 2025 |

**TRUST RISK REGISTER**

Trust Board January 2025

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 15 | 346812.09.2024 | 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) |  | 1.Continue to pay on session to an academic to support the SACT clinic once a week.<br><br>2.Discussion with existing post holder in relation to delaying resignation date<br><br>3. Discussion with Health Board across the region in relation to gaps in service<br><br>4.Currently out for Expression of Interest on BMJ and social media platforms Linked In and Twitter/X. Contacted international recruitment agencies asking for clinical/medical oncologist. | 28.11.2024<br>1.Will continue to pay on session to an academic to support the SACT clinic once a week.<br>2. agreed to extend resignation date for 12 months<br>3. CAV escalated to Executive Function to consider providing support<br>Discussion with SBUHB to share sarcoma CNS.<br>4.recruitment process continuing.<br><br>16.01.2025<br>Proposed risk reduced from 16 to 12 due to Consultant agreement, in principle, to stay Dec 2025. |
| 18 | 3538<br>New to risk register as of 02.12.2024 | 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) | New Risk | 1. A contingency plan is being developed for consideration by VUNHST TrAMS Project Board and subsequently VCSF Board2025. | 8th Jan 2025. Draft options appraisal discussed at Jan VCS TraMS Programme Board. Next step, to discuss with Executive professional leads - in process of being arranged.<br><br>Further discussion with VUNHST triumvirate - paper to be updated for EMB consideration in February. |
| 19 | 3541<br>New to risk register as of 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) | New Risk | 1. Option appraisal being developed in response to potential delay in TrAMS project resulting technical pharmaceutical services not being available in advance of nVCC. | 8.01.25<br>Draft options appraisal discussed at January VCS TraMS programme board. Next step to discuss with Exec professional leads in process of being arranged. |
| 22 | 2249<br>New to Risk Register due to rating increase as of 27.11.2024 (from 9 to 16) | 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. | **9** (3x3) | **16** (4x4) | **6** (2x3) | New to Risk Register | 1. At risks posts to be identified as part of IMTP 2025/26 and business cases developed as requested for discussion with Commissioners. | 06.01.2025<br>Business cases have been submitted. |
| | **Welsh Blood Service** | | | | | | | | | | |
| | **12+ Risks in the Quality and Safety domains** | | | | | | | | | | |

**TRUST RISK REGISTER**

Trust Board January 2025

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| 23 | 2774<br>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**<br>(4x4) | **12**<br>(3x4) | **4**<br>(1x4) | | 1. Discovery and planning Transformation Workstream:<br>process redesign and system configuration.<br>2. Data workstream: migration of legacy data<br>3. Application workstream: build of environments, database and interfaces. | 03.01.2025<br>Trend/Direction of Travel - no movement. 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.<br><br>Configuration of HistoTrac system and migration of Legacy data is underway. UAT expected to start by end Jan 2025, validation expected to commence April 2025 and go live planned for June/July 2025<br><br>All activity on track for planned go live 30/06/2025. |
| | **15+ Risks in other domains** | | | | | | | | | | |
| 24 | 3350<br>04/03/24 | 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. | **15**<br>(5x3) | **15**<br>(5x3) | **12**<br>(3x4) | | Review of risk assessment required by 25/12/2024. | 22/10/24<br>BJC signed off by SLT, and to be endorsed by SDC for Trust Board approval. |
| 25 | 3306<br>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**<br>(4x5) | **15**<br>(3x5) | **5**<br>(1x5) | | Review of risk assessment required by 27/01/2025. | Tender exercise completed for WBS electrical resilience (ACB replacement). Currently working with departments to complete critical list of equipment to produce end to end plan. This information will support a robust risk assessment for identified works. Work estimated for completion Dec/ Jan 24/25 pending WBS operational requirements.<br>Risk assessment on track for target date. |

**TRUST RISK REGISTER**

Trust Board January 2025

**Section 2 - summary of risk movement since Quality, Safety and Performance Committee review, undertaken by Interim Director of Cancer Service w/c 20 January**

Risk 4 – was closed as of 6 January due to duplication.

Risk 5 – was reduced to 9 during reporting period as a result of further actions being complete.

Risk 6 - was closed following confirmation of restricted access to MRI Controlled Access Area, Communications to be shared with staff.

Risk 7 – was reduced due to volume of MR compatible equipment. Monitor with anticipated closure end of January.

Risk 8 – was reduced during the reporting period due to numbers reducing month on month, maintaining less than 30.

Risk 9 – was reduced during the reporting period. Current risk rating reduced from 16 to 12 due to completed actions.

Risk 16 – was reduced to 8 as a result of actions completed and service able to deliver full expansion plan.

Risk 17 – was reduced during the reporting period following Finance colleagues' discussions with WG.

Risk 20 – was closed on 20 January following confirmation that CEX will attend as the Executive representative in line with other NHS Wales organisations.

Risk 21 – was reduced during the reporting period.

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| 4 | 3472<br>19.09.2024 | Velindre Cancer Service | Safety/Quality | Consultant | There is a risk to patient safety as a result of the DHCR system not allowing outpatient oncology notes to be rapidly identified. | **16** Likelihood 4 x Impact 4 | **16** Likelihood 4 x Impact 4 | **2** Likelihood 1 x Impact 2 | RISK CLOSED | 1. Engage with relevant officers at DHCW to discuss the relevant issues. | This risk was closed as of 06.01.2025<br><br>Narrative within the risk has been reviewed and the risk is not clear.<br><br>Following review, there is a separate risk linked to use of OON to record information relating to other clinical activities such as SACT delivery in the absence of another data space within the electronic record. |

**TRUST RISK REGISTER**

Trust Board January 2025

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| 5 | 3346<br>11.03.2024 | Velindre Cancer Service | Safety | Head of Outpatients and Medical Records | There is a risk that the continuation of safe patient care and financial income may be adversely affected due to the delay in the processing of outpatient activity. | **12** Likelihood 3 x Impact 4 | **9** Likelihood 3 x Impact 3 | **6** Likelihood 2 x Impact 3 | RISK REDUCED ↓ | 1.Review of Current PAS system to develop Change Request Documentation to National CAB to deliver Workflow functionality.<br>2.Review of demand and capacity and development of Workforce Plan. Workforce Plan to incorporate head room.<br>3.Urgent request for increase in Bank Staff to process activity (which does not fall into the rapid returner category) to enable reporting timelines to be achieved to reduce financial risk.<br>4.Implementation of new medical secretarial team model to support the implementation of standardised ways of working and consistency with pr and post clinic checks. | 1.Complete<br>2.Complete. Outcome, x2 new roles, review of banding and increase to band 4<br>3. Complete 1/11/2024<br>4. In place.<br><br>Risk reduced to 9 during reporting period as a result of further actions being complete. |
| 6 | 2233<br>27.05.2020 | Radiology | Safety | Head of Radiology | There is a risk to patient, staff and MRI scanner safety as a result of inadequate controlled access to the MR Controlled Access Area. This could lead to injuries to staff, patients or damage to the equipment. | **15** Likelihood 3 x Impact 5 | **12** Likelihood 3 x Impact 4 | **4** Likelihood 1 x Impact 4 | RISK CLOSED | 1. Fixed security door to be installed. | Risk closed following confirmation of restricted access to MRI Controlled Access Area, Communications to be shared with staff.<br><br>15.01.2025<br>New approved user list for badge access now limited and with approval from Radiology Manager. Most extraneous personnel excluded risk considerably reduced. |
| 7 | 3513<br>New risk to Trust Risk Register<br>08.11.2024 | Radiology | Safety | Radiology Services | There is a risk to patient, staff and equipment safety as a result of attraction to the magnet (non-ionising radiation) which may occur from unauthorised access to the MR Environment from the waiting area, leading to patient or staff harm. | **15** Likelihood 3 x Impact 5 | **8** Likelihood 2 x Impact 4 | **2** Likelihood 1 x Impact 2 | RISK REDUCED ↓ | | 07.01.2025 risk rating changed as all mitigation feasible is in place.<br><br>Reduced due to volume of MR compatible equipment.<br>Monitor with anticipated closure end of January. |

**TRUST RISK REGISTER**

Trust Board January 2025

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| 8 | 3215<br>28.10.2024 | Health Records | Safety | Head of Outpatients and Medical Records | There is a risk that clinical instruction or information may not be received or acted on by primary or secondary care medical colleagues for patient management due to clinical correspondence not being signed off via the Document Management System (DMS). | **16** Likelihood 4 2 Impact 4 | **8** Likelihood 3 x Impact 4 | **6** Likelihood 3 x Impact 2 | RISK REDUCED | 1. Continue escalation to clinical staff.<br>2. Review of the Document Management System Dashboard daily by Health Records Manager.<br>3. Heath Records Manager to review outstanding correspondence for potential issues. | Risk reduced during the reporting period. Numbers reducing month on month, maintaining less than 30. We continue to review and anticipate closure in 3 months following monitoring providing position continues to improve and is maintained.<br><br>03.12.2024<br>Review and escalation in place. Communication targeted to individuals, to complete sign off process. The report includes false positives, and these are being managed separately. |
| 9 | 3247<br>8.11.23 | Medical | Workforce | Head of Outpatients and Medical Records | There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times. | **16** Likelihood 4 x Impact 4 | **12** Likelihood 3 x Impact 4 | **9** Likelihood 3 x Impact 3 | RISK REDUCED | 1. Clinic templates to be reviewed to manage patient flow<br>2. Full review of demand and utilisation of capacity within OPD.<br>3. Business case to be developed to obtain funding to covert accommodation to delivery an additional four consultation rooms.<br>4. further 2 consultation rooms being created will be handed to service by end of February | 1. Action ongoing as good practice<br>2.Baselining clinic demand has been completed. Review of room allocation to be completed, with the aim of aligning to the SST way of working.<br>3. Capital monies agreed for two additional consultation rooms. Estates Department obtaining quotes.<br>4. Anticipated handover end of January 2025.<br>5. Risk reduced due to completed actions. Anticipated further reduction in risk at handover of 2 rooms |
| 16 | 3478<br>23.09.2024 | Velindre Cancer Service | Performance & Sustainability | Chief Pharmacist | There is a risk that Pharmacy Expansion Plan cannot be implemented in full caused by inability to recruit into the 1.26 wte Band 7 Pharmacist post which is a key requirement for the final step up in capacity for the 15 regimens per week (Cleaning) and 40 regimens per week (Outsourcing). | 16 Likelihood x Impact | 8 | 4 Likelihood x Impact | RISK REDUCED | 1. Exploring use of locum to cover time period before appointment of Band 7.<br>2. Substantive post to be re-advertised in early new year and to consider at the point option of including, "subject to attainment of the relevant post-grad qualification" (this will not overall delay start date of post given academic term dates of potential applicants).<br>3. Advice to be sought from VCC WF and OD partner as to potential to release pharmacist capacity by job planning solution. Action to re-advertise band 7 post has been brought forward to November. | Risk reduced to 8 as a result of actions complete, and able to deliver full expansion plan.<br><br>Anticipated risk to be closed once substantive pharmacists starts Feb 2025.<br><br>1. Locum Pharmacist onboarded. Locum Pharmacy Technician due to start in post 2 Jan 2025. With these in post, Pharmacy to deliver full capacity as outlined in expansion plan w/c 13 Jan 2025<br>2. Substantive Pharmacist recruited Dec 24 - anticipated start date at VCC March 2025. Substantive Technician - anticipated start date at VCC Feb 25. Subsequent training for both post holders |
| 17 | 3517<br>New to risk register as of 05.12.2024 | Velindre Cancer Service | Financial Sustainability | CSMO Project Manager | There is a risk to the financial balance of the trust. As a result of no agreement to fund the revenue costs (post implementation of EPMA) for the duration of the contract. Leading | **16** Likelihood 4 x Impact 4 | **8** Likelihood 2 x Impact 4 | **4** Likelihood 1 x Impact 4 | RISK REDUCED | 1. Business case being submitted to Commissioners as part of IMTP 2025/28 process. | 10.02.25<br>Inherent risk was reduced during the reporting period following Finance colleagues' discussions with WG. |

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| | | | | | to the Trust's financial balance being in deficit. | | | | | | |
| 20 | 3542<br>New to risk register as of 02.12.2024 | Velindre Cancer Service | Multiple Risk Domains (Quality, Safety, Performance and Service Sustainability) | Director of Cancer Service | There is a risk that decisions made within the NWSSP TrAMS Programme could negatively impact VCS service delivery as a result of the current governance arrangements, leading to operational challenges for the Trust including, financial and sustainability risks. | **16** Likelihood 4 x Impact 4 | **16** Likelihood 4 x Impact 4 | **8** Likelihood 2 x Impact 4 | RISK CLOSED | 1. Confirm VUNHST Executive representation on National Programme Board | This risk was closed on 20 January 2025.<br><br>Confirmation received that the CEX will attend as the Executive representative in line with other NHS Wales organisations. |
| 21 | 3543<br>New to Risk Register as of 02.12.2024 | Velindre Cancer Service | Financial Sustainability | Chief Pharmacist | There is a risk to financial sustainability of VUNHST as a result of increased costs within the business cases for Radiopharmacy and the TrAMS hub, that the LHB commissioners do not accept, leading to cost pressure for the Trust1 | **5** Likelihood 5 x Impact 15 | **3** Likelihood 3 x Impact 1 | **8** Likelihood 2 x Impact 4 | RISK REDUCED ↓ | 1. Costs included in IMTP 2025-2028 for consideration by Commissioners. | Scoring has been reviewed. The score falls below the Trust's risk appetite level for the Trust Risk Register.<br><br>Rationale for changing in scoring: in conjunction with Finance, impact reduced to reflect the scoring matrix aligned to TAF. |

# TRUST BOARD

## TRUST ASSURANCE FRAMEWORK UPDATE

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| **DATE OF MEETING** | 30 January 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** | To provide the Trust Board with the opportunity to review the updates to the Trust Assurance Framework and the actions planned for the next period. |
| **RECOMMENDATION / ACTIONS** | The Trust Board is asked to **NOTE** the current status and on-going management of the Trust Assurance Framework. |

| **COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING** | |
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| **COMMITTEE OR GROUP** | **DATE** |
| **Executive Management Board** | 08.01.2025 |
| **Quality, Safety and Performance Committee (QSP)** | |

EMB discussed the updated noted. There was agreement to explore the inclusion of a succinct narrative from the Executive Leads on the latest position in the cover paper in future reports.

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| EMB also discussed the need to progress with pace the next phase of development for the 2025-26 TAF which will be developed as part of the IMTP process.<br><br>Quality Safety and Performance Committee<br>The Committee noted<br>- progress made with the template and the cycle of review.<br>- discussed the merits of including a summary from strategic risk leads to be included for the March cycle of reporting. | |
| **ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR** | 2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed. |
| **APPENDICES** | |
| 1 | Strategic Risks |
| 2 | Trust Assurance Framework |

## 1. SITUATION

### 1.2 Trust Assurance Framework

The Trust Assurance Framework (TAF) was established in 2020.

The Trust Assurance Framework template was reviewed and updated further in consultation with the Audit Committee in early 2025. A refreshed Trust Assurance 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 TAF was presented to Board in November.

| Number | Risk Title | Movement since last reporting period |
|---|---|---|
| **TAF 1** | There is a strategic risk of failure to deliver timely, safe, effective and efficient services for | • **Risk 2187**<br>Added from the Trust Risk Register dated 18.12.2024<br>• **Action 01.01 updated on December 2024** |

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| | the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources. | 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.<br>• **Action 01.03 updated on December 2024**<br>Business case has been produced and presented to commissioners for consideration of funding uplift to support improved collection of blood throughout Wales. |
| **TAF 2** | 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. | • **Action 02.01 updated 08.01.25**<br>Completion update amended to March 2025.<br><br>Progress against PMF packages of work are tracked in Quality, Safety and Performance Committee and Trust Board<br><br>• **Action 02.03 updated 08.01.25**<br>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. |
| **TAF 3** | There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives. | • **Change to the Risk Title following Trust Board 28 November:**<br>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.<br>• **Risk added from Trust Risk Register**<br>Risks 3468 and 2187 have been added as detailed on the Trust Risk Register 18.12.2024.<br><br>• **Action 03.06 updated December 2024:** |

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| | | 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.<br><br>• **Action 03.08 updated December 2024:**<br>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<br><br>• **Action 03.09 updated November 2024:**<br>Contact with HEIW to scope train the trainer programme and costs<br><br>• **Action 03.10 updated December 2024:**<br>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.<br><br>• **Action 03.11 updated December 2024**<br>01.10.2024 New Attraction and Resourcing Lead appointed to take actions from the project forward.<br><br>14.10.2024 Options paper for recruitment campaign agreed to EMB.<br><br>• **Action 03.12 updated December 2024**<br>Nurse Retention Plan currently in draft. Divisional Heads of Nursing added as co-owners with Nicola Williams. Due date moved to April 2026 as work has not commenced. |

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| | | • **Action 03.13 was completed December 2024**<br>Learning from implementation of the Nurse Retention used to develop a Trust Retention Plan. |
| **TAF 4** | 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 | • **Action 04.05 was updated December 2024**<br>Culture Framework is in development. Engagement sessions took place with senior leaders in November 2024. Culture Framework encompasses the speaking up safely mechanisms.<br>• **Action 04.06 completed in December 2024**<br>Paper going to EMB in December 2024.<br>• **Action 04.07 updated in December 2024**<br>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.<br>• **Action 04.08 updated in December 2024**<br>Compassionate Leadership Pledge was signed on 26 September 2024 by leaders in the Trust. Action plan is in development and will be governed by the People Development and Education Steering Group.<br>• **Action 04.09 Updated December 2024**<br>Paper being submitted to Healthy and Engaged Steering Group on 19.12.2024.<br>• **Action 04.10 Updated December 2024**<br>Regular updates have been submitted to EMB, committees and Trust Board. An assurance level of 3 was agreed. |
| TAF 5 | 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 | • **Action 05.01 updated November 2024**<br>Digital Design Authority will meet for the first time on the 12 December. Impact of change on risk noted as inclusion of ToR for the Digital Design of Authority captured in the Digital Programme.<br><br>• **Action 05.02 updated November 2024** |

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| | considerations of Artificial Intelligence and Information Security | Data and Insight formative paper due at SDC in Feb '24. Prioritisation paper presented to EMB in Nov '24<br>Data and Insight included as part of the Change Advisory Board for Control 9. Additional resource being recruited<br><br>• **Action 05.03 updated November 2024**<br>Digital strategy and plan approved by EMB Nov '24 and on Dec '24 SDC agenda |
| TAF 6 | 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. | • **Overall trend in assurance updated December 2024**<br>Assurance level rating takes into account output from discussions with VCS in December workshop<br><br>• **Action 06.05 updated December 2024**<br>Refresh of GAR underway to be discussed by GAR group on 20 January 2025, to include revised reporting mechanisms.<br><br>• **Action 06.06 updated December 2024**<br>Benchmarking underway against key NHS Wales and UK organisations (cancer and blood). Activity ongoing, no firm date for completion.<br><br>• **Action 06.07 updated 06.01**<br>GAR Group meeting in January to decide on programme scope.<br><br>• **Action 06.08 updated 06.01**<br>Risk Policy Review Group meeting scheduled for 15 January |
| TAF 7 | 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 | • **Control C3 updated December 2024**<br>Key Control updated, "Multiprofessional Workforce Planning which includes a workforce tool and the practice of benchmarking and incorporating Royal College guidance.<br><br>Control effectiveness level updated from not yet effective to partially effective. |

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| | transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics. | • **Control C4 updated December 2024**<br>Key control descriptor updated "Quality and Safety monitoring (via PF and AMaT Quality and Regulatory tracker)."<br><br>Control effectiveness level updated from not yet effective to partially effective.<br><br>Assurance rating updated from negative assurance to inconclusive assurance.<br><br>• **Control C12 added December 2024**<br>"SACT Transformation Programme established to deliver the SACT Improvement Plan". The control has a partially effective control effectiveness rating and an inconclusive assurance rating.<br><br>• **Risks added from the Trust Risk Register**<br>Risks 3338, 3431, 3270, 3392 and 3468 were added to TAF 07 from the Trust Risk Register.<br><br>• **Action 07.03 updated December 2024**<br>Initial quality, safety and outcome metrics& implementation plan agreed Oct 24- development commenced - 12 week development programme<br><br>• **Action 07.04 updated December 2024**<br>Implementation Working Sub-Group established within VCS.<br>Business Case for digital PROMS approved. Procurement now delayed for Q4 due to need for due diligence of supplier. Preparatory work nearing completion with Prostate, Lung and Neuro-Oncology for phase 1 implementation. 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 |

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| | | purposes, including at Board level. This is expected in Q1 25/26 for the areas which will have PROMS deployed<br><br>• **Action 07.05 Updated December 2024**<br>Conversations commenced with DHCW re: hospital initiated referrals, including COO and Chief digital officer.<br><br>DHCW indicated potential date of April 2025. Interim position is to adopt internal supported system. Finalisation of position to be confirmed w/c 9th December 2024<br><br>• **Action 07.06 Updated December 2024**<br>General Outpatient Booking, process reviewed and pre and post clinic checks supported by SOP, data quality report to support management of activity, escalation 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.<br><br>• **Action 07.07 Updated December 2024**<br>New workforce model in place, relocation of helpline complete, amendments to clinical tool complete, funding secured for 12 months to develop patient education.<br><br>• **Action 07.08 Updated December 2024**<br>Description updated "Transformational multi professional workforce plans across all areas of the cancer service"<br><br>Team job planning currently taking place across the SSTs. Workforce plans to support RSU being implemented with move to medical light model. |

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| | | • **Action 07.09 and 07.10 updated December 2024**<br>Significant work undertaken in respect of mortality review oversight - SACT mortality added to PMF - Work remains underway.<br><br>Action 07.11 updated December 2024<br>phase 1 roll out to radiotherapy to commence January 2025. Phase 2 roll out to wider Division April 2025<br><br>• **Action 07.13 updated December 2024**<br>Clinical & Scientific Board established. Clinical and Scientific Strategy has been approved by Trust Board (September 2024) Clinical & Scientific Manager appointed commencing 6.12.2024 (date included)<br><br>• **Action 07.15 added December 2024**<br>"Establish a regional delivery group to support the work from the Regional Cancer Meeting"<br><br>Regional Cancer Board re-established, active participation by VUNHST<br><br>• **Action 07.16 added December 2024**<br>"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"<br><br>Paper to EMB outlining proposal, funding identified and in process of going to procurement for identified system. |
| TAF 8 | 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 | • **Risks added to Trust Risk Register**<br>Four new risks have been added to the Trust Risk Register relating to TAF 8; 3517, 3543, 2249 and 3537, which is a private risk.<br><br>• **Action 08.01 updated 09.01.25** |

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| | use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive. | 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 project kick-off. Formal kick-off meeting scheduled for 13th Jan '25. Implementation due to be completed by end of Mar '25.<br><br>• **Action 08.02 was updated 08.01.25**<br>Medicines Strategy Group established by SRO (Medical Director) for Medicines Group with first meeting to be held Jan '25.<br><br>• **Action 08.03 was updated 08.01.25**<br>Final Audit Report was received at Dec '24 Audit Committee with reasonable assurance. Management actions agreed to respond to small number of recommendations<br><br>• **Action 08.04 was updated 08.01.25**<br>Investment appraisal process, prioritisation framework and business case templates have been obtained from AB and C&V Health Boards and will be used to help inform development of the Velindre process.<br><br>• **Action 08.05 was updated 08.01.25**<br>Liaison Financial external consultants have been re-engaged for Jan - Mar '25 to support the Trust in completion by 31.03.5 of the remaining financial / commercial actions in the private patient improvement plan which are to negotiate new contracts with the three main insurance companies revisions to tariffs, additional 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 .<br><br>• **Action 08.06 was updated 08.01.25** |

| | | |
|---|---|---|
| | | 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<br><br>• **Action 08.07 was updated 08.01.25**<br>Work completed to ensure RT treatment activity 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 |

All changes within the TAF since November 2024 have been marked in red in Appendix 2.

## 4 IMPACT ASSESSMENT

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

| | |
|---|---|
| **RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK** | 06 - QUALITY & SAFETY |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | Tick all relevant domains.<br>Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>Patient Cantered ☒<br>The risk register and associated risk framework are imperative to quality and safety in the organisation. |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED** | Not required - there are no socio-economic impacts linked directly to the current risks in paper. |
| **TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT** | A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health<br>The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| **EQUALITY IMPACT ASSESSMENT** | No - Include further detail below<br>There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate. |
| **ADDITIONAL LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report |

## 3 RISKS

| | |
|---|---|
| **ARE THERE RELATED RISK(S) FOR THIS MATTER** | Yes |

| | |
|---|---|
| **WHAT IS THE RISK?** | The strategic Risks outlined in the TAF are informed by the Trust's active management and reporting of its operational risks. |
| **WHAT IS THE CURRENT RISK SCORE** | n/a |
| **HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?** | Consideration of the impact of the actions outlined in this paper on the current scoring of the strategic risks will be managed by the Executive Management Board at its monthly Run meetings. |
| **BY WHEN?** | Ongoing |
| **ARE THERE ANY BARRIERS TO IMPLEMENTATION?** | No |
| **All risks must be evidenced and consistent with those recorded in Datix** | |

**Appendix 1 – Trust Strategic Risks**

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

## SECTION 1

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

## SECTION 2

**RISK SCORE** (see definitions tab)

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

## SECTION 3

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

**KEY CONTROLS** — **SOURCES OF ASSURANCE**

| ID | Key Control | Owner | Preventative | Mitigating | Detective | Control Effectiveness Rating | 1st Line of Defence | Assurance Rating | 2nd Line of Defence | Assurance Rating | 3rd Line of Defence | Assurance Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Trust Risk Register associated risk on Datix. (see section 4) | | | X | | | | | | | | |
| C1 | Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings. | Director WBS | X | | | E | Annual Service Level Agreement meetings with Health Boards to review supply 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<br>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.<br>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<br>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.<br>NICE Guidelines re Cancer drugs | Not Assessed | Trust wide clinical and scientific board.<br>Senior Leadership Team and EMB Review. | Not Assessed | QSP, SDC | Not Assessed |
| C6 | SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections. | Director VCS | X | X | | PE | SE Wales Group | Not Assessed | Performance Report - SLT, EMB, QSP and Board | Not Assessed | Welsh Government Quality, Planning and Delivery Review | Not Assessed |
| C7 | Demand and Capacity Plan for each service area of VCS | Director VCS | X | X | | PE | Service area operational planning meeting | Not Assessed | Performance Report - SLT, EMB, QSP and Board | Not Assessed | Welsh Government Quality, Planning and Delivery Review | Not Assessed |

| GAPS IN CONTROLS | GAPS IN ASSURANCE | ASSOCIATED ACTION REFERENCE/ |
|---|---|---|
| Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand 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 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 | Risk increasing |
| 3338 | There is a risk that unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in-patient treatment | 16 | Risk decreasing |
| 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 |
| 3350 | There is a risk to performance and service sustainability due to the Welsh Blood Service transport function being unable to deliver services due to operating an ageing fleet of commercial vehicles | 15 | Stable |
| 3431 | There is a risk that insufficient time to undertake an appropriate clinical assessment ahead of patients receiving their SACT for Skin/Melanoma, as a result of a significant gap between the demand and capacity in place for Pre SACT Assessments may lead to sub optimal clinical care for patients receiving SACT, missed/incomplete/incorrect or delayed patient related administration which can affect patient care and safety, poor patient experience for patients and an impact on the wellbeing of clinical staff. | 16 | Risk decreasing |
| 3461 | 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 | New risk |
| 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 | Risk increasing |
| 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 |

## 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 |
|---|---|---|---|---|---|---|---|---|
| 01.01 | The Infected Blood Inquiry (IBI) report was published in May 2024.<br>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.<br>This will be reported into the Welsh Government IBI next steps working group.<br>The fating of blood at the patient bedside in turn will enable | Alan Prosser | IA | 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. | 2.12.24 | No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24. | |
| 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 | IA | Oct-24 | Paper has been endorsed by National Blood Oversight Group on October 8th and will be presented to Welsh Government IBI next steps working Group for consideration in November. | 08.10.24 | No current funding route identified within LIMS and may need to be considered when the Infected Blood Inquiry (IBI) reports in May 24. | |
| 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 | PA | Nov-24 | Business case has been produced and presented to commissioners for consideration of funding uplift to support improved collection of blood throughout Wales. | 2.12.24 | All Wales programmes which will ensure equity of care for patients. | |
| 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 | | | Progress against action and further actions to be undertaken in month to provide updated position for November EMB reporting. | | | |
| 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 Hennesey | | | Progress against action and further actions to be undertaken in month to provide updated position for November EMB reporting. | | | |

## 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)<br>2. Implementation of Integrated Radiotherapy Solution Programme by 2026/27<br>3. Implementation of Outreach Programme by 2025-26<br>4. Implementation of the Transforming Access to Medicines (TrAMs) Model at Velindre Cancer Services<br>5. Implementation of Regional Acute Oncology Delivery Model and Network Structure<br>6. Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services<br>7. Implementation of the Approved Full Business case for the Development of the New Velindre Cancer (nVCC)<br>8. Implement Relevant Standards of the National Pre-habilitation to Rehabilitation / 3 Ps Deliverables<br>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<br>12. Expand capacity and capability of VAP (Virtually Assessed Patient) Clinics<br>13. Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy Transformation Programme<br>14. Design, Commission and Deploy Revised Patient Transport Model<br>15. Undertake Digitisation of Medical Records<br>16. Respond to Low / Limited Audit Assurance Findings<br>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.<br>2. Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model and its ambition by 2026/27.<br>3. Implement new donor strategy by 2025/26. (platelet, blood, bone marrow, plasma)<br>4. Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25.<br>5. Develop and implement a platelet strategy by 2025/26.<br>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.<br>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.<br>8. Implementation of Foetal DNA typing by 2024/25.<br>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.<br>11. Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26. | | |

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## SECTION 1

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RISK ID** | 02 | **RISK TITLE** | There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives. | **STRATEGIC GOAL** | 2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations | **RISK SCORE TREND** | No change to risk score since previous reporting period. |
| **RISK LEADS** | Lauren Fear | | | **RISK THEME** | Partnership Alignment | | |

## SECTION 2

**RISK SCORE** (see definitions tab)

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

## SECTION 3

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

**KEY CONTROLS** / **SOURCES OF ASSURANCE**

| ID | Key Control | Owner | Preventative | Mitigating | Detective | Control Effectiveness Rating | 1st Line of Defence | Assurance Rating | 2nd Line of Defence | Assurance Rating | 3rd Line of Defence | Assurance Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Trust Risk Register associated risk on Datix. (see section 4) | | | X | | | | | | | | |
| 1.3 | Performance data and measures to clearly track progress against objectives | | | | X | PE | Linked through performance framework insight; new performance management framework implemented March 2023 | E | Strategic Development Committee/ Quality Safety and Performance Committeee | 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 | E | Strategic Development Committee/ Quality Safety and Performance Committees; introduction of | 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 | 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 | 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 | | 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 | 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 | 08/01/2025 | 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 revew of collective cancer strategies and exisiting programmes of work. This was reported to Trust Board in Stratgeic Planning update in November 2024. Work progressing to next meeting in February 2025. | 08/01/2025 | 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**<br>**An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations** | 1. Delivering the Fundamental Cornerstones of Healthcare Provision:<br>• 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<br>• Delivering services that meet the national clinical quality and safety standards and provide an excellent experience<br>• Treating patients as quickly as possible (SACT and RT)<br>• Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales<br>• Developing agile and flexible capacity plans which allow us to respond quickly to changes in demand for our services<br>• Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past three years<br>• 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:<br>• Improving access to our services to increase uptake and reduce inequalities and ill-health<br>• Strengthening our decision-making to consciously address poor outcomes and inequalities in the communities we serve<br>• 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<br>• Work with Local Health Board partners to strengthen our support to the delivery lead of improved cancer outcomes for patients in South East Wales<br>• Develop the Velindre@ research hub philosophy across all LHB partners in South East Wales<br>• Further develop the Blood Health Oversight Group work programme to improve the prudent use of blood and blood products across Wales<br>4. Delivery of Transformation Programmes<br>Non-surgical Tertiary Oncology Services:<br>• Implementing the final phase of the Acute Oncology Service regional model<br>• Continue to improve pathways for unscheduled care patients<br>• Delivery of the Cardiff Cancer Research Hub<br>• Implementation of the Integrated Radiotherapy Solution in 2025<br>• Construction and delivery of the new Velindre Cancer Centre in Whitchurch, Cardiff in 2027<br>• Construction and opening of the Radiotherapy Satellite Centre, at Nevill Hall Hospital in Abergavenny, in 2025 | | |
| | Blood and Transplant Services<br>• Laboratory Modernisation programme:<br>• Refurbishment of the Talbot Green facility by 2027<br>• Work with the Welsh Government to develop and implement the Plasma for Medicines model for Wales | | |

## SECTION 1

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RISK ID** | 03 | **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. | **STRATEGIC GOAL** | 1 - Outstanding for quality, safety and experience | **RISK SCORE TREND** | No change to risk score since previous reporting period. |
| **RISK LEADS** | Sarah Morley | | | **RISK THEME** | Workforce Supply and Shape | | |

## SECTION 2

**RISK SCORE** (see definitions tab)

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

## SECTION 3

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

| KEY CONTROLS | | | | | | | SOURCES OF ASSURANCE | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ID** | **Key Control** | **Owner** | **Preventative** | **Mitigating** | **Detective** | **Control Effectiveness Rating** | **1st Line of Defence** | **Assurance Rating** | **2nd Line of Defence** | **Assurance Rating** | **3rd Line of Defence** | **Assurance Rating** |
| | Trust Risk Register associated risk on Datix. (see section 4) | | | X | | PE | | | | | | |
| C1 | Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce' | Sarah Morley | X | | | E | Tracking key outcomes and benefits map – aligned to Trust People Strategy | PA | Performance reporting to Executives and Trust Board | PA | Internal Audit Reports | PA |
| C2 | Approved Workforce Planning Methodology aligned to Trust Values and Beahviours | Susan Thomas | X | | | E | Monthly Divisional Senior Leadership Team feedback | IA | Trust Board reporting against Trust People Strategy | PA | To be completed as per compliance/reg tracker update | IA |
| C3 | Workforce planning - skills development | Susan Thomas | X | | | PE | Provide operational managers with skills and capabilities to undertake effective | IA | Supply and Shape paper to EMB then QSP | PA | Wales Audit Workforce Planning National Review | PA |
| C4 | Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills | Susan Thomas | X | | | E | Evaluation sheets | PA | Supply and Shape paper to EMB then QSP | PA | Wales Audit Workforce Planning National Review | PA |
| C5 | Educational pathways in place to support the recruitment of new skills and development of new roles | Susan Thomas | X | | | PE | People Development and Education Steering Group | PA | Supply and Shape paper to EMB then QSP | PA | Internal Audit Reports | PA |
| C6 | Widening Access Programme to support development of new skills and roles | Susan Thomas | X | | | PE | People Development and Education Steering Group | PA | Supply and Shape paper to EMB then QSP | PA | Internal Audit Reports - Education Strategy Audit | PA |
| 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. | PA | Regular performance reports and Supply and Shape paper are submitted to EMB and QSP | PA | Internal Audit Reports - Managing Attendance at Work, Recruitment and Retention and Education Strategy Audit (ongoing) | PA |
| C8 | Hybrid Working Principles established to support workforce planning methodology | Sarah Morley | | | X | E | Flexible Working Policy | PA | Supply and Shape paper to EMB then QSP | IA | Internal Audit | NA |
| C9 | Consistent recruitment and selection process | Sarah Morley | X | | | PE | Recruitment and Selection Policy | IA | Dashboards on recruitment and selection reported monthly to divisional SLTs. Supply and Shape paper to EMB then QSP | PA | Internal Audit | PA |

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

## SECTION 4

**ASSOCIATED OPERATIONAL RISKS - According to risk appetite**

| DATIX RISK REF | RISK TITLE | Current Risk Rating | RISK TREND |
|---|---|---|---|
| 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. | 16 | Stable |
| 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 |

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|---|---|---|---|
| 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 | 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 |
|---|---|---|---|---|---|---|---|---|
| 03.06 | Development of a Trust Workforce Plan | Susan Thomas | **IA** | 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.<br><br>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 | **IA** | Sep-24 | 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.<br><br>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. | 24.09.2024 | | |
| 03.08 | Embed workforce planning progress into monthly Divisional Senior Leadership Team Workforce reports | Amanda Jenkins | **NA** | Oct-24 | 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.<br><br>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. | 02.12.2024 | | |
| 03.09 | Staff educators to undertake HEIW train the trainer on workforce planning | Amanda Jenkins | **NA** | Jan-25 | 29.11.2024 in contact with HEIW to scope train the trainer programme and costs | 29.11.2024 | | |
| 03.10 | Embed Hybrid working principles in training and reporting | Amanda Jenkins | NA | Jan-25 | 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. | 09.12.2024 | | |
| 03.11 | Implementation of the Attraction and Resourcing Project | Amanda Jenkins | NA | Mar-25 | 01.10.2024 New Attraction and Resourcing Lead appointed to take actions from the project forward.<br><br>14.10.2024 Options paper for recruitment campaign agreed to EMB. | 29.11.2024 | | |
| 03.12 | Implementation of the Nurse Retention Plan through the Professional Nursing Forum | Nicola Williams / Divisional Heads of Nursing | NA | Apr-26 | Nurse Retention Plan currently in draft | 02.12.2024 | | |
| | **CLOSED ACTIONS** | | | | | | | |
| 03.13 | Utilise the learning from implementation of the Nurse Retention to develop a Trust Retention Plan | Amanda Jenkins | NA | Oct-24 | Completed | 30.10.2024 | | |
| 03.01 | The Healthy and engaged workplan to be implemented to support workforce capacity within the Trust | Sarah Morley | **PA** | COMPLETE | The Healthy and Engaged workplan 2024-25 was agreed at the Healthy and Engaged Steering Group on 09.03.2024.<br><br>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 | **PA** | COMPLETE | The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023. | 21/12/2023 | This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates | |
| 03.03 | Participate in the NWSSP International nurse recruitment Project | Sarah Morley | **IA** | COMPLETE | International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024 | 21/12/2023 | 13 overseas nurses have been recruited and onboarded and will start in March 2024. | |
| 03.04 | Develop and Implementation Plan for the People Strategy | Susan Thomas | **PA** | COMPLETE | A plan to implement the People Strategy will be presented to EMB in December. | 21/12/2023 | Presented to EMB Shape | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 03.05 | Review Exit Interview Process | Susan Thomas | **IA** | COMPLETE | The Exit interview process has been rewritten. There is a new dashboard and automated process and engagement sessions have been delivered. A new procedure will be submitted to EMB | 20.03.2024 | | |

## SECTION 6

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

| IMTP 2024.25 to 2026.27 Service Area | 2024.25 | 2025.26 | 2026.27 |
|---|---|---|---|
| **Strategic Goal 1 Outstanding for quality, safety and experience** | Planned Ans Sustained Workforce<br>1. Implement the Education Strategy Implementation Plan 24/25<br>2. Following the agreement of the Clinical and Scientific Skills Strategy develop Trust wide priorities and implementation plan for multi-disciplinary workforce model<br>3. Manage the successful implementation of the WL service provision (SLA) to support service bi-lingualism<br>4. Agree a plan for the Widening Access Programme<br>5. Ongoing recruitment Marketing Campaigns for hard to fill roles<br>6. Develop a Nurse retention plan | | |
| | Skilled and Developed Workforce Achieving Excellence through our staff<br>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<br>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<br>3. To create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology<br>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 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 | **STRATEGIC GOAL** | 2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations | **RISK SCORE TREND** | No change to risk score since previous reporting period. |
| **RISK LEADS** | Sarah Morley | | | **RISK THEME** | Organisational Culture | | |

## SECTION 2

**RISK SCORE** (see definitions tab)

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

## SECTION 3

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

| **KEY CONTROLS** | | | | | | | **SOURCES OF ASSURANCE** | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ID** | **Key Control** | **Owner** | **Preventative** | **Mitigating** | **Detective** | **Control Effectiveness Rating** | **1st Line of Defence** | **Assurance Rating** | **2nd Line of Defence** | **Assurance Rating** | **3rd Line of Defence** | **Assurance Rating** |
| | Trust Risk Register associated risk on Datix. (see section 4) | | | X | | | | | | | | |
| C1 | Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation | Carl James | X | | | E | Working group led by CJ | PA | Trust Board reporting on strategy and controls via cycles of business | PA | To be completed as per compliance/ reg tracker updates | PA |
| C2 | Approved Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction | Susan Thomas | X | | | E | People Development and Education Steering Group | PA | Supply and Shape paper to EMB then QSP | PA | Internal Audit Reports - Education Strategy Audit | PA |
| C3 | Management and Leadership development programmes in place based on compassionate leadership principles | Susan Thomas | X | | | PE | People Development and Education Steering Group | PA | Reporting though relevant Trust governed processes and Trust Board cycles of business i.e. Steering group highlight report to EMB and Committees. | PA | Internal Audit Reports | NA |
| C4 | Trust Values and Behaviour Framework | Susan Thomas | X | | | PE | Healthy and Engaged Steering Group NHS Staff Survey | PA | Reporting though various Trust goverence processes and Trust Baord cycles of business i.e Steering group highlight report to EMB and Committees. | PA | Internal Audit Reports | NA |
| C5 | Communication infrastructure in place to support the communication of leadership messages and engagement of staff | Lauren Fear | X | | | PE | Healthy and Engaged Steering Group | PA | Reported through EMB to QSP | IA | Internal Audit Reports | IA |
| C6 | Health and Wellbeing infustructure for the Trust to support physical and psychological wellbeing of staff | Susan Thomas | X | | | E | Healthy and Engaged Steering Group Trust Polices and Proceedures to support health and wellbeing | PA | Reporting though various Trust goverence processes and Trust Baord cycles of business i.e Steering group highlight report to EMB and Committees. | PA | Internal Audit Reports - Evalution of wellbeing activites, MAWW Audit | PA |
| C7 | Governance arrangements in place to monitor and evaluate the implementation of plans | Non Gwilym | X | | | PE | Workforce and OD steering groups and internal governance | PA | Steering Groups' highlight reports to Executive Management Board | PA | Internal Audit Reports | IA |
| C8 | Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation | Carl James | X | | | PE | Perfromance Managment Framework Report | PA | Exucutive Management Board | PA | Internal Audit Reports | IA |
| C9 | Clear safe, effective and efficient services models to support role clarity aligned to compassionate leadership principles | Anne Carey | X | | | PE | Monthly Divisional Senior Leadership Meetings | IA | Supply and Shape paper to EMB then QSP | PA | Internal Audit Reports | NA |
| C10 | Operational workforce plans developed to support agreed service models | Anne Carey | X | | | PE | SLT Meetings and Educationa and Training Steering Group | IA | Supply and Shape paper to EMB then QSP | IA | Internal Audit Reports | NA |
| C11 | Employee Voice Framework | Sarah Morley | x | | | PE | Healthy and Engaged streerting group and Local Partenship Forum | PA | Reporting though various Trust goverence processes | PA | Internal Audit Reports | NA |
| C12 | Avoidable employee harm prinicples are embedded into the management of beahviours within the Trust | Sarah Morley | X | | | PE | Healthy and Engaged streerting group and Local Partenship Forum | PA | Reporting though various Trust governance processes | PA | Internal Audit Reports | NA |

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

## SECTION 4

## ASSOCIATED OPERATIONAL RISKS - According to risk appetite

| DATIX RISK REF | RISK TITLE | 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 |
| 3247 | There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times. | 16 | Stable |
| 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. | 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 | IA | **Mar-25** | 06.12.24<br>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 | IA | **Apr-25** | 06.12.2024<br>Session planned at Board Development on 17.12.2024. A Social Partnership update will be included.<br>Following session a meeting will be planned with the Chair of Strategic Development Committee to plan governance routes. | 06.12.24 | | |
| 04.08 | Implement the Compassionate Leadership Pledge and action plan within the Trust | Claire Budgen | IA | **Mar-25** | 06.12.2024<br>Compassionate Leadership Pledge was signed on 26 September 24 by leaders in the Trust.<br>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 | IA | **Dec-24** | 06.12.2024<br>Paper being submitted to Healthy and Engaged Steering Group on 19.12.2024. | 06.12.24 | | |
| 04.10 | Implement the actions of the Trust Strategic Equality Plan, incuding embedding the Anti-Racist Wales Action Plan in the Trust | Claire Budgen | IA | **Mar-25** | 06.12.2024<br>Regular updates have been submitted to EMB, committees and Trust Board.<br>An assurance level of 3 was agreed. | 06.12.24 | | |
| **CLOSED ACTIONS** | | | | | | | | |
| 04.06 | Embed the Values and Behaviours Framework into Trust communications, policies and processes | Claire Budgen | IA | **Dec-24** | 06.12.2024<br>This action is complete. Paper going to EMB in December 2024. | 06.12.24 | | |
| 04.01 | Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team. | Sarah Morley | PA | COMPLETE | The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message. A summary of the themes and proposed actions will be presented to EMB in May 2024. This paper also proposes that the conversations continue as routine in person and virtually. | 20/06/2024 | The outputs from the WT Sessions are being mapped into the Refresh of the Building Our Future Together Organisational Development Approach. New Sessions are now being scheduled which will cover staff across the bases in Wales | Identification of the needs for an Employee Voice Framework |
| 04.02 | Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture. | Sarah Morley | PA | COMPLETE | Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the orgnidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey have begun to be distilled to further develop our work programme | 20/06/2024 | We received the Trust level data from the 2023 staff survey with the more detailed dahsboards following in May. This data will be used to over lay with other feedback. The areas of data have been mapped onto the current workstreams and management groups to ensure that this will enusre action is taken under the appropriate workstream. | This will encompased I nthe revised BOFT approach in the Trust way of working. |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 04.03 | A staff engagement project to understand levels of staff engement and also review the Trust Values | Sarah Morley | PA | COMPLETE | A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023. | 21/12/2023 | | |
| 04.04 | Promotion of the Speaking Up Safely Framework | Sarah Morley | PA | COMPLETE | The initial task and finish group to establishe the Speaking up Safely Framework in Velindre has been completed. Communication and governance processes are in place. | 14/05/2024 | Initial programme completed - ongoing work to trianguate with wider cultural work | |

## SECTION 6

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

| IMTP 2024.25 to 2026.27 Service Area | 2024.25 | 2025.26 | 2026.27 |
|---|---|---|---|
| **Strategic Goal 2**<br>**An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations** | 1. Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence<br>2. Commence the Values and Behaviour framework project<br>3. Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working<br>4. Deliver an action plan for 2024/25 to support our committment to the Trust Anti- Racist Action plan<br>5. Monitor Welsh Language Standards, working with Divisions on improvement plans<br>6. Implement the WL Culture plan<br>7. Update all WOD related policies and procedures | | |

## SECTION 1

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

## SECTION 2

**RISK SCORE** (see definitions tab)

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

## SECTION 3

| **Overall Level of Effectiveness:** (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 | | | | | | |
| C1 | Trust Digital Strategy - Published Oct '23 | Carl James | X | | | E | Tracking key outcomes and benefits map – aligned to Trust Digital Strategy<br>- Digital Programme Board | PA | EMB Shape | PA | SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit | PA |
| C2 | Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS, EPMA | Chief Digital Officer | | X | | E | Trust Digital governance reporting<br>- WBS Futures<br>- Velindre Futures<br>- Digital Programme Board | PA | EMB Shape / National Programme Boards | PA | SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit | PA |
| C3 | Training & Education packages to develop internal capabilities – including for exec and Board | Chief Digital Officer | X | | | PE | Staff feedback<br>- KLAS Survey | IA | EMB Shape | IA | SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit | PA |
| C4 | Training & Education packages for donors, patients | Chief Digital Officer | X | | | PE | Patient and Donor feedback<br>Trust Digital Inclusion Plan | IA | EMB Shape / Digital Communities Wales | IA | Strategic Development Committee/ QSP Committee/ Internal Audit | Not Assessed |
| C5 | Ring-fencing digital advancement in Trust budget – benchmark 4% | Chief Digital Officer | X | | | E | Review of proposals via EMB/Board<br>Digital IMTP<br>Trust Capital Programme<br>Digital Spend included in PMF (Current 2.6%) | IA | EMB Shape / EMB Run | IA | Strategic Development Committee/ QSP Committee/ Internal Audit | IA |
| C6 | Specifically development of digital resources capacity and capability | Chief Digital Officer | X | | | PE | Review of proposals via EMB/Board<br>Digital Programme Board | PA | EMB Shape | PA | SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ Centre for Digital Public Services | PA |
| C7 | Digital inclusion in wider community | Chief Digital Officer | X | | | E | Tracking key outcomes and benefits map – aligned to Trust Digital Strategy<br>Joint plan with Digital Communities Wales | PA | EMB Shape | PA | Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales Accreditation | PA |
| C9 | Prioritisation and change framework to manage service requests | Chief Digital Officer | X | | | E | Trust Digital governance reporting<br>- WBS Futures<br>- Velindre Futures<br>- Digital Programme Board<br>IMTP | PA | EMB Shape | PA | Strategic Development Committee/ QSP Committee/ Internal Audit | PA |
| C10 | Levels of unsupported applications/ legacy systems | Chief Digital Officer | | | X | PE | Trust Digital governance reporting<br>Digital Programme Board | PA | EMB Shape / EMB Run / Cyber Action Plan | PA | SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Cyber Resilience Unit | PA |
| C11 | Trust digital Governance | Carl James | | X | | E | Trust Digital governance reporting<br>- WBS Futures<br>- Velindre Futures<br>- Digital Programme Board<br>IMTP | PA | EMB Shape | IA | Wales Audit OfficeSIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit | PA |
| C12 | Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework | Chief Digital Officer | | | X | PE | Review via Divisional SMT/SLT | PA | EMB Run | PA | SIRO Reports/ QSP Committee/ Internal Audit / WG IQPD | PA |
| C13 | Cyber Assurance Controls in place | Chief Digital Officer | | X | | E | Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions. | PA | EMB Shape / EMB Run | PA | SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS | PA |
| C14 | Digital transformation is guided by an agreed digtial architecture. | Chief Digital Officer | X | X | | PE | Digital Programme Board<br>Digital Design Authority being established | IA | EMB Shape | IA | SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit | Not Assessed |

| **GAPS IN CONTROLS** | **GAPS IN ASSURANCE** | **ASSOCIATED ACTION REFERENCE/ RATIONALE** |
|---|---|---|
| | Assurance Arrangements for Digital Architecture will need to be established - | |
| Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority inaugral meeting 12th Dec 24 | 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 |
|---|---|---|---|

| | | | |
|---|---|---|---|
| 3472 | There is a risk to **Quality and Safety** as a result of the DHCR system not allowing outpatient oncology notes to be rapidly identified. This leads to missing key information relevant for outpatient clinics.<br>- a lack of visibility for oncology information (e.g prognosis/intent) for acute teams (VCC and HB) and primary care which is affecting patient management<br>- an impact on patient experience due to slower clinics and increased waiting times<br>- an increase in staff stress; funding the relevant information can be time consuming and stressful | 16 | New risk |
| 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 | 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 |
|---|---|---|---|---|---|---|---|---|
| 05.01 | Create the Trust Digital Reference Architecture to support C14 and others | Chief Digital Officer | IA | Oct-24 | Terms of reference drafted for approval at Aug Digital Programme Board<br><br>Digital Design Authority will meet for the first time on the 12th December | Nov-24 | Terms of reference for the Digitial Programme include the creation of Digital Design Authority which is in the process of being stood up in Q3 24/25. | The level of assurance should increase. |
| 05.02 | C9 - Prioritisation framework needs to be established for the Data and Insight Service | Chief Digital Officer | IA | Oct-24 | Data and Insight formative paper due at SDC in Feb '24<br>Prioritisation paper presented to EMB in Nov '24<br>Data and Insight incuded as part of the Change Advisory Board for C9<br>Additonal resource being recruited | Nov-24 | Will contribute to reduction in likelihood of risk | C9 would move to Effective |
| 05.03 | Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment | Chief Digital Officer | IA | Dec-24 | Digital strategy and plan approved by EMB Nov '24 and on Dec '24 SDC agenda | Nov '24 | Will contribute to reduction likelihood of risk | Assurance controls should better represent best practice |
| 05.04 | Reviewing control framework with Head of Information Governance for cross-check and alignment | Chief Digital Officer | IA | Nov-24 | Initial review undertaken and updates will be made for Nov TAF | Oct-24 | 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 | CAB is now meeting regularly<br>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 |

# 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**<br>**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**<br>**2. New Patient Reported Outcome Measures (PROMS) system for Value Based Healthcare**<br>**3. Digital Inclusion - digitally connect our donors, patients, and carers and staff to our services 24/7**<br>**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)**<br>**5. Introduce new Digital Training Platform** | | |
| | **6. Performance Management Framework (Quality Measures) dashboard**<br>**7. National Data Resource roadmap**<br>**8. Trust wide Data and Insight plan**<br>**9. New Velindre Cancer Centre (nVCC) digital enablement**<br>**10. Digital enablement of the integrated Radiotherapy Solution Programme by 2026/27**<br>**11. Implementation of electronic prescribing and medicines administration (ePMA) for Use by Velindre Cancer Services**<br>**12. Digital Enablement of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital)** | | |

## SECTION 1

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

## SECTION 2

**RISK SCORE** (see definitions tab)

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

## SECTION 3

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

RATING: **E**

**Overall Trend in Assurance**
Refer to 7 Levels of Assurance (see definitions tab)

During December 2024, the Governance, Assurance and Risk programme was further informed through dialogue with VCS regarding their service's management of governance and risk. Whilst dialogue remains positive overall, the overall risk is with increased focus on describing the outcome to be achieved.

**KEY CONTROLS**

**SOURCES OF ASSURANCE**

| ID | Key Control | Owner | Preventative | Mitigating | Detective | Control Effectiveness Rating | Assurance Rating | 1st Line of Defence | Assurance Rating | 2nd Line of Defence | Assurance Rating | 3rd Line of Defence | Assurance Rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C1 | Trust Risk Register associated risk on Datix. (see section 4) | Non Gwilym | | X | | PE | 4 | Risk reporting arrangements at divisional, corporate/programme level | 4 | QSP/Audit Committees, Trust Board | 6 | Internal Audit Reports | 4 |
| C2 | Annual Assessment of Board Effectiveness | Kay Barrow | | | X | E | 6 | Annual Board Effectiveness Review<br>Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017 | 6 | Audit Committee<br>Trust Board | 6 | Internal Audit Reports<br>Audit Wales Structured Assessment Programme / Reports<br>Joint Escalation & Intervention Arrangements | 6 |
| C3 | Board Committee Effectiveness Arrangements | Non Gwilym | X | | | E | 4 | Internal Audit Review | 4 | Audit Committee<br>Trust Board | 4 | Internal Audit of Board Committee Effectiveness<br>Audit Wales Structured Assessment<br>Audit Wales Review of Quality Governance Arrangements | 4 |
| C4 | Board Development Programme | Non Gwilym | X | | | PE | 4 | 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 | 4 | 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 | 4 | 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 | | | No | 1 | Exercise to be completed | 1 | Trust Board in Board Development | 1 | | |

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

## SECTION 4

**ASSOCIATED OPERATIONAL RISKS - According to risk appetite**

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

**SMART ACTION PLAN**

| Action Ref | Action Plan | Owner | Assurance Level | Due Date | Progress Update | Date of Update | Impact of Changes on Risk | When the action is complete, detail the impact on assurance level/control |
|---|---|---|---|---|---|---|---|---|
| 06.05 | Revised reporting mechanism to be developed | Non Gwilym | 4 | Oct-24 | Progress delayed - Refresh of GAR underway to be discussed by GAR group on 20 January 2025, to include revised reporting mechanisms as per below: Project TAF 2.0 within the GAR Programme is due to complete in January 2025 and will implement and ongoing with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams, and progress is being made with the embedding. Next progress with Senior Leadership Teams. | 15.12.24 | Impact to be assessed when delivered. No risks identified currently. | |
| 06.06 | External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work | Non Gwilym | 4 | Nov-24 | Benchmarking underway - WAST, CAV/UHB, ABUHB and Hywel Dda, Royal Marsden and Christie, NHSBT). Activity is be ongoing to inform further improvements. | 15.12.24 | Impact to be assessed when delivered. No risks identified currently. | Activity to deliver assurance to Board membership on quality of GAR output.<br>Also 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 (18 November) confirmed that the priority for the next phase is a review of the status of the GAR Framework, Policy, Strategy, Terms of Reference and separately, Review to be considered by the next GAR Group meeting in January. | 21.11.24 | Impact to be assessed when programme delivered. | GAR increasingly positioned as the Governance Team service plan. Careful consideration of desired impact of Phase 1 prioritised by the GAR Group. Phase 2 programme of work to be developed and aligned with outstanding actions of Phase 1 where appropriate. |
| 06.08 | Review Trust Risk Policy | Non Gwilym | 2 | Mar-25 | Risk Policy Group meeting scheduled for 15 January 2025. | 18.11.24 | Risk Policy review to consider benefits it aims to achieve as part of its planning. | 1. Reviewed policy incorporating learning from GAR Phase 1 and 2 actions on risk.<br>2. Ongoing training programme (f2f and virtual/online and resources) established.<br><br>Assurance level will increase when action has been delivered. |

**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.<br>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. |

**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.**<br><br>**Trust Purpose and Vision, aligned to**<br>**• Trust Strategic Goals**<br>**• VCS Strategy and Priorities and Service Plans**<br>**• WBS Strategy and Priorities and Service Plans**<br>**• Support Functions Strategies and Plans** | | |
| | **Building our Future Together 'destination 2032' 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.**<br><br>**Delivery of the BOFT Programme:**<br>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 overriding aim<br>2. Provide a way of working and shape to the organisation which enables us to maintain focus<br>3. Improve accountability and ownership in 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<br>4. Draw together our organisational developments with a common sense of purpose<br>5. Improve our effectiveness, efficiency and value based approach<br>6. Develop the mechanisms which enable us to prioritise where and when we need to change<br>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<br>8. Support realistic, authentic and compassionate leadership | | |

## SECTION 1

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RISK ID** | 07 | **RISK TITLE** | There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics. | **STRATEGIC GOAL** | 1 -Outstanding for quality, safety and experience | **RISK SCORE TREND** | No change to risk score since previous reporting period. |
| **RISK LEADS** | Jacinta Abraham | Nicola Williams | Anne Carey | **RISK THEME** | Patient Outcomes | | |

## SECTION 2

**RISK SCORE** (see definitions tab)

| | LIKELIHOOD | IMPACT | | | LIKELIHOOD | IMPACT | | | LIKELIHOOD | IMPACT | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **INHERENT RISK** | 4 | 4 | **TOTAL** | **16** | **CURRENT RISK** | 4 | 4 | **TOTAL** | **16** | **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**

**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 C12 | | | | | | | | | |
| 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 | IA | Quality, Safety and Performance Committee | IA |
| 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 | PE | VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group | IA | Executive Management Board | IA | Quality, Safety and Performance Committee | 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 | NA | Quality, Safety and Performance Committee | NA |
| C6 | Effective processes in place to capture patient experience, ensuring effective listening and learning | Interim Director VCS / Exec Director Nursing, AHP & HCS | | | X | PE | Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group | PE | Executive Management Board | IA | Quality, Safety and Performance Committee | 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 | IA | Quality, Safety and Performance Committee | 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 | NA | Quality, Safety and Performance Committee | NA |
| C9 | Velindre Oncology Acadamy establishment | Exec Director Nursing, AHP & HCS | X | X | | PE | VOA Implementation Group | IA | Executive Management Board | IA | Strategic Development Committee | 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 | IA | Quality, Safety and Performance Committee | IA |
| C11 | Quality & Safety Tracker (improvement monotoring) | Interim Director VCS / Exec Director Nursing, AHP & HCS | | X | X | E | VCS Quality & Safety Group / VCS SLT | IA | Integrated Quality & Saefty Group / Executive Management Board | IA | Quality, Safety and Performance Committee | IA |
| C12 | SACT Transformational Programme established to deliver the SACT Improvement Plan | Exec Director of Nursing, AHP &HCS, Executive Medical Director, Chief Operating Officer and Director of Cancer Service. | | x | | PE | SACT Delivery Group | IA | SACT Steering Group | IA | Quality, Safety and Performance Committee | 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. | 12 | 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 | new risk |
| 3461 | 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 | new risk |
| 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 |
| 3338 | There is a risk that unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in patient treatment | 16 | Stable |
| 3431 | significant gap between the demand and capacity in place for Pre SACT Assessments may lead to sub optimal clinical care for patients receiving SACT, missed/incomplete/incorrect or delayed patient related administration which can affect patient care and safety, poor patient experience for patients and an impact on the wellbeing of clinical staff. | 20 | Stable |
| 3270 | 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 | Increasing |
| 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 | Increasing |
| 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. | 16 | Increasing |
| | | | |

## SECTION 5

**SMART ACTION PLAN**

| Action Ref | Action Plan | Owner | Assurance Level | Due Date | Progress Update | Date of Update | Impact of Changes on Risk | When the action is complete, detail the impact on assurance level/control |
|---|---|---|---|---|---|---|---|---|
| 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 | 0 | ~~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 | 04.12.24 | 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 | Aug-24 | Initial quality, safety and outcome metrics& implementation plan agreed Oct 24- development commenced - 12 week development programme | 02.12.24 | 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.<br><br>Business Case for digital PROMS approved. Procurement now delayed for Q4 due to need for due diligence of supplier. Preparatory work nearing completion with Prostate, Lung and Neuro-Oncology for phase 1 implementation. 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 areas which will have PROMS deployed | 03/12/2024 | Should long term reduce risk | 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.<br>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 | 06/12/2024 | 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 | Team job planning currently taking place across the SSTs Workforce plans to support RSU being implemented with move to medical light model | 05/12/2024 | 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 Manager appointed commencing 6.12.2024 | 02.12.2024 | 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 | 31/06/2024 | As above - once Clinical & Scientific Manager in post - implementation plan will be drafted | 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 | | | 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 | | | paper to EMB outlining proposal, funding identified and in process of going to procurement for identified system | 05/12/2024 | 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 |
|---|---|---|---|

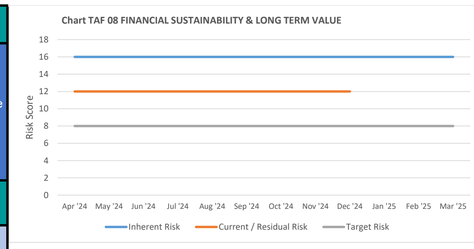
| | | | |
|---|---|---|---|
| **Strategic Goal 1 Outstanding for quality, safety and experience** | **Clinical Quality and safety Priorities:**<br>1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.<br>2. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.<br>3. To Integrate Clinical Audit within VCS Quality and Safety function<br>4. Development of robust Site- Specific Quality Metrics<br>5. To improve incident and risk management.<br>6. Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System<br>7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service.<br>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.<br>9. Review and improvement of donor selection and screening processes<br>10. Introduction of all Wales foetal D Screening for RhD negative pregnant women.<br>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.<br>12. Achieve JACIE accreditation for the WBMDR<br>13. Commencing rollout of live connectivity of the BECS at community- based donation clinics<br>14. Implement an outcome recording system for patients (digital PROMS) | | |
| | | | |
| | | | |

## SECTION 1

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **RISK ID** | 08 | **RISK TITLE** | There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive. | **STRATEGIC GOAL** | 1 -Outstanding for quality, safety and experience<br>5 - A sustainable organisation that plays it part in creating a better future for people across the globe | **RISK SCORE TREND** | No change to risk score since previous reporting period. |
| **RISK LEADS** | Matthew Bunce | | | **RISK THEME** | Financial Sustainability and Long-Term Value | | |

**RISK SCORE** (see definitions tab)

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




| | Apr '24 | May '24 | Jun '24 | Jul '24 | Aug '24 | Sep '24 | Oct '24 | Nov '24 | Dec '24 | Jan '25 | Feb '25 | Mar '25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Inherent Risk | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 |
| Current / Residual Risk | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | | | |
| Target Risk | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 |

## SECTION 3

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

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

| GAPS IN CONTROLS | GAPS IN ASSURANCE | ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION. |
|---|---|---|
| Scheme of Delegation and Governance Framework for the nVCC | 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 |
|---|---|---|---|
| 3517 | There is a risk to the financial balance of the trust. As a result of no agreement to fund the revenue costs (post Implementation of EPMA) for the duration of the contract. Leading to the trusts financial balance being in deficit Est £1.891M over 7 years (5+2) needing to be made available from the growth / inflation funding from the LTAs. | 16 | New Risk |
| 3543 | There is a risk to financial sustainability of VUNHST as a result of increased costs within the business cases for Radiopharmacy and the TrAMS hub, that the LHB commissioners do not accept, leading to cost pressure for the Trust. | 20 | New Risk |
| 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 | Risk raring increased on 27.11.2024 resulting in the risk passing the threshold to reporting to Trust Board |
| 3537 | This is a private TCS risk in the Financial Sustainability domain. | | |

## 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.<br><br>2024-25 Objectives:<br>• Digital PROMS platform Business Case approved by Trust Board and procurement complete. Currently commencing implementation.<br>• PROMS Questionnaires agreed for use in Prostate, Lung and Neurology. Good progress with national questionnaires for CUP and Breast<br>• SST Data Insights Dashboard launched in March 2023 with development improvements made during 2024 through development group to ensure benefits maximised<br>• Data quality group mobilised focussing on improving data quality in arease of clinical and financial risk<br>• 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"<br>Digital PROMS Business Case approved by Trust Board<br>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.<br><br>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.<br><br>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. "<br><br>Final Audit Report was received at Dec '24 Audit Committee with reasonable assurance. Management actions agreed to respond to small number of recommendations | 08.01.2025 | 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.<br>Progress delayed due to lack of finance resource, but aim to have agreed criteria and process for investment appraisal and prioritisation by April 2025 . "<br><br>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.<br>Private patient cash collection and pricing continues to be developed and progress being made in the backlog of cash collection. "<br><br>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.<br>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.<br>This financial scheme of delegation will sit alongside the updated MIM Governance protocol to provide the integrtaed governance framework for the n VCC | 08.01.2025 | 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 teh 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.<br><br>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.<br><br>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.<br><br>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**<br>**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:<br>• Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit.<br>• 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.<br>• 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.<br>• Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.<br><br>Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre<br>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). | | |

| RISK DESCRIPTORS | | | |
|---|---|---|---|
| **RISK NUMBER** | **RISK THEME/TITLE** | **DRAFT RISK DESCRIPTION** | **RISK OWNER** |
| **01** | **Service Capacity** | There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources. | **Cath O'Brien<br>Rachel Hennessey<br>Alan Prosser** |
| **02** | **Partnership Alignment** | There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives. | **Carl James<br>Nicola Williams<br>Jacinta Abraham** |
| **03** | **Workforce Supply and Shape** | There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives. | **Sarah Morley** |
| **04** | **Organisational Culture** | There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes. | **Sarah Morley** |

| | | | |
|---|---|---|---|
| **05** | **Digital Transformation** | There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security | **Carl James** |
| **06** | **Organisational and Clinical Governance** | There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives. | **Lauren Fear** |
| **07** | **Patient Outcomes** | There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics. | **Nicola Williams<br>Jacinta Abraham<br>Cath O'Brien** |
| **08** | **Financial Sustainability** | There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive. | **Matt Bunce** |

## DEFINITIONS

**CONTROL EFFECTIVENESS**

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

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

## LEVELS OF ASSURANCE DESCRIPTORS

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

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

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

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

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

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

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

## RISK SCORE

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

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

# IMPACT MATRIX

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

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

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

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

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

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

SUMMARY STATEMENTS OF 7 LEVELS

| RAG rating | SUMMARY |
|---|---|
| 7 | Improvements sustained over time - BAU |

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

# TRUST BOARD

## VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT DETAILED ANALYSIS FOR NOVEMBER 2024/25

| | |
|---|---|
| **DATE OF MEETING** | 30 JANUARY 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** | Peter Gorin, Head of Strategic Planning and Performance |
| **PRESENTED BY** | Lauren Fear, Director of Transformation (Interim), Anne Carey Chief Operating Office (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, Director of Transformation – Interim |
| **EXECUTIVE SUMMARY** | **PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW:**<br><br>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 November 2024. |

| | |
|---|---|
| **RECOMMENDATION / ACTIONS** | **The Trust Board is asked to:**<br>• Note the Performance Management Framework detailed analysis for the month of November 2024.<br>• Note the progress against the nine agreed work packages.<br>• 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.<br>• Note 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. |

**GOVERNANCE ROUTE**

| **List the Name(s) of Committee / Group who have previously received and considered this report:** | **Date** |
|---|---|
| WBS SMT / Performance Review | 11 December 2024 |
| VCS SLT / Performance Review | 18 December 2024 |
| Executive Management Board | 8 January 2025 |
| Quality, Safety and Performance Committee | 16 January 2025 |

**Summary and outcome of previous governance discussions:**

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

The summary from the Executive Management Board is included in the recommendations section above.

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

**The QSP Committee also noted:**

- Overall, the Committee Chair welcomed the development of the report. It was agreed that the format of highlighting performance, with key actions and expected outcomes provided far clearer assurance to the Committee.

**Velindre Cancer Service**

- It was noted by the Chief Operating Officer that analysis of radiotherapy utilisation through the Aria insight programme, due to be delivered in March 2025. This will then be shared with the Committee, as per page 11.
- It was highlighted by a Committee Member that where there was a breach of radiotherapy waiting times, the days of waiting for treatment had reduced and that appropriate harm reviews had been conducted.
- It was noted by the Chief Operating Officer that additional capacity for SACT had been operational from w/c 13th January, as per plan stated in this report. The impact is being monitored and will be shared with the Committee in next reporting period. The objective is to develop a six-seven day working business case.

**Welsh Blood Service**

- It was noted by the Chief Operating Officer that there had been a good outcome of demand and capacity planning for Christmas period, with no alerts required.
- The Deputy WBS Director noted that that the Medicines and Healthcare Regulatory Agency (MHRA) have conducted an on-site review in December and the results will be shared with the Committee.
- There were questions by Committee Members regarding the adverse event regarding loss of 84 donations was discussed and it was agreed that further detail and context should be added to this report, including the consideration under Duty of Candour. This is now included on page 13 for Trust Board.
- Deputy WBS Director noted that 100% of incidents had been closed within the 30 day target and the root cause theme analysis for this period had resulted in a focus on training on equipment set up.
- The performance in stem cell collection was welcomes by Committee Members.

**Patient and Donor Experience**

- The previous challenge from Committee Members regarding the 85% target for patient and donor experience under the Civica framework was discussed.
- It was noted that there is national work on a patient experience framework. This will include the introduction of SMS text messaging platform for a revised Civica feedback tool rolled out from April 2025. This should provide significantly higher volumes of response for Velindre Cancer Service.
- Based on the existing feedback, it was noted that there has been further work on the c10% of patients who rated their experience as fair or poor to understand the root causes further and this enhanced narrative is forming part of the Q3 patient and donor experience report, which will be brought to the next Committee.

| **7 LEVELS OF ASSURANCE - ASSURANCE RATING ASSESSED BY BOARD DIRECTOR / SPONSOR** | |
|---|---|
| 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 and 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** | |
|---|---|
| N/A | |
| **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

**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 of 1st January 2025 is reported below.

| 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<br><br>(To be repeated 6 - monthly) | **Completed** – Compliance summary table now included in each PMF | Director of Velindre Cancer Service<br><br>Director of Welsh Blood Service<br><br>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' reporting on key performance areas. | 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 weeks. This will be completed | Executive Director of Nursing, Allied Health Professionals and Health Science |

| | | | | |
|---|---|---|---|---|
| | | | in time for reporting from Quarter 2 (2025 / 2026). | Director of Transformation – Interim |
| 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.<br><br>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. | Executive Director of Executive Director of Nursing, Allied Health Professionals and Health Science<br><br>Director of Transformation – Interim<br><br>Trust Digital PMF Lead |
| 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 it has been agreed that this will be completed by 31st January 2025. | 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 | Director of Transformation – Interim |

| | | | | |
|---|---|---|---|---|
| | | | for the Trust Executive Management Board, the Trust Quality, Safety and 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.<br><br>New measures being developed for:<br><br>R&D KPIs<br>Phycology service KPIs | Director of Velindre Cancer Service<br><br>Director of Welsh Blood Service<br><br>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<br><br>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 |

**a. Radiotherapy**

# Radiotherapy Waiting Times

**November 2024**

| | | |
|---|---|---|
| **Scheduled** | Number referrals | 240 |
| | % within 21 days (target 100%) | 222 (93%) |
| | Longest wait | 32 days |
| | 99.6% (239) patients seen within 28 days* | |
| **Urgent SC** | Number of referrals | 26 |
| | % within 7 days (target 100%) | 17 (73%) |
| | 100% (26) patients seen within 14 days* | |

**Updates on Last Month:**

- Pre – treatment CT capacity remained constant at 17 hrs per day.
- Planned Linac Capacity is 75 hours per day with an increase to 76.5 planned for December
- Linac uptime Varian 99% and Elekta 95% - reduction in Elekta uptime due to age of machine (repeated kV enable drop fault)
- November Radiotherapy referrals saw a decrease since October to 346, just under the Q1- Q2 expected average of 359.
- This drop in demand benefited performance.
  - Scheduled from 82% to 93%,
  - Urgent SC from 61% to 73%
  - Emergency maintained at 100% compliance.
- Longest wait for scheduled treatment decreased from 41 to 32 days

**Action / Mitigation Underway:**

- Short term capacity has been offered prior to confirmation of extending life of LA1 to May 2025, with a benefit of 7.5 hrs /day.
- 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 full fleet replacement.

**Key Issues / Risks**

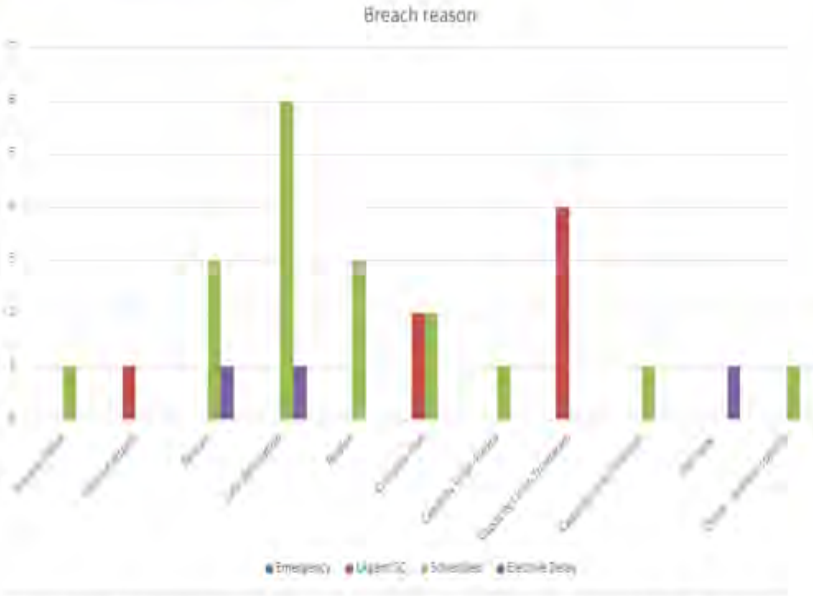
- Alignment of consultant job plans with radiotherapy pathway timings results in non-capacity related breaches.
- Ability to forecast and manage this will increase once Aria InSightive. Now expected post-March '25, as a result of the delays in the DHCW 'Go paperless' programme

**Forecast / Next Month:**

- Performance will continue to recover and stabilise due to capacity gained from LA1 extension
- Actual performance improvements may be evident in the medium to long term, linked to improvement in pathway management as well as linac capacity
- December capacity is planned to be maintained at 76.5 hours per day
- Additional weekend capacity has been created to compensate for Bank holidays for category 1 patients

# Radiotherapy - Breach data

November 2024




*Trend analysis - 2x complex plan required, 6 x late delineation, 3 x rescan required*

## Improvement Plan (Breach Themes

The analysis of breaches has identified the three themes below;

### Capacity

To mitigate these risks as part of the paperless implementation March '25 & to ensure capacity is maintained through Radiotherapy Satellite at Nevill Hall Hospital implementation. The following steps have been taken;

- a business case is underway to support locum staff
- extension of LA7 end of life from 1/5/2025.
- Review of linac uptime to be undertaken with Radiotherapy and Radiotherapy physics

### Pathway

Implementation of Aria Radiotherapy system to reduce the risk of process failures in requesting radiotherapy .
Implementation of Carepath for Radiotherapy IR(ME)R practitioners to improved visibility of the individual patient pathway.

### Activity reporting

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

- Capacity utilisation
- Development in readiness to InSightive (Oncology Specific Analytics) implementation
- Development of activity reporting for Brachytherapy and activity report – following paperless go live
- Undertaken by Co-ordinator & Data & Insight team until functionality comes on-line in March

# Radiotherapy – utilisation

November 2024

| | October | November | December |
|---|---|---|---|
| Planned Linac Clinical capacity | 1522 hrs | 1438.5 hrs | *1318.5 hrs |
| Scheduled (booked) Linac activity | 1429 hrs | 1306.5 hrs | TBC |
| Delivered Linac activity | **1359.8 hrs** | **1186.6hrs** | **TBC** |
| Cancelled Linac activity | 69.2 hrs | 50.5 hrs | TBC |

- Due to the age of our linacs and the need to maintain capacity while delivering the ambitious IRS roll-out programme, to ensure the available capacity is maximised utilisation is continually monitored
- This equates to approximately 8.24 hours per day across 20 working days in December.
- Linac capacity for Truebeam has been extended in December to provide additional capacity for Urgent Symptom Control referrals.

**December hours include reduction due to bank holiday days .*

# SACT Non-Emergency Waiting Times

**November 2024**

| Month | Unvalidated Performance* | Validated Performance |
|---|---|---|
| July 2024 | 65% | 89% |
| August 2024 | 60.45% | 87% |
| September 2024 | 65.44% | 88% |
| October 2024 | 70.81% | 91% |
| November 2024 | 68.5% | 91% (awaiting formal report) |

**We typically see a 16-20% increase in position following Breach Validation.*

**Updates on Last Month:**

- Improved booking utilisation of Medicine at Home to achieve 80 slots per week.
- On going work via SACT delivery group implemented to increase capacity by 45 treatment slots.
- Work started to review the Model of Care for SACT pre-assessment from Consultant delivered to Consultant led (phase 1) . Recruitment processes under way for ACP posts and to expand the VAP service to deliver the workforce change.
- SACT performance oversight now available by 4th of the month.
- The Cancer PTL (single source of the truth) has been commissioned and the 16week programme will commence in Jan'25

**Key Issues / Risks:**

- Referral rate up in line with projections, resulting in demand spikes across all aspects of the SACT treatment pathway.
- Known seasonal spike forecast January
- Work underway with HBs to forecast demands, as part of Cancer PTL project
- Mitigations developed by Data & Insight and local teams to try to offset the lack of visibility
- Workforce capacity issues have been identified across Nursing, Pharmacy and Digital & Insight. Bespoke recruitment support has come on-line to support.

**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 now engaged in clinical validation to support timely reporting and free up clinical resource and undertaking QA process for full patient pathway to rectify issues early
- Unused capacity report live to maximise scheduling of chemotherapy delivery
- Soft launch of SharePoint data site in January 2025.

**Forecast / Next Month:**

- A further 45 treatments per week from the Pharmacy expansion plan will be implemented from 13th Jan 2025 . Temporary staffing solutions in place until all substantive recruitment concluded for nursing and pharmacy.
- Update on-going initiatives via the SACT delivery group
- Exploring options for further hours required per week.
- Focus on 36 hr compliance for confirmation and authorisation of prescriptions.

# Breach data

November 2024

| | Sep 24 | | October 24 | |
|---|---|---|---|---|
| Number of days waiting | Referrals | Percentage of referrals treated within time frame | Referrals | Percentage of referrals treated within time frame |
| 0-7 days | 131 | 33.5% | 380 | |
| 8-14 days | 94 | 24.0% | | |
| 15-21 days | 118 | 30.2% | | |
| 22 - 28 days | 44 | 11.3% | 38 | |
| 29 - 35 days | 3 | 0.8% | 1 | |
| 36 - 42 days | 1 | 0.3% | | |
| 43-49 days | | | 4 | |
| Total | 390 | | 423 | |

**Capacity Actions**

- 48 patients over 21days for Oct (decreased by 5 since Sept)
- De-couple cycle 1 to enable early treatment start date.
- All breaches are related to capacity
- Unused capacity are being investigated and report available to identify avoidable and unavoidable reasons to support service improvements .
  Themes include;
  - OON completion and processing,
  - clinic-based issues,
  - booking errors.

  Corrective actions including implementing increased quality assurance steps and OON process failures presented at SMSC medical teams, to increase awareness etc
- On-going review of SACT performance and capacity via the SACT Steering and Delivery groups.
- Nursing support increased activity and match pharmacy from mid-January .
- Review of shift pattern in Nursing moving to 12-hour shifts from mid-March 2025.
- Pharmacy review as part of next phase

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**b. Welsh Blood Service**

# WBS Key Points / Highlights

November 2024

Gwasanaeth Gwaed Cymru
Welsh Blood Service

**Adverse Events**

- Two adverse events were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in November. The total amount of reportable incidents to date is comparable with the same period last year and is consistent with other UK Blood Services.
  - Incorrect assessment of donor travel risk.
  - The loss of 84 donations due to donor data from USB drives from clinic failing to integrate to the Blood Establishment Computer System (ePROGESA).
  - The digital outage prevented these donations undergoing their mandatory safe testing, meaning that they were not safe for patient use and needed to be discarded. The WBS Quality and Safety team took advice on the reporting requirement under the Duty of Candour. In discussion with the by the NHS Executive it was confirmed due to the volume of donors affected and the potential, that the thresholds for reporting had not been met as there was no harm to patients or donors.

  Multidisciplinary reviews were performed for each event including a risk review. Both events are under Root Cause Analysis (RCA) investigation. Confirmatory reports are due to be submitted to the MHRA on 24/12/24.

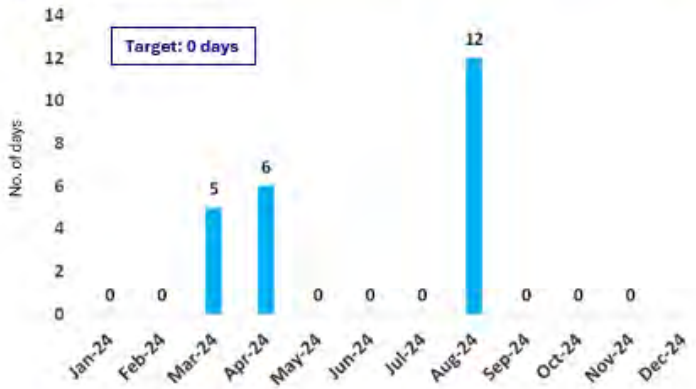
**Quality Incidents (closed within 30 days)**

- Quality incidents closed within 30 days reached 100% against a target of 90%, surpassing the target every month for the past 12 months.

# Red Cell Stock Level (below 3 days) – O, A & B+

Gwasanaeth Gwaed Cymru
Welsh Blood Service

**November 2024**




**Key Issues / Risks:**

- Variations in demand or collection across different blood groups can result in a mismatch between supply and demand.

**Action / Mitigation Underway:**

- Continued daily Resilience Group meetings to ensure immediate operational responses to mitigate predicted issues.
- A Task & Finish Group has been established, and collaboration with the Data & Insights team is underway to distinguish between regular fluctuations and unusual changes in the blood supply chain, to enable more informed decision making. The next meeting is scheduled in January 2025.

**Updates on Last Month:**

- In November, all clinical demand was met without triggering any alert or escalation measures for the third consecutive month, which compares favourably to NHSBT.
- We currently have 1000 units more in stock compared to the same period last year.

**Forecast / Next Month:**

- Christmas bank holiday planning has been ongoing for the last few months, with a focus on stock growth through September, October and November. To ensure adequate blood supply over the Christmas and New Year period, additional weekend clinics have been scheduled.

# Stem Cell Collections

Gwasanaeth Gwaed Cymru
Welsh Blood Service

**November 2024**

## Updates on Last Month:

- Transplant Centre demand for Stem Cell collections was met, but we 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.
- The total cell provision for the service was 9: 4 stem cell collections from Welsh donors (PBSC), one lymphocyte collection from a Welsh donor, and 4 cell imports from other registries for the University Hospital of Wales. There is currently no KPI target for overall provision.

## Key Issues / Risks:

- The number of donors on the volunteer panel directly affects the stem cell collection requests the Welsh Bone Marrow Donor Registry receives. The annual target of 80 collections, set in 2016, has been unrealistic due to reduced donor recruitment. With the current panel at **73,500**, achieving this target would require over **123,000** donors.
- Although swab recruitment has increased volunteers, 24% of these donors have sub-optimal genetic typing results, unlike blood donor volunteers, making them less likely to be selected for collection.

## Action / Mitigation Underway:

- WBS has prioritised stem cell donor recruitment via buccal swabs and blood donor clinics, reaching 4,000 donors by November. Sustaining this will boost stem cell product requests and collections.
- Several actions are in progress to improve genetic test results, including increasing awareness of proper swab techniques, introducing electronic processes for donor information to speed up genetic testing, and increasing resources to prevent delays and DNA degradation.
- WBS will review this KPI and incorporate a more realistic income projection for the next financial year.

## Forecast / Next Month:

- The strong performance in recruiting stem cell donors is expected to enhance overall performance. However, the target needs to be reviewed to ensure it remains realistic and achievable, whilst being mindful of advances in other therapies.

# Reference Serology Turnaround Times (2 working days)

Gwasanaeth Gwaed Cymru
Welsh Blood Service

**November 2024**

**Updates on Last Month:**

- Performance did not meet the target this month. The downward trend is partly due to a section leader vacancy, which left only one person to authorise test results. This role has now been filled, and a review of business continuity is underway to further increase authorisation capacity.
- **Compatibility testing (46% of referrals) continues to meet clinical need with 'time critical' tests prioritised and completed within required timeframe, maintaining safety of clinical care.**

**Key Issues / Risks:**

- Ongoing staff turnover and the replacement of key roles are hampering performance. This area requires specialist skills, adding to the risk.
- This metric is currently under review to align with the agreement with customer hospitals, as outlined in the RCI User Guide, which specifies that 90% of results should be delivered within 5 working days.

**Action / Mitigation Underway:**

- Addressing turnover through retention strategies, succession planning, effective onboarding and review of exit interviews.
- Recommendations from the RCI independent review are being prioritised, with an action plan targeting critical areas first for systematic improvements.
- Metric to be updated to bring in line with RCI User Guide as part of current review of WBS KPIs.

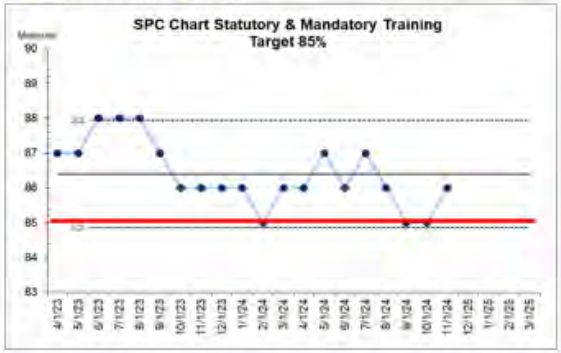
**Forecast / Next Month:**

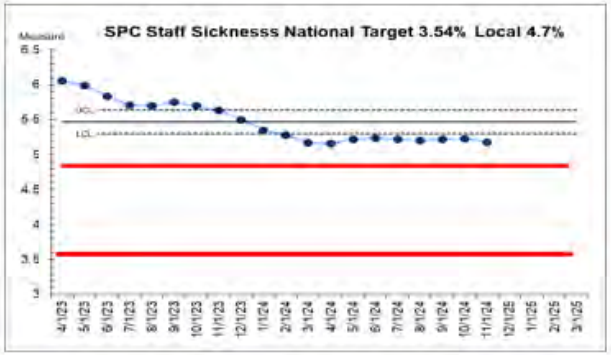
- Short-term improvements are expected from additional results authorisation capacity.
- Medium to longer term improvements will come from mitigating workforce issues and implementing the review recommendations.

**c. Workforce and Wellbeing**

# Workforce, Wellbeing & Organisational Development

November 2024






**Updates on Last Month:**

- **Statutory &Mandatory Training** – remains above target of 85% and has been for the year to date.
- **PADR** – New PADR Policy approved by Trust Board in September 2024.
  **Sickness** – Deep dive analysis on data presented to QSP in November 2024. Divisional action plans in development for December 2024.

**Forecast / Next Month:**

- **PADR** – Supporting PADR documents are in development to streamline the process and underpin the new PADR Policy. This work will support managers to undertaken PADRs more effectively.
- **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, processes and data analysis to draft comprehensive and holistic action plans for improvements.
- Fundamentals of Management Training Package to Launch December 2024

**Key Issues / Risks:**

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

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**d. Patient and Donor Experience**

# Patient and Donor Experience

**November 2024**

| VCC | Sep 23 | Oct 23 | Nov 23 | Dec 23 | Jan 24 | Feb 24 | Mar 24 | Apr 24 | May 24 | June 24 | Jul 24 | Aug 24 | Sep 24 | Oct 24 | Nov 24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Would you recommend us? % | 95 | 95 | 94 | 95 | 89 | 97 | 96 | 92 | 93 | 98 | 98 | 96 | 95 | 97 | 97 |
| Your Velindre Experience? % | 83 | 83 | 87 | 95 | 98 | 94 | 94 | 92 | 96 | 93 | 96 | 96 | 88 | 93 | 91 |
| Target CIVICA 85% | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 | 85 |

**Updates on Last Month:**

- **VCS Friends and Family** (would you recommend us?) target = good or above (Good + very good) Very Good 86.87% + Good 10.10% = 96.97%
- **VCS Your Velindre Experience** target = good or above (good + very good +excellent) Excellent (10/10) 71.62% + Very good (9/10) 15.54% + Good (8/10) 6.08% = 93.24%
- **WBS At 95.8%,** donor satisfaction decreased slightly, but performance remained above target in October.

**Forecast / Next Month:**

- **VCS** Q+S team to work with each directorate to provide further analysis on responses
- **WBS** Findings are reported at Collections Services Monthly Performance Meetings (OSG) to address any actions for individual teams.

**Action / Mitigation Underway:**

- **VCS** Outcomes from CIVICA are reviewed monthly and form part of SLT Q&S highlight report and the QSP report
- **WBS** 'You Said, We Did' actions are also reported.

**Key Issues / Risks:**

- **VCS** Q+S team to review the difference in positive percentages for both surveys

**f. Digital Services**

# Digital Services

November 2024

**Updates on Last Month:**

- **Phishing campaign** - The November campaign wasn't as complex as October but still shows a remarkable drop in users clicking URL compared to recent campaigns which validates the campaigns effectiveness.
- One **significant incident** in November 2024, relating to server outages at Velindre Cancer centre Node Room B, due to an air conditioning failure.
- Achieved a 90% incident resolution rate through improved performance and efficiency again for a second month.

**Forecast / Next Month:**

- Further Cyber Phishing campaigns to improve awareness
- New Print management service currently being deployed in the Welsh Blood Service and Trust Headquarters. Further installation to be completed in January at the Velindre Cancer Centre with the full removal of the legacy service.
- Additional Capital funding approved for the Technical refresh of digital client devices and Network/Server infrastructure. Procurement underway.

**Action / Mitigation Underway:**

- Significant incident action - Replacement Air conditioning unit in Node Room B (Completed)
- Significant incident mitigation - Smarter temperature and monitoring solution being scoped and purchased for all critical digital node rooms (Data centres), to link to the building management system. (Jan 2025)

**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%.

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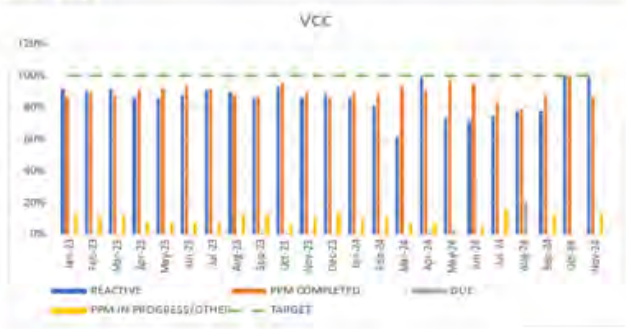
**g. Estates Infrastructure and Sustainability**

# Estates, Infrastructure and Sustainability

**October 2024**



**Updates on Last Month:**

- VCC – PPM 87% Reactive 100%
- WBS HQ PPM 89% Reactive 98%
- Dafen PPM & Reactive 100%
- North Wales - Bangor & Wrexham PPM & Reactive 100%
- 19 Park Road PPM & Reactive 100%
- Nantgarw HQ PPM & Reactive 100%

**Forecast / Next Month:**

- 476 PPMs planned for VCC
- 193 PPMs planned for WBS sites.
- Backlog of November tasks have been prioritized through December

**Action / Mitigation Underway:**

- Manually cross referencing PPM tasks to ensure system continuity of work PPM tasks to be distributed.
- All Statutory obligations were completed in November

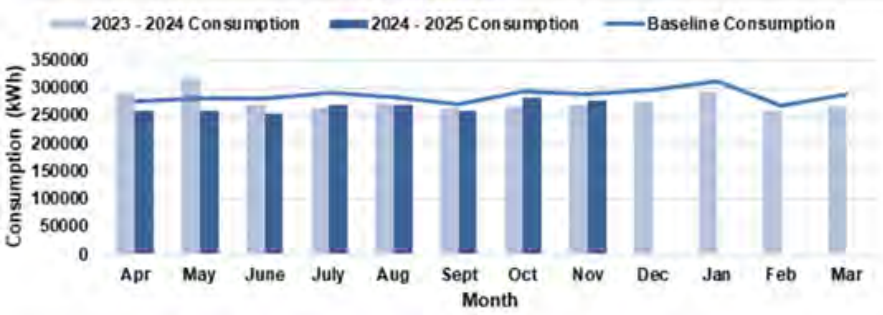
**Key Issues / Risks:**

- Reporting function on Symbiotic currently causing issue. Road map to resolve fix estimated by 31st March 2025.
- Unable to meet benchmark compliance at WBS HQ & VCC due to staff sickness absence 2 staff members absent for a total of 3 weeks through November
- Staff vacancy in department for Mechanical Technician recruitment completed start date January 2025

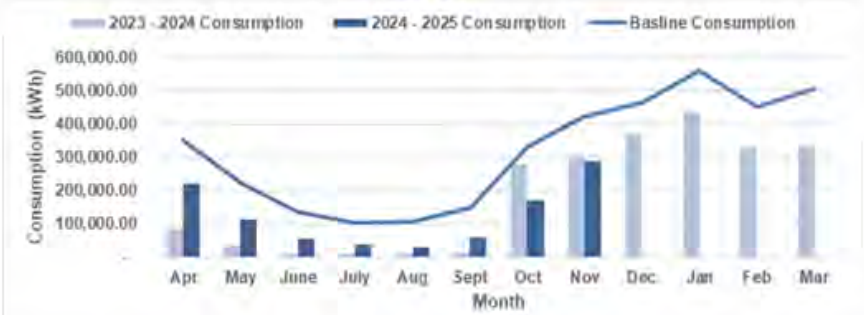
# Estates Sustainability

November 2024

Electricity - VCC




Gas - VCC




**Updates on Last Month:**

- Reduction of gas consumption.
- Slight increase in electricity consumption across the Trust, still lower than baseline consumption.

**Forecast / Next Month:**

- Continued elevation in gas / electricity consumption and associated costs.
- Ongoing Building Management system Monitoring to improve levels of usage within VUNHST Buildings.

**Action / Mitigation Underway:**

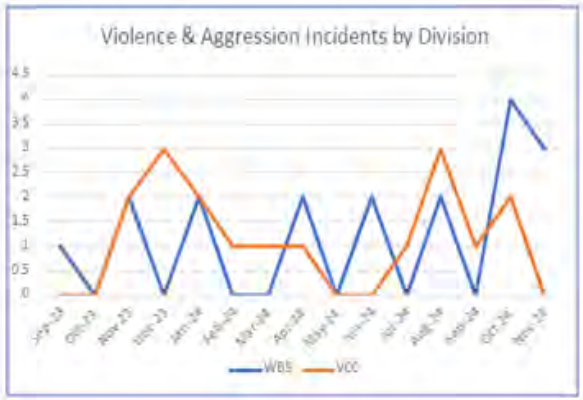
- Internal Energy Management Audits of departments. Seeking enhanced energy controls on the BMS to increase energy efficiency across the Estate. Monitoring of consumption ongoing through EMG.
- LINAC consumption under review with benchmarking against SBUHB, Meeting to be arranged with RT Staff to explore further improvements in January 2025.

**Key Issues / Risks:**

- Elevated gas usage for the Trust due to cooler temperatures in the last quarter and 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 frequently attend.

# Health & Safety

**November 2024**




**Updates on Last Month:**

- WBS – 1 x Riddor incident
- VCC – 6 x Incidents
- Corporate – 0 x incidents

**Forecast / Next Month:**

- To engage with staff surrounding the safety culture survey

**Action / Mitigation Underway:**

- The Health and Safety Culture survey is currently on hold until the star of the new year, during which time we will keep gathering information for the yearly plans' action plan
- Organisational change request to integrate the divisions' health and safety personnel with corporate has now been signed off by EMB.

**Key Issues / Risks:**

- Patient manual Handling compliance has dropped this month; PMH equipment purchased, ongoing recruitment part of OCP to employ inhouse Trainer. Engagement with clinicians to discuss the releasing of staff to undertake PMH training courses to support training compliance.

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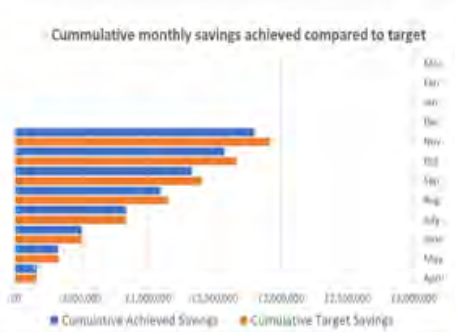
**h. Finance**

# Financial Services

**November 2024**

| 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 | | | | |
| 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 | | | | |
| Target £17.784m CEL | | 0.416m | 2.113m | 4.925m | 6.322m | 7.419m | 8.153m | 14.749m | 23.018m | | | | |




**Updates on Last Month:**

- The revenue position for October 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 it 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 November is 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 it CEL (Capital Expenditure limit) subject to receiving funding from WG to support the nVCC enabling and project costs.

**Action / Mitigation Underway:**

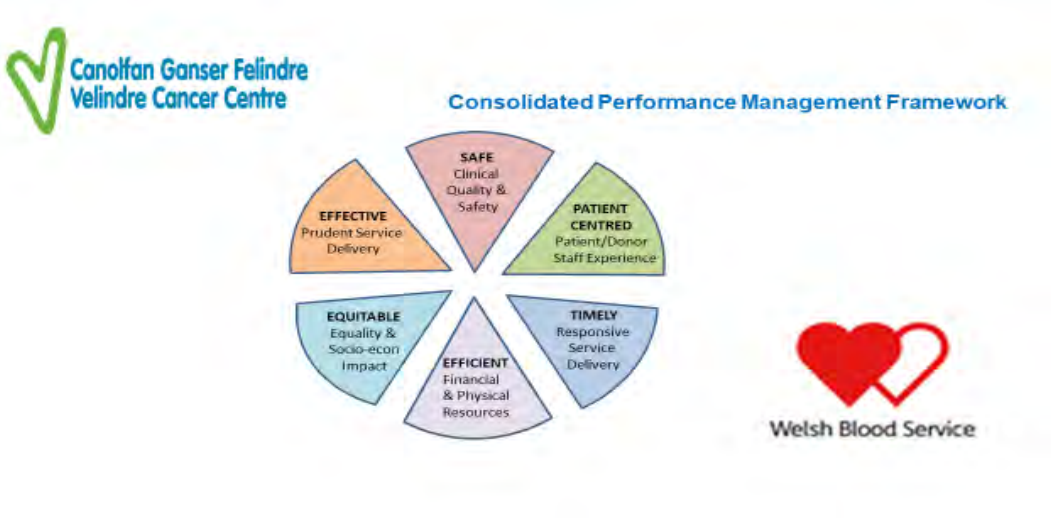
- VCS LTA Activity is under urgent review within the Division to assess if the original forecast income will recover to forecast demand and ensure that all activity is being captured and costed correctly.
- Finance colleagues in conversations with the WG Capital team to secure the nVCC funding requirement required for 2024-25.

**Key Issues / Risks:**

- VCS LTA income activity will not match the level of investment into services at VCS.
- Risk to the Trust achieving its CEL if funding is not secured to support the nVCC. However, the risk is low following the nVCC FBC approval.

## 4 ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION - VELINDRE UNHST PERFORMANCE SCORECARDS FOR NOVEMBER 2024.

a. 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.




### b. 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.

## Cancer Services Scorecard as at November (month 08) 2024/25.

| QSF Domain | Cancer Services Safety Scorecard | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | Key Performance Indicator (KPI) | Target | Reported | Baseline March 23 | Target | Actual | In Month Position | Cumulative data trend |
| Safety | Number of Cancer Service acquired (avoidable) patient pressure ulcers | National | Monthly | 1 | 0 | 0 | ✓ | ➔ |
| | Number of VCC Inpatient (avoidable) falls | National | Monthly | 4 | 0 | 1 | ✓ | ➔ |
| | % 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 | 0 24/25 | ✓ | ➔ |
| | 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 | 2 24/25 | ✓ | ➔ |
| | Number of Healthcare acquired Infections (HAIs) E Coli bacteraemia **(WHC 2024 (38) target)** | National | Monthly | 23/24 Base | 3 24/25 | 2 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% | 97% | ✓ | ➔ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Number of Health and Safety Incidents recorded | Local | Monthly | 9 | 9 | 6 | ✓ | ↑ |
| | Number of National VCS Reportable Incidents | National | Monthly | 0 | 0 | 0 | ✓ | → |
| | Number of Duty of Candour Incidents recorded | National | Monthly | 0 | 0 | 0 | ✓ | → |
| | 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% | 82% | ✗ | → |
| | Number of Staff RIDDOR Incidents, Injuries and Work Related Accidents | Local | Monthly | 0 | 0 | 0 | ✓ | → |

| QSF Domain | Cancer Services Effectiveness Scorecard | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | 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 | 0.02% | ✓ | → |
| | | Palliative | Monthly | TBA | TBA | 1.30% | ✓ | → |
| | Inpatient Mortality | Inpatient | Monthly | TBA | TBA | 3 | ✓ | → |
| | Number of Pathway of Care Delays | National | Monthly | 1 | 0 | 0 | ✓ | → |
| | % Personal Appraisal Development Reviews (PADR) Compliance | National | Monthly | 72% | 85% | 73% | ✗ | ↓ |
| | % Rolling average Staff sickness levels | National | Monthly | 6.43% | 3.54% 4.70% | 5.06% | ✗ | ↑ |

| QSF Domain | Cancer Services Experience Scorecard | Performance as at Month 08 (November) | Compliance against Target or Standard |
|---|---|---|---|

| | 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% | 97%<br>91% | ✓ | ➔ |
| | % of 'formal' concerns responded to within 30 working days | Local | Monthly | 100 | 85% | 83% | ✗ | ➔ |
| | Number of Incidents of violence and aggression to staff | Local | Monthly | 7 | 0 | 3 | ✗ | ↑ |

| QSF Domain | Cancer Services Timeliness Scorecard | | | Performance as at Month 07 (October) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | 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%<br>47% | 80%<br>100% | 25%<br>93% | ✗ | ↓ |
| | Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days | National | Monthly | 6%<br>50% | 80%<br>100% | 8%<br>73% | ✗ | ➔ |
| | Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days | National | Monthly | 94%<br>100% | 80%<br>100% | 96%<br>100% | ✓ | ↑ |
| | Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days | National | Monthly | 27%<br>32% | 80%<br>100% | 94%<br>94% | ✓ | ↑ |
| | % Patients Beginning Non-Emergency SACT within 21 days June **Position** | National | Monthly | 98% | 98% | 88%<br>(Oct) | ✗ | ↑↓ |
| | % Patients Beginning Emergency SACT within 5 days June Position | National | Monthly | 100% | 98% | 100%<br>(Oct) | ✓ | ↑ |
| | % Patients receiving equitable and timely access to Therapy Services | Local | Monthly | 100% | 100% | 100% | ✓ | ↑ |

| QSF Domain | Cancer Services Efficient Scorecard | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | Key Performance Indicator (KPI) | Target | Reported | Baseline March 24 | Target | Actual | In Month Position | Cumulative data trend |
| | Electricity performance in kilowatt hours (kWh)against target consumption budget profile | National | Monthly | N/A | 261k | 277k | ✗ | ↑↓ |
| | Gas performance in kilowatt hours (kWh) against target consumption budget profile | National | Monthly | N/A | 293k | 288k | ✓ | ↑↓ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Water performance usage in cubic metres against target consumption | **Local** | **Monthly** | **N/A** | **2250m3** | **2000m 3** | ✓ | 🡅 |
| | Financial Balance – achievement of VCC forecast (£k) in line with revenue expenditure profile | **National** | **Monthly** | **£0k** | **£0k** | **£(65)k** | ✗ | 🡇 |
| | VCC expenditure (£k) on Bank and Agency staff against target budget profile | **National** | **Monthly** | **£156k** | **£156k** | **£291k** | ✗ | 🡆 |
| | Cost Improvement Programme – VCC achievement of savings (£k) in line with profile | **National** | **Monthly** | **£939k** | **£566k** | **£560k** | ✗ | 🡅 |

## Blood and Transplant Scorecard as at November (month 08) 2024/25.

| QSF Domain | Blood and Transplant Safety Scorecard | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | **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** | **1** | n/a | 🡇 |
| | Quality Incidents closed within 30 days | **Local** | **Monthly** | **96%** | **90%** | **100%** | ✓ | 🡅 |
| | Number of Incidents reported to Regulator / Licensing Authority | **Local** | **Monthly** | **0** | **0** | **2** | ✘ | 🡇 |
| | 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%** | **91%** | ✓ | 🡇 |
| | Number of Staff RIDDOR Incidents, injuries, and work-related accidents. | **Local** | **Monthly** | **0** | **0** | **1** | ✘ | 🡇 |

| QSF Domain | Blood and Transplant Effectiveness Scorecard | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | 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 | n/a | n/a | n/a |
| | % Demand for Red Blood Cells Met | Best practice | Monthly | 104% | 100% | 105% | ✓ | 🡻 |
| | % Demand for Platelet Supply Met | Best practice | Monthly | 133% | 100% | 119% | ✓ | 🡻 |
| | Red Blood Cell Stock Level (below 3 days) | Local | Monthly | 0 | 0 | 0 | ✓ | 🡺 |
| | % Time Expired Platelets (adult) | Local | Monthly | 20% | 10% | 6% | ✓ | 🡹 |
| | % Time Expired Red Blood Cells (adult) | Local | Monthly | 0.02% | 1% | 0.02% | ✓ | 🡻 |
| | New Apheresis Donors | Local | Quarterly | 21 | 14 | n/a | n/a | n/a |
| | Number of Stem Cell Collections per month | Local | Monthly | 6 | 7 | 4 | ✗ | 🡻 |
| | New WBMDR Marrow Donors | National | Monthly | 3341 | 333/month 4000/year | 4238 | ✓ | 🡻 |
| | Enhance the impact of RD&I & celebrate success - number of conference presentations | Local | Monthly | n/a | 5/year | 10 | ✓ | 🡹 |
| | % Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers | National | Monthly | 86% | 85% | 82% | ✗ | 🡻 |
| | % Rolling average Staff sickness levels | National | Monthly | 6.8% | 3.54% 4.70% | 6.31% | ✗ | 🡹 |

| QSF Domain | Blood and Transplant Experience Scorecard | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | 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% | 1.5% | ✓ | 🡺 |
| | % Part Blood Bags collected | Best practice | Monthly | 2.7% | 3.0% | 2.5% | ✓ | 🡹 |
| | % Donor Satisfaction | Local | Monthly | 95% | 95% | 98% | ✓ | 🡻 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Number of Concerns | **Local** | **Monthly** | **9** | **0** | **2** | ✗ | 🡅 |
| | % 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** | ✓ | 🡅 |

| **QSF Domain** | **Blood and Transplant Timeliness Scorecard** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target or Standard** | |
|---|---|---|---|---|---|---|---|---|
| | **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%** | **n/a** | n/a | n/a |
| | % Antenatal Turnaround Times (within 3 working days) | **Best practice** | **Monthly** | **96%** | **90%** | **94%** | ✓ | 🡇 |
| | % Reference Serology Turnaround Times (2 working days) | **Best practice** | **Monthly** | **70%** | **80%** | **62%** | ✗ | 🡇 |
| | % Turnaround Time (Deceased Donors Typing / Cross matching) | **Best practice** | **Quarterly** | **84%** | **80%** | **n/a** | n/a | n/a |

| **QSF Domain** | **Blood and Transplant Efficient Scorecard** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target or Standard** | |
|---|---|---|---|---|---|---|---|---|
| | **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** | **1.13** | ✗ | 🡇 |
| | Manufacturing Productivity | **Best practice** | **Monthly** | **418** | **392** | **419** | ✓ | 🡇 |
| | % Controllable Manufacturing Losses | **Best practice** | **Monthly** | **0.06%** | **0.5%** | **0.27** | ✓ | 🡇 |
| | Electricity performance kilowatt hours (kWh) against target consumption budget profile | **National** | **Annually** | **N/A** | **123k** | **129k** | ✗ | 🡆 |
| | Gas performance in kilowatt hours (kWh) against target consumption budget profile | **National** | **Annually** | **N/A** | **118k** | **122k** | ✗ | 🡅🡇 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Water performance usage in cubic metres against target consumption | **Local** | **Monthly** | **N/A** | **285m3 Apr** | **272m3** | ✗ | ↑ |
| | Financial Balance – achievement of WBS forecast (£k) in line with revenue expenditure profile | **National** | **Monthly** | **£0k** | **£0k** | **£(263)k** | ✗ | ↓ |
| | WBS expenditure (£k) on Bank and Agency staff against target budget profile | **National** | **Monthly** | **£0k** | **£0k** | **£22k** | ✗ | → |
| | Cost Improvement Programme – WBS achievement of savings (£k) in line with profile | **National** | **Monthly** | **£569K** | **£467k** | **£355k** | ✗ | ↓ |

## 2.5 Trust-wide Services Scorecards as at November (month 08) 2024/25.

## Estates Services.

| **QSF Domain** | **Estates Safety Scorecard – Trust-wide position** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target Standard** | |
|---|---|---|---|---|---|---|---|---|
| | **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 $kgCO_2$** | **-16% 18/19 $kgCO_2$** | **1600 $kgCO_2$** | ✓ | → |
| **QSF Domain** | **Estates Timeliness Scorecard – Trust-wide position** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target or Standard** | |
| | **Key Performance Indicator (KPI)** | **Target** | **Reported** | **Baseline March 23** | **Target** | **Actual** | **In Month Position** | **Cumulative data trend** |
| **Timeliness** | % PPM undertaken completed against plan | **Local** | **Quarterly** | **90%** | **95%** | **87% Sept** | ✗ | ↑ |
| | % Reactive maintenance achieved within agreed days/hours | **Local** | **Quarterly** | **80%** | **95%** | **85% Sept** | ✗ | ↑ |
| **QSF Domain** | **Estates Efficient Scorecard – Trust-wide position** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target or Standard** | |
| | **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** | **2412** | **2371** | ✗ | ↑ |
| | Trust HQ Gas performance in kilowatt hours (kWh) against target consumption budget | **National** | **Quarterly** | **N/A** | **5761** | **na** | ✗ | ↑ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Trust Waste Recycling performance by weight (Kg) | **Local** | **Monthly** | **4500Kg** | **4500Kg** | **4800Kg** | ✗ | ↑ |

## Health and Safety Services

| QSF Domain | Health and Safety Scorecard – Trust-wide position | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | **Key Performance Indicator (KPI)** | **Target** | **Reported** | **Baseline March 23** | **Target** | **Actual** | **In Month Position** | **Cumulative data trend** |
| **Safety** | RIDDOR reportable incidents of workforce | **Local** | **Quarterly** | **0** | **0** | **1** | ✗ | → |
| | % Fire Action Plan actions implemented | **Local** | **Quarterly** | **78%** | **100%** | **97%** | ✗ | ↑ |
| | Number of Health and safety incidents recorded | **Local** | **Monthly** | **14** | **14** | **7** | ✓ | ↑↓ |
| | % Fire Drills completed accordance with schedule | **Local** | **Quarterly** | **paused** | **100%** | **6 Jun** | ✗ | → |
| **QSF Domain** | **Health and Safety Effectiveness Scorecard – Trust-wide position** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target or Standard** | |
| | **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%** | **80%** | ✗ | → |
| | % 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%** | ✗ | ↓ |
| **QSF Domain** | **Health and Safety Experience Scorecard – Trust-wide position** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target or Standard** | |
| | **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** | **3** | ✗ | ↓ |

## Workforce and Organisational Development

| QSF Domain | Workforce and OD Safety Scorecard – Trust-wide position | Performance as at Month 08 (November) | Compliance against Target or Standard |
|---|---|---|---|

| | 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%** | ✓ | 🡅 |
| **QSF Domain** | **Workforce and OD Effectiveness Scorecard – Trust-wide position** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target or Standard** | |
| | **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%** | **74%** | ✗ | 🡅🡇 |
| | % Rolling average Staff sickness levels | **National** | **Monthly** | **6.22%** | **3.54% 4.70%** | **5.18%** | ✗ | 🡅 |
| **QSF Domain** | **Workforce and OD Experience Scorecard – Trust-wide position** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target or Standard** | |
| | **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%** | ✗ | 🡆 |
| **QSF Domain** | **Workforce and OD Equitable Scorecard – Trust-wide position** | | | **Performance as at Month 08 (November)** | | | **Compliance against Target or Standard** | |
| | **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%** | **6.16%** | ✓ | 🡆 |
| | Diversity of Workforce – % People with a Disability within workforce | **Local** | **Quarterly** | **4.63%** | **22%** | **6.43%** | 🡅 | 🡆 |
| | % of Workforce who have declared Welsh Language Listening/Speaking capability | **National** | **Quarterly** | **89.37%** | **100%** | **93.90 %** | 🡅 | 🡅 |

## Digital Services

| QSF Domain | Digital Safety Scorecard – Trust-wide position | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | 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% | ✗ | 🡻 |
| | % compliance with cyber security statutory & mandatory training | Local | Monthly | TBA | 85% | 82% | ✗ | 🡺 |
| | % of Trust expenditure in digital | Local | Annually | TBA | 4% | 2.6% | ✗ | 🡹 |
| | Number of significant IT business continuity incidents | Local | Monthly (rolling 12 months) | 12 | 6 | 11 | 🡹 | 🡻 |
| | Cyber Security - % of employees clicking on internal phishing campaigns | Local | Quarterly | TBA | <10% | 1.5% | ✓ | 🡹 |
| QSF Domain | Digital Experience Scorecard – Trust-wide position | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
| | 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% | ✓ | 🡹 |
| QSF Domain | Digital Timeliness Scorecard – Trust-wide position | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
| | KPI Measure | Target | Reported | Baseline March 23 | Target | Actual | In Month Position | Cumulative data trend |
| Timelines s | % 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% | ✓ | 🡺 |

| QSF Domain | Digital Efficient Scorecard – Trust-wide position | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | 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 | 25% | TBD | 🡻 |
| | % of donors booking online | Local | Monthly | 82.2%* | TBA | 82% | TBD | 🡻 |

## Finance Services

| QSF Domain | Finance Timeliness Scorecard – Trust-wide position | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
|---|---|---|---|---|---|---|---|---|
| | 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% | ✓ | ➔ |
| QSF Domain | Finance Efficient Scorecard – Trust-wide position | | | Performance as at Month 08 (November) | | | Compliance against Target or Standard | |
| | 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 | £0.023 m | ✓ | ➔ |
| | Trust expenditure (£k) on Bank and Agency staff against target budget profile | National | Monthly | N/A | £0.179 m | £0.433 m | ✗ | ➔ |
| | Financial Capital spend (£m) position against forecast expenditure profile | National | Monthly | £17.784m | £23.0189 | £23.018m | ✓ | ➔ |
| | Cost Improvement Programme £2.6 achievement of savings (£k) in line with profile | National | Monthly | N/A | £1.921 m | £1.8023 | ✗ | 🡻 |

## 5. IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below | |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety and experience ☒<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒<br>• A beacon for research, development and innovation in our stated areas of priority ☒<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒<br>• A sustainable organisation that plays its part in creating a better future for people across the globe ☒ | |
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)**<br>*For more information: STRATEGIC RISK DESCRIPTIONS* | 06 - Quality and Safety<br>Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | Yes -select the relevant domain/domains from the list below. Please select all that apply |
| | Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>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).<br><br>Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives |

| | |
|---|---|
| **TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT** | A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health |
| | If more than one wellbeing goal applies please list below:<br>Click or tap here to enter text |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| **EQUALITY IMPACT ASSESSMENT**<br>*For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx* | Not required - please outline why this is not required |
| | PMF report is focused upon monitoring performance against statutory and local stretch targets |
| **ADDITIONAL LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| | Click or tap here to enter text |

| TRUST BOARD | |
|---|---|
| **FINANCE REPORT FOR THE PERIOD ENDED 31ST DECEMBER (M9)** | |
| **DATE OF MEETING** | 30 January 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** | 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 December 2024.<br><br>The three main issues are highlighted below:<br><br>**1. Long Term Agreement (LTA) Financial values & Contract Rebase**<br><br><u>LTA Financial Values</u><br>All 2024-25 LTA financial values have been agreed and signed.<br><br>The financial settlement resulted in a:<br><br>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.<br><br>ii. £483k reduction in Hywel Dda UHB income non-recurrently compared to plan.<br><br>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.<br><br>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, the Trust will not be in a position to sign the LTAs for 2025-26 which may lead to arbitration.<br><br><u>LTA Contract Rebase</u><br><br>The Chair of the Collective Commissioners Group wrote to all Commissioner DoF on 25th September seeking responses by 18th October to the rebasing proposals:<br><br>• Retain the original principles of the 2019/20 rebasing exercise.<br>• Revise the original rebasing exercise to update the baseline using 2023/24 actual activity, expenditure, and income.<br>• 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£0.700m 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 quarter of the

| | |
|---|---|
| | financial year it is now very unlikely to recover before the end of March.<br><br>**3. Key Financial targets / KPIs**<br><br>• The Trust is currently reporting a small underspend on revenue and is forecasting to achieve an outturn position of Breakeven.<br><br>• 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.<br><br>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.<br><br>• 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 December2024 financial report and in particular:<br><br>• The year to date and forecast revenue and Capital out turn position, and PSPP performance.<br><br>• The agreed position on LTA income for 2024-25 from our Commissioners.<br><br>• 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 | 28.01.2025 |
| **SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS**<br>The Finance paper will be received at Executive Management Board on the 28 January 2025. | |
| **7 LEVELS OF ASSURANCE** | |
| **ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR** | **Select Current Level of Assurance** |

| **APPENDICES** | |
|---|---|
| Appendix 1 | Trust Finance Report – December 2024 |
| Appendix 2 | TCS Finance Report – December 2024 |

## 1. SITUATION / BACKGROUND

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

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 | 0.006 | 0.029 | 0.000 |
| **Capital** (To ensure that costs do not exceed the Capital Expenditure limit) | Actual Spend | 1.433 | 24.451 | 34.490 |
| **Public Sector Payment Performance** (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid). | % | 98.9% | 97.7% | 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 December 24 is an underspend of **£0.029m** 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£0.700m 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 quarter 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. The HEIW model shared suggests that there will be a funding gap of c£0.247m on the AFC pay award with M&D position still to be confirmed. Due to a number of organisations including Velindre questioning the reliability of the HEIW model the Trust is currently assuming that funding will be provided based on actual costs. 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.

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

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

*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. Hywel Dda UHB has

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, the Trust will not be in a position to sign the LTAs for 2025-26 which may 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.

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

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

The overall Trust savings performance as of December'24 is an underachievement against plan of **£(0.131)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.

## 2.4 PSPP Performance

During December'24 the Trust (core) achieved a compliance level of **98.9%** (November 98.8%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.7%** at the end of month 9, and a Trust position (including hosted) of **98.4%** compared to the target of 95%.

## 2.5 Covid Expenditure

The Trust is 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 December the majority have now either been reduced in risk or mitigated completely for 2024-25, however the two new risks have emerged recently in relation to the VCS LTA Activity performance and the funding expected to be provided against the 2024/25 pay award which have been flagged to WG.

There are several opportunities highlighted in the finance report including utilisation of the uncommitted investment reserves and the emergency reserve which would be used to support these risks should they crystallise.

**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 at the WG CRM meeting on the 21st of January that funding would be provided to support the 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**

Following the Trust receiving notification of funding for the WHAIS programme and some cost slippage on pre-approved schemes the Capital Planning Group during December approved and allocated out a further £0.483m to support prioritised schemes that could be delivered before the end of the financial year. The Discretionary programme currently has a remaining balance of £0.100m (including £0.025m contingency) to be utilised before the end of the financial year which will be considered for use against prioritised schemes at the Capital Planning Group in January.

*The CEL will be 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:<br>YES - Select Relevant Goals below | |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety, and experience ☒<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐<br>• A beacon for research, development, and innovation in our stated areas of priority ☐<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐<br>• A sustainable organisation that plays its part in creating a better future for people across the globe ☐ | |
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)** | 08 - Trust Financial Investment Risk |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | **Select all relevant domains below** |
| | Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>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 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:<br>YES - Select Relevant Goals below | |
|---|---|
| If yes select the relevant goals:<br><br>• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ | |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes - please Include further detail below, including funding stream<br>The Trust reported a revenue financial position of **£0.029m** underspend to December '24, 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.<br>**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) |
| **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 DECEMBER 2024/25

**TRUST BOARD**
**30/01/2025**

## 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, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2024-25

## 2. Background / Context

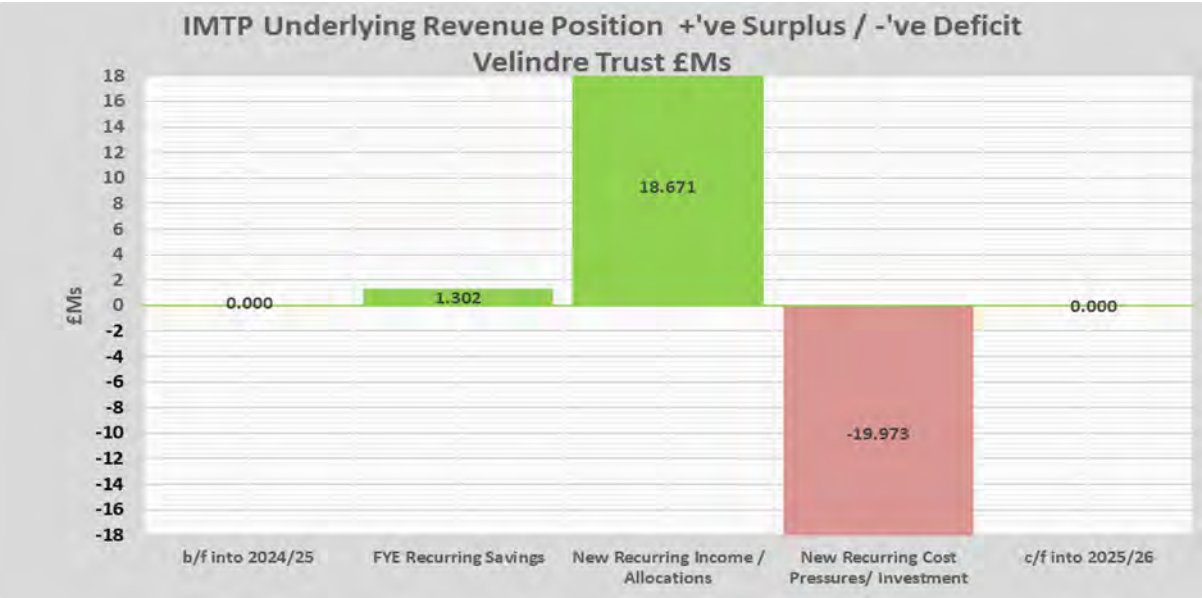
The draft Trust IMTP Financial Plan for the period 2024-2027 was set within the following context.

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

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

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

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




| Underlying Position +Deficit/(-Surplus) £Ms | b/f into 2024/25 | Recurring Savings | New Recurring Income / Allocations | FYE New Cost Pressures/ Investment | c/f into 2024/25 |
|---|---|---|---|---|---|
| Velindre NHS Trust | 0.000 | 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 | 0.006 | 0.029 | 0.000 |
| **Capital** (To ensure that costs do not exceed the Capital Expenditure limit) | Actual Spend | 1.433 | 24.451 | 34.490 |
| **Public Sector Payment Performance** (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid). | % | 98.9% | 97.7% | 97.0% |

### Performance against Planned Savings Target

| | Unit | Current Month £m | Year to date £m | Year End Forecast £m |
|---|---|---|---|---|
| Efficiency / Savings | Variance | (0.012) | (0.131) | 0.000 |

**Revenue**

The core Trust has reported £0.006m underspend position for December'24, which give a cumulative year to date position of **£0.029m** 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 December'2024 is **£33.694m**. This represents all Wales Capital funding of **£31.873m**, and Discretionary funding of **£1.911m.** The Trust reported total Capital spend to December'24 is £24.451m and is forecasting to remain within the CEL of £33.694m, which is following the Trust securing the funding requirement toward the nVCC Enabling and Project costs.

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

| | CEL | Movement | Current CEL |
|---|---|---|---|
| | £m | £m | £m |
| **Discretionary Capital** | **1.911** | | 1.911 |
| **All Wales Capital:** | | | |
| IRS | 5.164 | | 5.164 |
| IRS RSC | 11.265 | -1.200 | 10.065 |
| Digital RISP | 0.160 | | 0.160 |
| BECS | 0.750 | -0.416 | 0.334 |
| Backlog Maintenance | 0.350 | -0.200 | 0.150 |
| WG Year End Capital | | 0.220 | 0.220 |
| Whitchurch Land Transfer | | 7.800 | 7.800 |
| nVCC Enabling Costs | | 3.500 | 3.500 |
| nVCC Project Fees | | 4.390 | 4.390 |
| **Total All Wales Capital** | **17.689** | **14.904** | **31.783** |
| **Total CEL** | **19.600** | **14.904** | **33.694** |

**PSPP**

During December'24 the Trust (core) achieved a compliance level of **98.9%** (November 98.8%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.7%** at the end of month 9, and a Trust position (including hosted) of **98.4%** compared to the target of 95%.

**Efficiency / Savings**

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

The overall Trust savings performance as of December'24 is an underachievement against plan of **£(0.131)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 | | | | Forecast | | |
|---|---|---|---|---|---|---|
| £0.029m Underspent | | | | Breakeven | | |
| Type | YTD Budget (£m) | YTD Actual (£m) | YTD Variance (£m) | Full Year Budget (£m) | Full Year Forecast (£m) | Forecast Variance (£m) |
| Income | (168.604) | (169.356) | 0.752 | (228.648) | (229.400) | 0.752 |
| Pay | 72.677 | 71.695 | 0.982 | 97.067 | 96.085 | 0.982 |
| Non Pay | 95.927 | 97.633 | (1.706) | 131.581 | 133.315 | (1.735) |
| **Total** | **(0.000)** | **(0.029)** | **0.029** | **0.000** | **(0.000)** | **0.000** |

The overall position against the profiled revenue budget to the end of December 2024 is an underspend of **£0.029m** 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.

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. Initial indications are that WBS will not 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£0.700m 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 quarter 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.

The AFC and M&D pay award processed in November cost the Trust £4.811m based on actual staff in post. The HEIW model shared suggests that there will be a funding gap of c£0.247m on the AFC pay award with M&D position still to be confirmed. Due to a number of organisations including Velindre questioning the reliability of the HEIW model the Trust is currently assuming that funding will be provided based on actual costs. 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.

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

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

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 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.

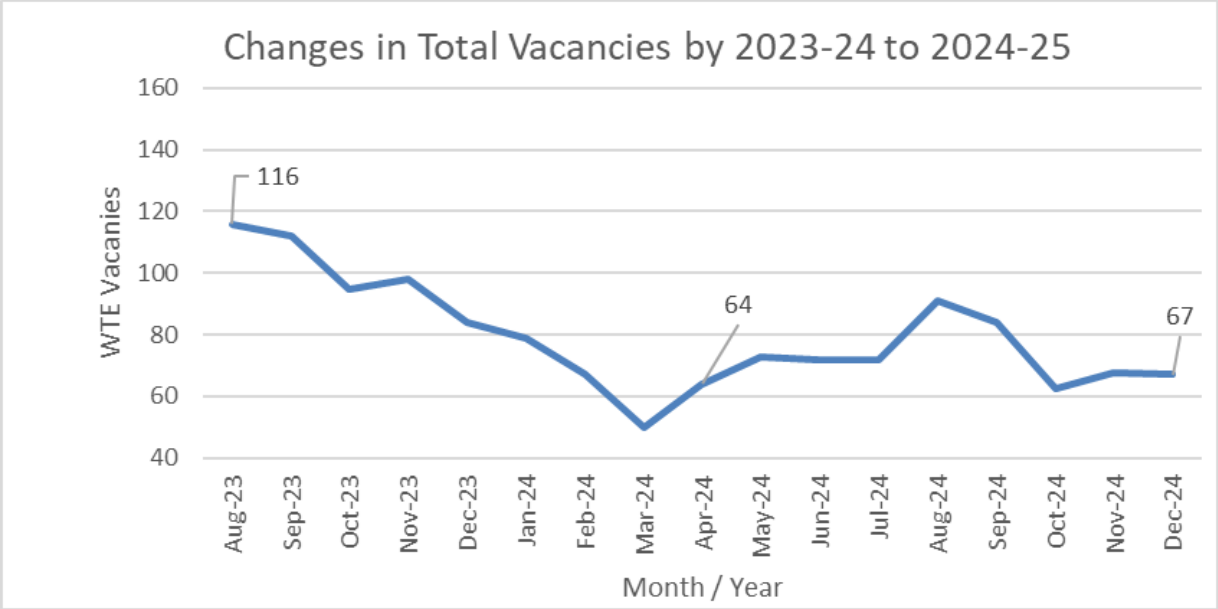
Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust revised savings target for each division has been updated as VCS £0.939m, WBS £0.569m (previously £0.650), RD&I £0.230m and Corporate £1.138m (previously £0.787m) for 2024-25.

**4.2 Pay Spend Trends (Run Rate)**

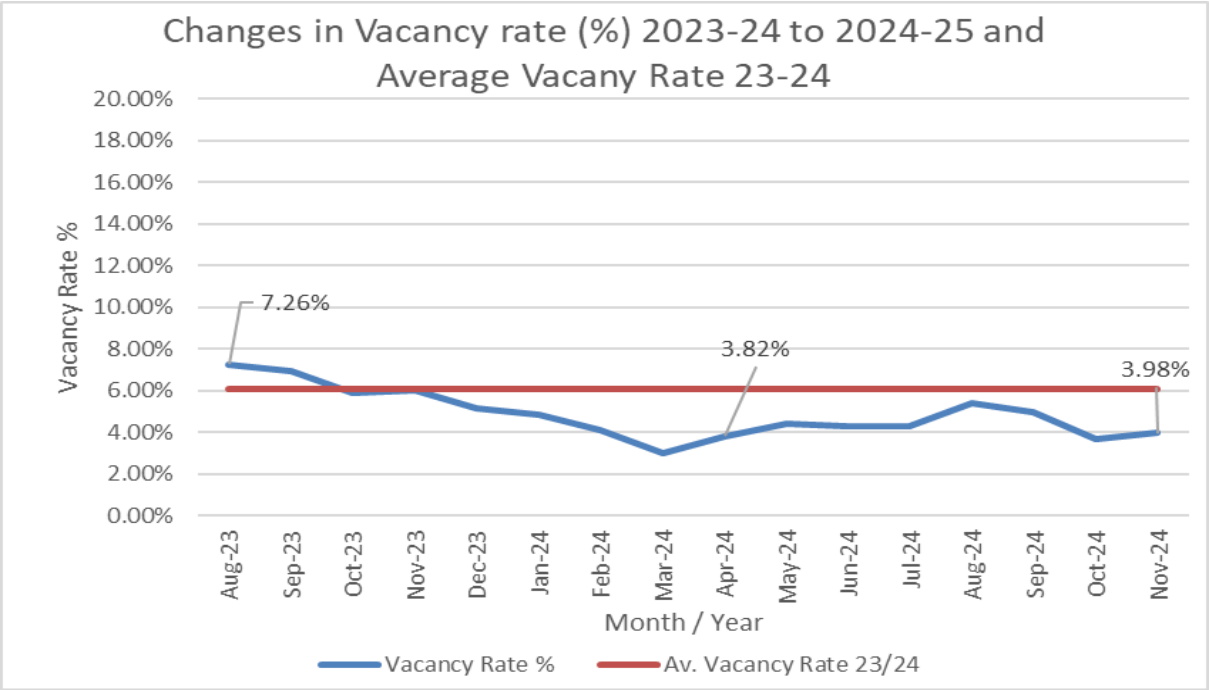
As of December 2024, the current staff in post is 1,638 WTE (November 1,632). The number of vacancies is 67 WTE, which represents a vacancy rate of 3.9% (4% November) against the budget of 1,705 WTE. The vacancy gap is largely being met using agency staff, overtime, or the use of bank, and is also supporting each of the division's vacancy factor savings target.

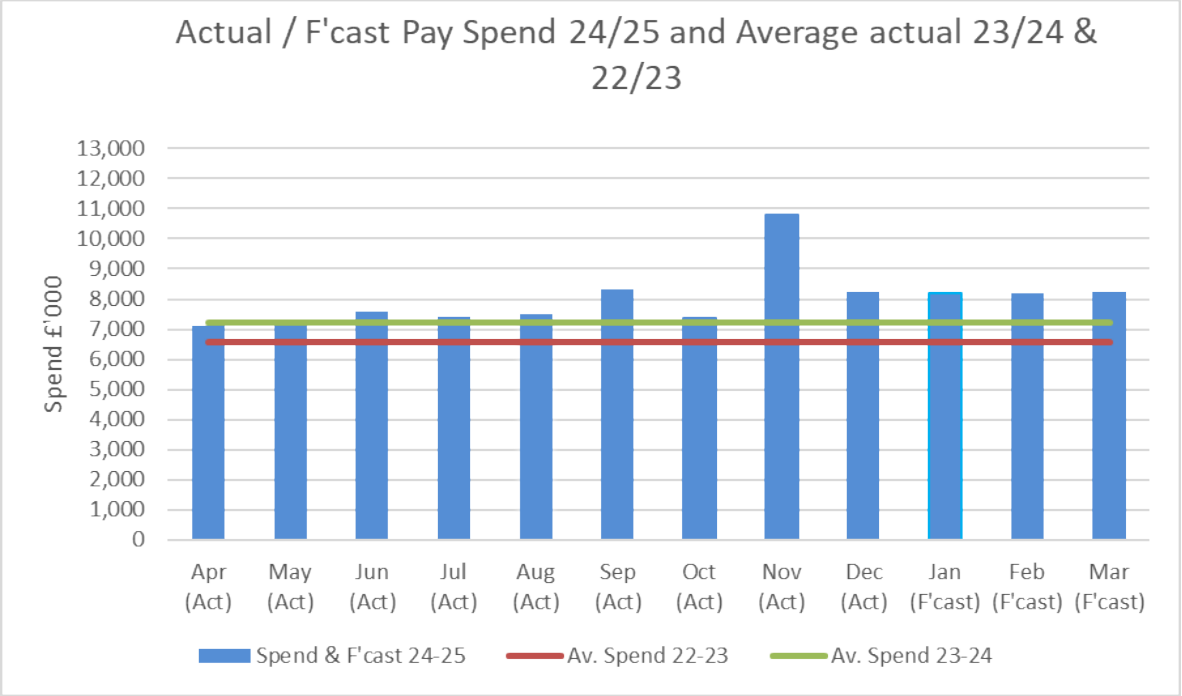
The level vacancies fell over the course of 2023-24 across several services areas but largely due to the recruitment of 17wte Nurses via the international recruitment scheme as demonstrated in the historic trend line on the chart below. As of August'24 vacancies had stated to rise again which is principally 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 recurited under Professional Scientific & Technical.



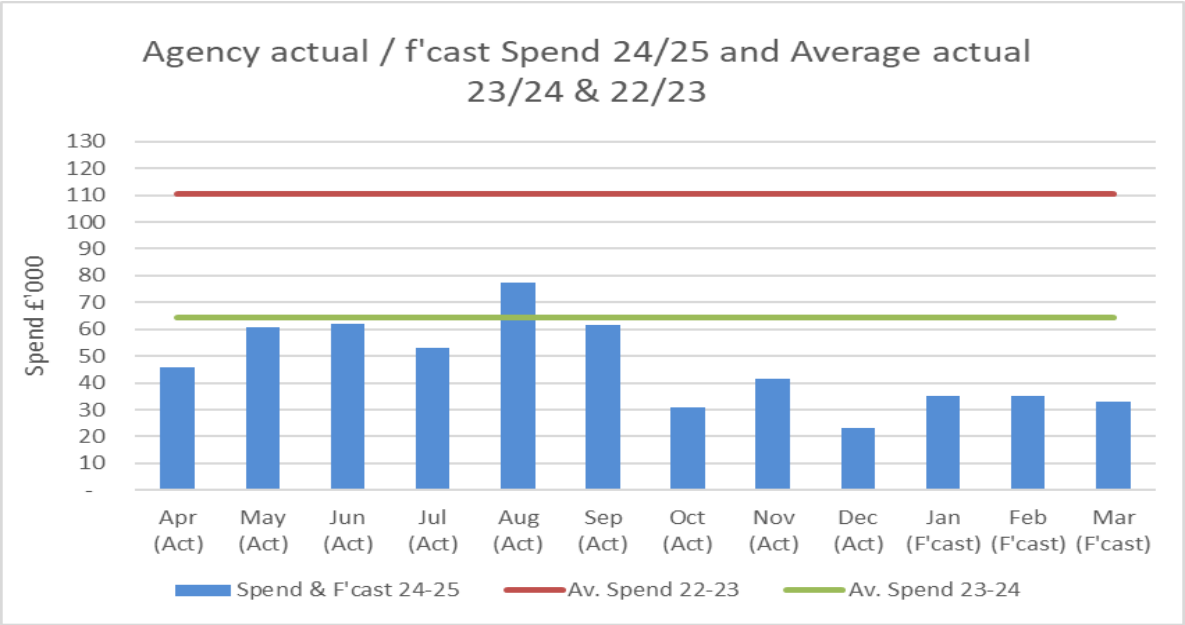

The total Trust vacancies as of December 2024 is 67wte (November 68wte), VCS (35wte), WBS (8wte), Corporate (11wte), R&D (8wte), TCS (3wte) and HTW (2wte).






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 which explains the step up in cost during the period and going forward.

The spend on agency for December'24 was **£0.023m** (November £0.042m) which gives a cumulative year to date position of **£0.456m** and a current forecast outturn spend of circa **£0.559m** (£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. 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.

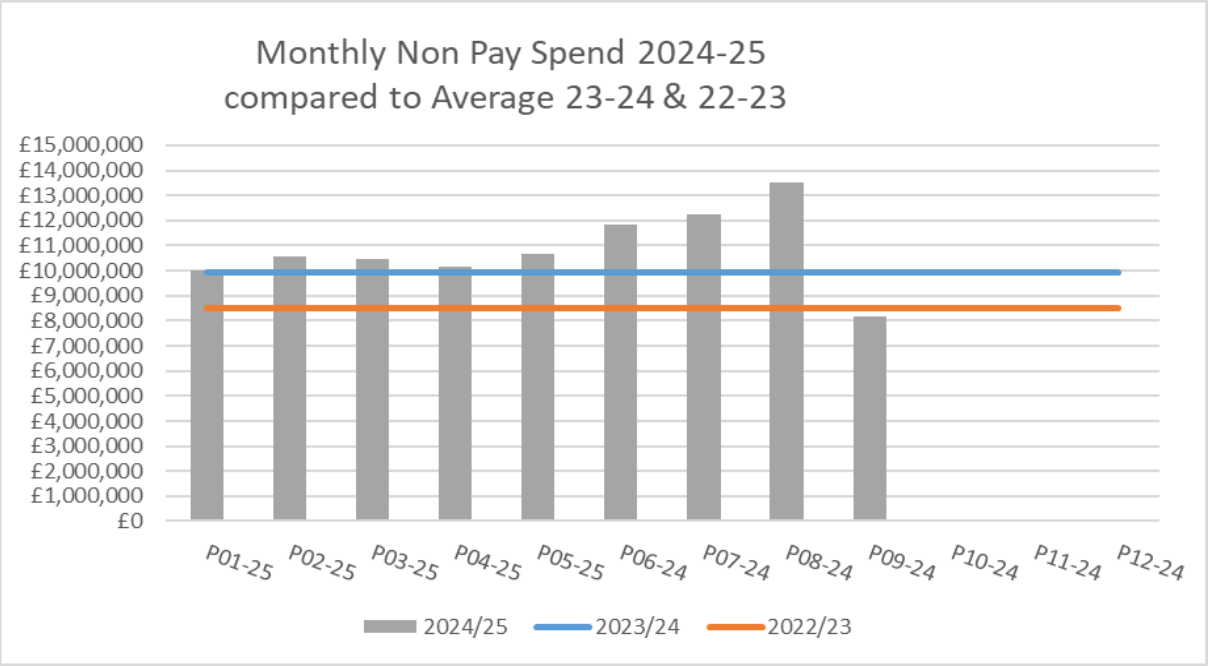
In line with the Value & Sustainability agenda and Finance &Investment Enhanced monitoring arrangements the Trust is aiming to move away from the dependence on agency, and where possible the Trust will aim to utilise bank staff to reduce reliance on agency and the premium costs associated.

**4.3 Non Pay**

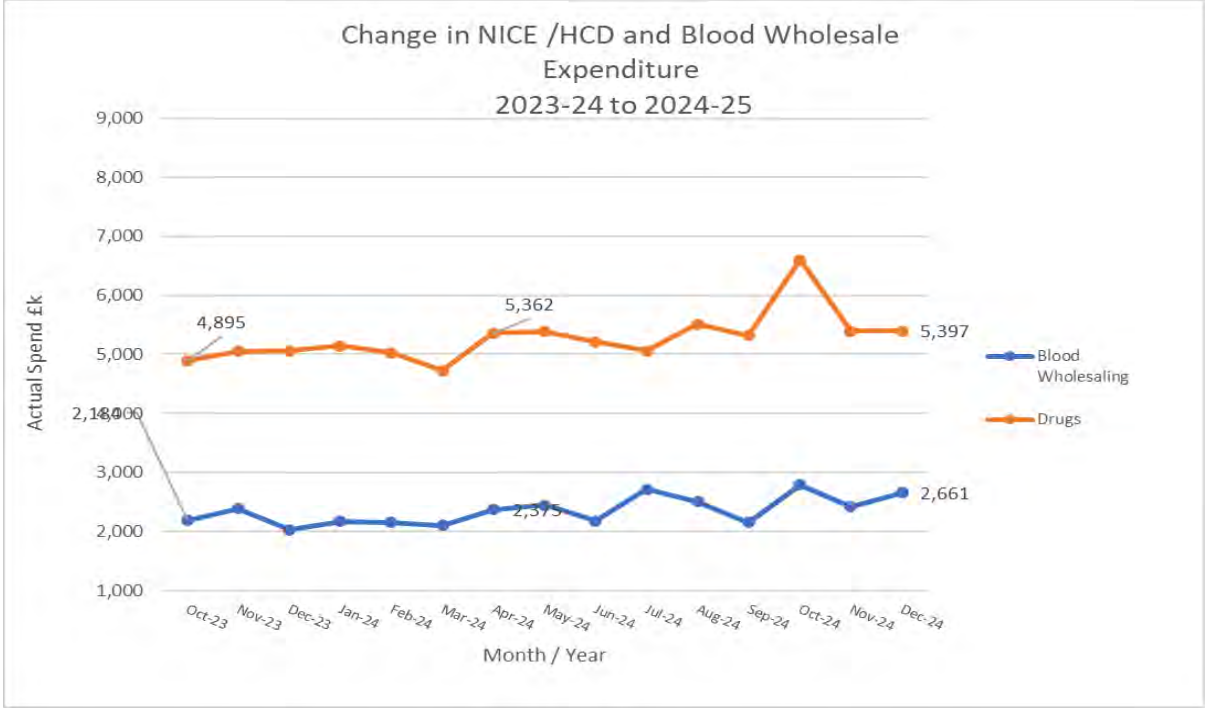
Average non-pay spend for 2023/24 was £9.8m per month which is a £1.4m increase from the previous whole year average. Largest movement was in drug spend which has increased by £10m in total or £0.9m average per month when compared with the previous year's spend for the same period. Other notable increases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

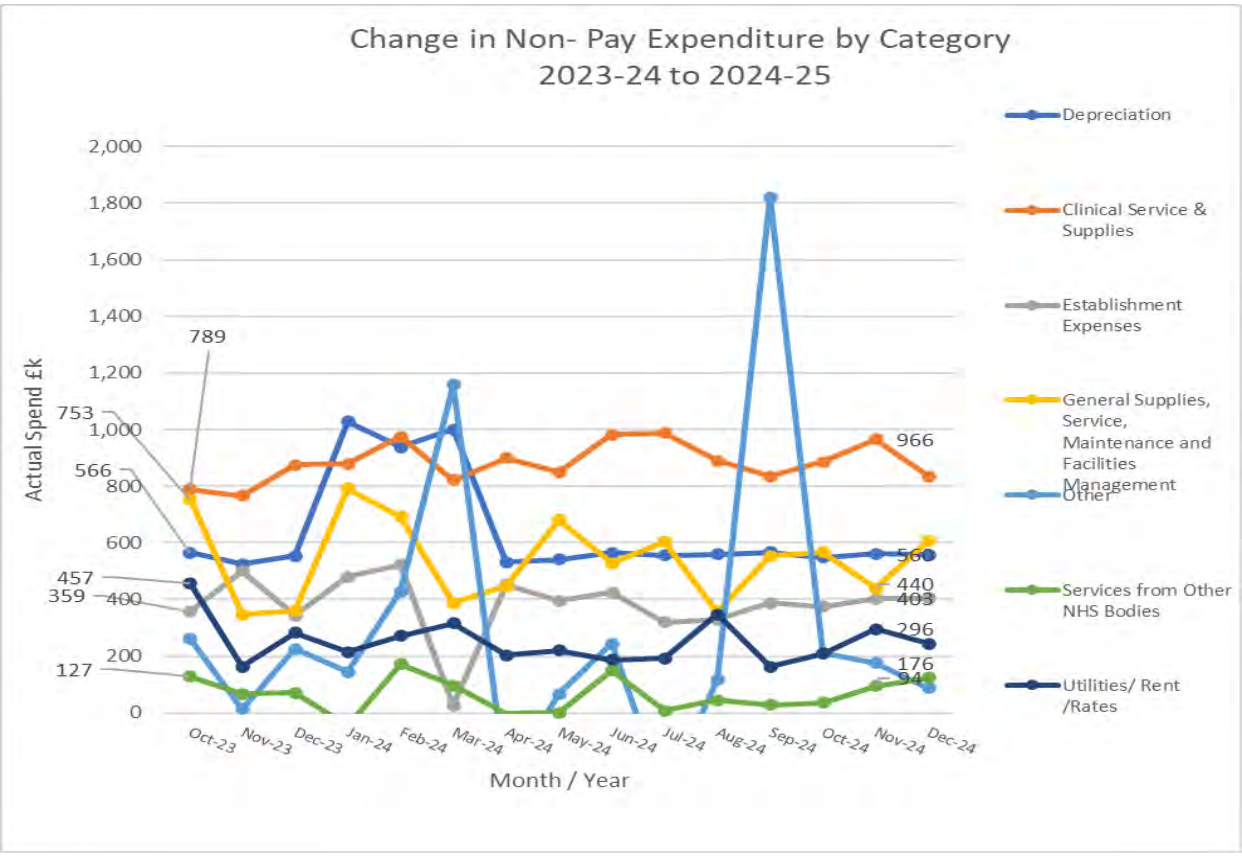
Non- Pay average spend so far for 2024/25 is currently £10.9m which is currently £1.1m higher than the average for last year. NICE and HCD drugs (£0.6m), blood wholesale costs (£0.5m) and Clinical Service & Supplies (£0.1m) have increased which are offset by income, whilst depreciation has currently 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 November 2024.




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

*Other spend in period M12 23-24 includes a provision for legal fees which has been partly released in 24-25. 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.

### 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 Trusts core LTA income and is required to support the level of investment plans and cost pressures within the system.

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

Of the revised £2.875m total savings target £1.267m (previously at IMTP planning stage £1.302m) is recurrent and £1.608m (IMTP £1.304m) is non-recurrent, with £1.193m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.682m (IMTP £1.427m) being via income generation.

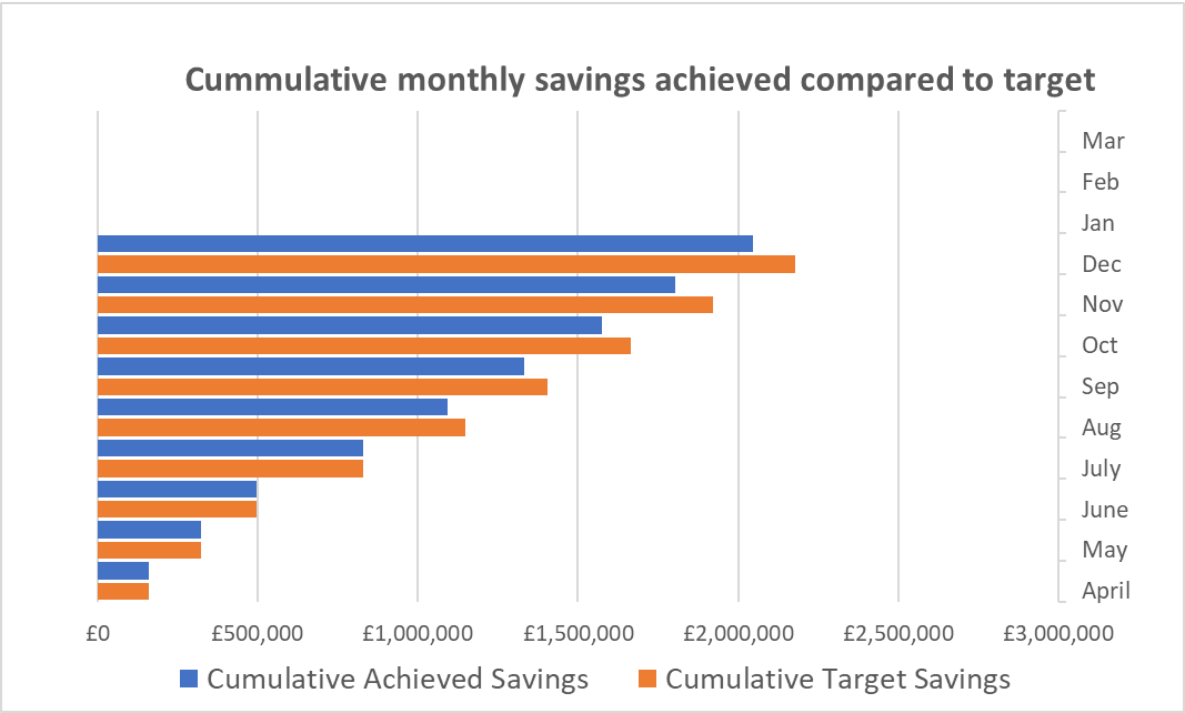
The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

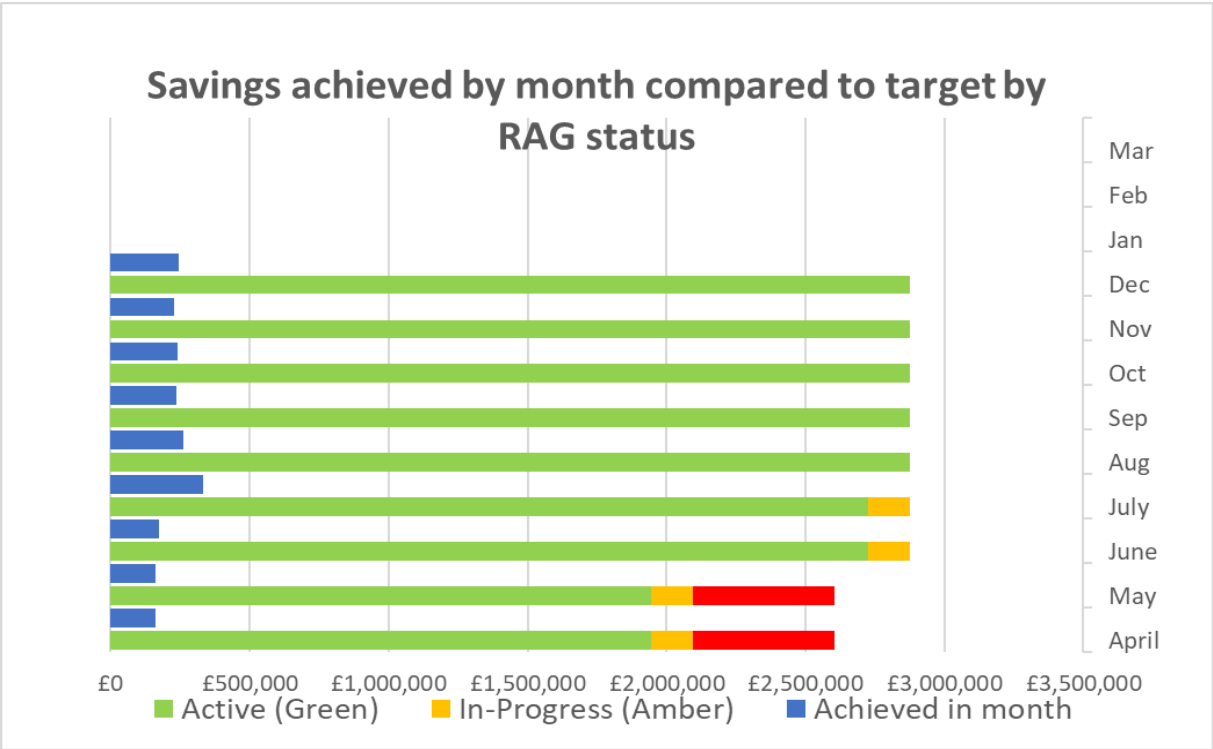
The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, the majority of the replacement schemes that were found are non-recurrent in nature. It is therefore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

<u>Performance</u>

The overall Trust savings performance as of December'24 is a underachievement against plan of **£(0.132)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 has yet to realise any savings and will need to be monitored closely to ensure the target can be met during 2024-25.

**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** | **654** | **658** | **4** | **939** | **0** |
| | | | **101%** | | **100%** | |
| **WBS TOTAL SAVINGS** | **569** | **516** | **382** | **(134)** | **569** | **0** |
| | | | **74%** | | **100%** | |
| **CORPORATE TOTAL SAVINGS** | **1,137** | **835** | **835** | **0** | **1,137** | **0** |
| | | | **100%** | | **100%** | |
| **RD&I TOTAL SAVINGS** | 230 | **173** | **173** | **0** | **230** | **0** |
| | | | | | **100%** | |
| **TRUST TOTAL SAVINGS** | **2,875** | **2,178** | **2,047** | **(132)** | **2,875** | **0** |
| | | | **94%** | | **100%** | |

| Scheme Type | Division | Recrrent / Non-Recurrent | RAG Rating | TOTAL £000 | Planned YTD £000 | Actual YTD £000 | Variance YTD £000 | F'cast Full Year £000 | F'cast Variance Full Year £000 |
|---|---|---|---|---|---|---|---|---|---|
| Savings Schemes | | | | | | | | | |
| Radiation Services - Agency Reduction | VCS | NR | Green | 50 | 38 | 50 | 12 | 50 | (0) |
| Establishment Control | VCS | R & N/R | Green | 234 | 161 | 175 | 14 | 234 | 0 |
| Service Workforce Redesign | VCS | R & N/R | Red | | | | | | |
| Procurement - Supply Chain | VCS | R | Green | 50 | 33 | 33 | 0 | 50 | 0 |
| Establishment Control | WBS | R | Green | 54 | 75 | 67 | (8) | 67 | 13 |
| Stock Control - Scan for Safety Enabled | WBS | NR | Green | 150 | 113 | 0 | (113) | 100 | (50) |
| WBS Demand Planning | WBS | R | Red | | | | | | |
| WBS Demand Planning | WBS | NR | Green | 75 | 75 | 54 | (21) | 95 | 20 |
| WBS Productivity Efficiencies | WBS | NR | Red | | | | | | |
| Procurement - Supply Chain | WBS | R | Green | 50 | 33 | 18 | (16) | 30 | (20) |
| Service Workforce Redesign | WBS | R | Red | | | | | | |
| Departmental CIP | Corporate | R | Green | 50 | 38 | 38 | 0 | 50 | 0 |
| Establishment Control | Corporate | R & N/R | Green | 75 | 56 | 56 | 0 | 75 | 0 |
| R&D Establishment Control | RD&I | R & N/R | Green | 80 | 60 | 60 | 0 | 80 | 0 |
| *New / Replacement Schemes* | | | | | 0 | | 0 | 0 | 0 |
| Productivity Efficiencies | VCS | R & NR | Green | 35 | 23 | 23 | 0 | 35 | 0 |
| SACT Provision | VCS | R | Green | 150 | 105 | 120 | 15 | 150 | 0 |
| Creditor Review | WBS | NR | Green | 100 | 100 | 100 | 0 | 100 | 0 |
| Budget Efficiences | WBS | NR | Green | 40 | 27 | 33 | 6 | 40 | 0 |
| **Total Saving Schemes** | | | | **1,193** | 936 | 826 | (110) | 1,155 | (38) |
| Income Generation | | | | | | | | | |
| Private Patients - Recovery of Debt | VCS | NR | Green | 150 | 113 | 80 | (32) | 150 | 0 |
| Private Patients - Contract Renewal | VCS | R | Amber | 150 | 100 | 95 | (5) | 150 | 0 |
| Productivity Efficiencies | VCS | R | Red | | | | | | |
| Sales of Plasma | WBS | R | Green | 100 | 94 | 110 | 16 | 138 | 38 |
| WBS Productivity Efficiencies | WBS | R | Red | | | | | | |
| Bank Interest | Corporate | R & N/R | Green | 662 | 497 | 497 | 0 | 662 | 0 |
| R&D Commercial Income | RD&I | R | Green | 150 | 113 | 113 | 0 | 150 | 0 |
| *New / Replacement Schemes* | | | | | 0 | | 0 | 0 | 0 |
| Private Patients | VCS | NR | Green | 70 | 47 | 47 | 0 | 70 | 0 |
| Maximising Income | VCS | R | Green | 50 | 35 | 35 | 0 | 50 | 0 |
| Bank Interest | Corporate | R | Green | 350 | 245 | 245 | 0 | 350 | 0 |
| **Total Income Generation** | | | | **1,682** | 1,242 | 1,221 | (21) | 1,720 | 38 |
| **TRUST TOTAL SAVINGS** | | | | **2,875** | **2,178** | **2,047** | **(131)** | **2,875** | **0** |
| | | | | | | **94%** | | **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**

<u>LTA Contract Activity Income – (Medium)</u>

A new financial risk emerged in October recently whereby LTA marginal income from cancer activity growth may not match the level of investment into services. Latest forecast position for 2024-25 is an underachievement of c£0.700m 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. If the income doesn't recover the Trust may need to utilise the emergency reserve to support the position on a non-recurrent basis during 2024-25.

Pay Award – (Medium)

The Trust is currently anticipating pay award funding of £4.811m for the AFC and M&D pay award processed in November, £1.121m for the 2023-24 Medical Pay Award paid in September, £0.306m for the Band 8 and above incremental spinal points to be processed in January and £0.091m for VSM relating to 2024-25. The Trust is not aware at this stage what funding will be provided so will remain a risk until confirmed.

**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 then like in 2023-24 the Trust may be in a position later in the year to release this funding on a non-recurrent basis. The emergency reserve is currently being held to support the risk on the cancer service LTA activity marginal income.

**Savings Opportunities Pipeline**

The Trust has identified some initial opportunities that could be explored but these require further development but are highlighted below:

Pre-Operative Anaemia Pathway Project (Health Board savings)

Value Based Healthcare project led by WBS where all patients undergoing elective major surgery in Wales will be screened pre-operatively and offered treatment with intravenous Iron as required prior to surgery. Savings to be established and delivered via Health Boards and represents WBS / VUNHST contribution to system wide financial performance.

Medicine Unit Supply

Identify opportunities to increase use of NWSSP Medicines unit to identify further potential cost savings for high cost drugs. Note that any cost savings are passed through to LHB Commissioners

Workforce Re-design

Review of workforce models and pathways to identify opportunities to deliver services more efficiently in addition to the schemes outlined in the savings tracker.

Procurement

Procurement working with divisions on a regular basis to review non pay spend and ensure delivery of savings target and identify other cost improvement opportunities above the savings target.

## 7. CAPITAL EXPENDITURE

*Administrative Target*

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

| | Approved CEL 2024/25 £m | YTD Spend £m | Budget Remaining @ M9 £m | F'cast Spend 2024/25 £m | Year End Variance 2024/25 £m |
|---|---|---|---|---|---|
| **All Wales Capital Programme** | | | | | |
| IRS - Integrated Radiotherapy Solution | 5.164 | 2.475 | 2.689 | 5.164 | 0.000 |
| IRS RSC - Radiotherapy Satellite Centre | 10.065 | 7.210 | 2.855 | 10.065 | 0.000 |
| nVCC Enabling Costs | 3.500 | 3.045 | 0.455 | 3.500 | 0.000 |
| nVCC Project Fees | 4.390 | 2.498 | 1.892 | 4.390 | 0.000 |
| nVCC Whitchurch Hospital Site | 0.000 | 0.020 | (0.020) | 0.353 | (0.353) |
| WBS TGI | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 |
| Digital - WHAIS | 0.000 | 0.332 | (0.332) | 0.443 | (0.443) |
| Digital - RISP | 0.160 | 0.101 | 0.059 | 0.160 | 0.000 |
| BECS | 0.334 | 0.088 | 0.246 | 0.334 | 0.000 |
| WBS Electrical Resilience - Backlog Maintenance | 0.150 | 0.022 | 0.128 | 0.150 | 0.000 |
| WG Year End Capital Slippage Funding | 0.220 | 0.000 | 0.220 | 0.220 | 0.000 |
| Whitchurch Land Transfer | 7.800 | 7.800 | 0.000 | 7.800 | 0.000 |
| **Total All Wales Capital Programme** | 31.783 | 23.591 | 8.192 | 32.579 | (0.796) |
| **Discretionary Capital** | 1.911 | 0.860 | 1.051 | 1.911 | 0.000 |
| | 33.694 | 24.451 | 9.243 | 34.490 | (0.796) |

The approved 2024-25 Capital Expenditure Limit (CEL) as of December 2024 is £33.694m (November £25.804m). This includes All Wales Capital funding of £31.783m, 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 Whitchurch site fees required this financial year which was confirmed at the WG Capital meeting on the 21st January.

Whilst not currently showing the Trust CEL a funding award letter has been received to support the WHAIS project during 2024-25.

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.

Following the Trust receiving notification of funding for the WHAIS programme and some cost slippage on pre-approved schemes the Capital Planning Group during December approved and allocated out a further £0.483m to support prioritised schemes that could be delivered before the end of the financial year. The Discretionary programme currently has a remaining balance of £0.100m (including £0.025m contingency) to be utilised before the end of the financial year which will be considered for use at the Capital Planning Group in January.

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 is 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 will be 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 December 2024 on the All-Wales Capital Programme schemes was £23.591m, this is broken down between spend on the nVCC schemes of £5.563m, the IRS £2.475m, RSC £7.210m, RISP £0.101m, BECS £0.088m, WBS Electrical Resilience £0.022m and the Whitchurch Land Transfer £7.800m.

The current spend on the Discretionary Capital programme as of December is £0.860m.

**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 position of schemes that was included in the IMTP for 2024-25 is provided in the table below with the 2025/26 IMTP development in progress:

| All Wales Approved and Unapproved Capital Schemes | 2024-25 £m | 2025-26 £m | 2026-27 £m | 2027/28 £m | Further Years £m | Total All Wales Schemes £m |
|---|---|---|---|---|---|---|
| **All Wales Approved Schemes** | | | | | | |
| TCS nVCC enabling works | | 1.547 | | | | 1.547 |
| Integrated Radiotherapy Solution (IRS) | 5.164 | 2.040 | 15.800 | 0.839 | | 23.843 |
| Radiotherapy Satellite Unit | 11.265 | | | | | 11.265 |
| **Total Approved Capital Schemes** | **16.429** | **3.587** | **15.800** | **0.839** | **0.000** | **36.655** |
| **All Wales Unapproved Schemes** | | | | | | |
| TCS nVCC | 15.791 | 11.000 | 36.962 | 1.741 | | 65.494 |
| TCS nVCC Enabling works | 2.900 | | 0.600 | | | 3.500 |
| Digital - IT Infrastructure | 1.086 | 0.688 | 0.680 | 0.400 | | 2.854 |
| WHAIS | 0.494 | 0.092 | | | | 0.586 |
| WBS Electrical Resilience | 0.320 | | | | | 0.320 |
| Liquid Nitrogen Vessel | 0.500 | | | | | 0.500 |
| Welsh Plasma - Medicine | 0.970 | 0.064 | 0.064 | 0.203 | | 1.301 |
| Talbot Green - Infrastructure | 0.303 | 1.346 | 10.633 | 10.640 | 19.707 | 42.629 |
| WBS Fleet Replacement | | 0.373 | 1.112 | 1.285 | | 2.770 |
| WBS Asset Replacement | 0.100 | 0.494 | 0.121 | | 1.560 | 2.275 |
| First Floor Ward Ventilation | 0.370 | | | | | 0.370 |
| Condition Survey Recommendations | 0.250 | 0.200 | 0.150 | | | 0.600 |
| BECS Blood Mangagement System | 0.100 | 0.200 | 0.200 | 1.000 | | 1.500 |
| **Total Unapproved Capital Schemes** | **23.184** | **14.457** | **50.522** | **15.269** | **21.267** | **124.699** |
| | | | | | | |
| **Total All Wales Capital Plans** | **39.613** | **18.044** | **66.322** | **16.108** | **21.267** | **161.354** |

## 8. BALANCE SHEET (Including Hosted Organisations)

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

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

| | Opening Balance Beginning of Apr 24 | Closing Balance End of Dec-24 | Movement from 1st April Dec-24 | Forecast Closing Balance End of Mar 25 |
|---|---|---|---|---|
| **Non-Current Assets** | **£'m** | **£'m** | **£'m** | **£'m** |
| Property, plant and equipment | 226.135 | 244.414 | 18.279 | 244.414 |
| Intangible assets | 10.893 | 10.894 | 0.001 | 10.894 |
| Trade and other receivables | 1,316.876 | 1,316.751 | (0.125) | 1,316.751 |
| Other financial assets | 0.000 | 0.000 | 0.000 | 0.000 |
| Non-Current Assets sub total | 1,553.904 | 1,572.059 | 18.155 | 1,572.059 |
| **Current Assets** | | | | |
| Inventories | 31.227 | 31.201 | (0.026) | 31.201 |
| Trade and other receivables | 530.547 | 555.065 | 24.518 | 542.768 |
| Other financial assets | 0.000 | 0.000 | 0.000 | 0.000 |
| Cash and cash equivalents | 20.956 | 6.083 | (14.873) | 18.380 |
| Non-current assets classified as held for sale | 0.000 | 0.000 | 0.000 | 0.000 |
| Current Assets sub total | 582.730 | 592.349 | 9.619 | 592.349 |
| | | | | |
| TOTAL ASSETS | 2,136.634 | 2,164.408 | 27.774 | 2,164.408 |
| **Current Liabilities** | | | | |
| Trade and other payables | (229.886) | (258.121) | (28.235) | (258.121) |
| Borrowings | (1.020) | (0.910) | 0.110 | (0.910) |
| Other financial liabilities | 0.00 | 0.00 | 0.000 | 0.00 |
| Provisions | (338.517) | (588.552) | (250.035) | (588.552) |
| Current Liabilities sub total | (569.423) | (847.583) | (278.160) | (847.583) |
| | | | | |
| NET ASSETS LESS CURRENT LIABILITIES | 1,567.211 | 1,316.825 | (250.386) | 1,316.825 |
| **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 | 211.368 | 0.121 | 211.368 |
| **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 | 19.488 | 0.029 | 19.488 |
| Other reserve | 0.000 | 0.000 | 0.000 | 0.000 |
| Total Taxpayers' Equity | 211.247 | 211.368 | 0.121 | 211.368 |

## 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.

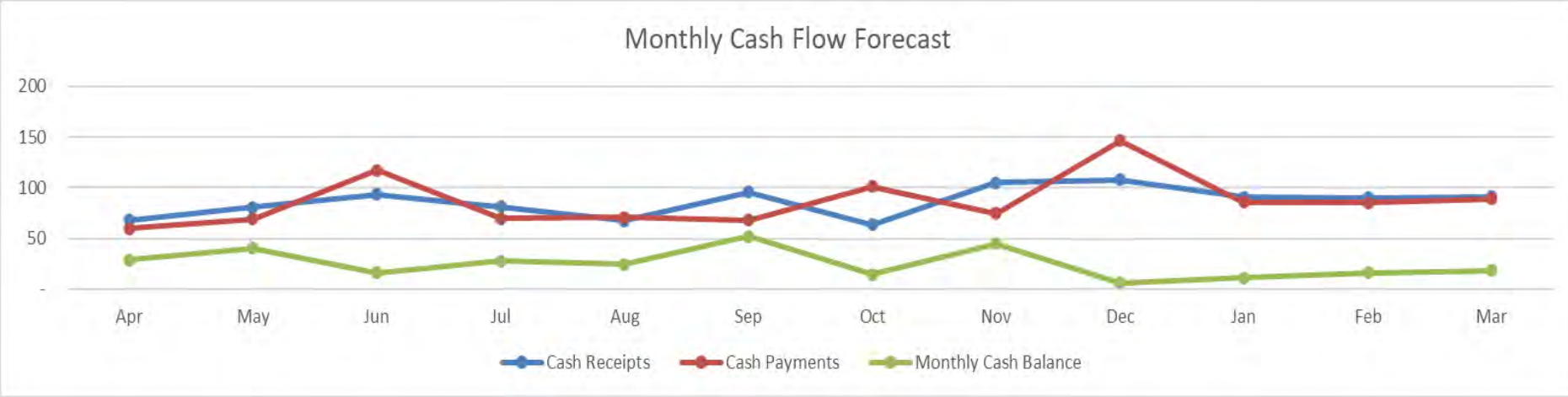
As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

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 the final pay award settlement has been agreed with 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 | 52.334 | 55.117 | 54.854 | 621.497 |
| 2 | WG Revenue Funding | 10.504 | 31.147 | 45.405 | 20.761 | 10.370 | 24.691 | 9.261 | 26.885 | 52.615 | 33.576 | 30.725 | 31.023 | 326.963 |
| 3 | Short Term Loans | | | | | | | | | | | | | 0.000 |
| 4 | PDC | | | | | | | | 7.800 | | | | 0.290 | 8.090 |
| 5 | Interest Receivable | 0.179 | 0.143 | 0.186 | 0.158 | 0.155 | 0.167 | 0.197 | 0.156 | 0.161 | 0.150 | 0.150 | 0.150 | 1.952 |
| 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 | 4.800 | 4.068 | 5.000 | 76.082 |
| 8 | TOTAL RECEIPTS | **67.860** | **80.558** | **93.521** | **81.109** | **67.372** | **95.598** | **63.771** | **104.841** | **107.718** | **90.859** | **90.060** | **91.317** | **1,034.583** |
| | *PAYMENTS* | | | | | | | | | | | | | |
| 9 | Salaries and Wages | 25.845 | 35.256 | 35.185 | 35.848 | 37.838 | 48.036 | 51.634 | 47.845 | 51.069 | 41.953 | 41.661 | 41.497 | 493.667 |
| 10 | Non pay items | 31.288 | 30.780 | 81.237 | 33.050 | 32.438 | 19.146 | 48.747 | 12.495 | 94.037 | 42.428 | 40.325 | 43.605 | 509.576 |
| 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 | 3.014 | 4.150 | 33.917 |
| 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** | **85.686** | **85.000** | **89.252** | **1,037.159** |
| | | | | | | | | | | | | | | |
| 17 | Net cash inflow/outflow | 7.846 | 11.344 | (23.878) | 11.378 | (3.374) | 27.571 | (37.260) | 30.296 | (38.797) | 5.173 | 5.060 | 2.065 | |
| 18 | Balance b/f | 20.956 | 28.802 | 40.146 | 16.268 | 27.646 | 24.272 | 51.844 | 14.584 | 44.880 | 6.083 | 11.256 | 16.316 | |
| 19 | Balance c/f | 28.802 | 40.146 | 16.268 | 27.646 | 24.272 | 51.844 | 14.584 | 44.880 | 6.083 | 11.256 | 16.316 | 18.380 | |



# 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 | (35.688) | (35.669) | 0.019 | (47.815) | (47.796) | 0.019 |
| RD&I | 0.210 | 0.137 | (0.072) | 0.284 | 0.212 | (0.072) |
| WBS | (16.930) | (17.312) | (0.382) | (22.613) | (22.995) | (0.382) |
| **Sub-Total Divisions** | **(52.408)** | **(52.843)** | **(0.435)** | **(70.144)** | **(70.579)** | **(0.435)** |
| Corporate Services Directorates | (10.551) | (10.163) | 0.389 | (14.147) | (13.787) | 0.360 |
| **Delegated Budget Position** | **(62.959)** | **(63.006)** | **(0.047)** | **(84.291)** | **(84.366)** | **(0.075)** |
| TCS | (0.521) | (0.446) | 0.075 | (0.720) | (0.644) | 0.075 |
| Health Technology Wales | (0.130) | (0.130) | (0.000) | (0.174) | (0.174) | 0.000 |
| Trust Income / Reserves | 63.611 | 63.611 | 0.000 | 85.184 | 85.184 | 0.000 |
| **Trust Position** | 0.000 | 0.029 | 0.029 | (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** | **65.294** | **66.060** | **0.765** | **87.031** | **87.796** | **0.765** |
| Expenditure | | | | | | |
| Staff | 42.889 | 42.569 | 0.320 | 57.176 | 56.856 | 0.320 |
| Non Staff | 58.093 | 59.160 | (1.067) | 77.669 | 78.735 | (1.067) |
| **Sub Total** | **100.982** | **101.729** | **(0.747)** | **134.845** | **135.592** | **(0.747)** |
| **Total** | **(35.688)** | **(35.669)** | **0.019** | **(47.815)** | **(47.796)** | **0.019** |

### VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of December 2024 was **£0.019m 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 9 represents a surplus of **£0.765m**. A significant overachievement on private patient drug income which is offsetting £0.677m of 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£0.700m against the target and the £1.3m investment which has been made in the service. This is currently 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 currently being flagged as a risk whilst under investigation so is not currently reflected in the divisional position, however given that we are going into the final quarter 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 **£0.320m** 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. There are also vacancies within Pharmacy pending recruitment. The vacancies are helping to support the posts appointed at risk, and the divisional savings target and vacancy factor.

Non-Staff Expenditure at Month 9 was **£(1.067)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 anticipating to receive funding 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** | **26.564** | **26.372** | **(0.191)** | **33.782** | **33.590** | **(0.191)** |
| Expenditure | | | | | | |
| Staff | 14.048 | 14.208 | (0.161) | 18.583 | 18.744 | (0.161) |
| Non Staff | 29.446 | 29.476 | (0.030) | 37.812 | 37.842 | (0.030) |
| **Sub Total** | **43.493** | **43.684** | **(0.191)** | **56.395** | **56.586** | **(0.191)** |
| **Total** | **(16.930)** | **(17.312)** | **(0.382)** | **(22.613)** | **(22.995)** | **(0.382)** |

## Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of December 2024 was an overspend of **£(0.382)m** with an **overspend** outturn forecast position now expected for 2024-25.

An underachievement of **£(0.191)m** on income due to underperformance on bone marrow (currently achieving c50% of target year to date), partly offset by increased activity on plasma sales and 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 was £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. Initial indications are that WBS will not be able to recover the full selling price, however any Income from re-sale off the plasma is not currently reflected in the position.

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.

Staff overspend of **£(0.161)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 underspend of **£0.030m** as at month 9. There are overspends in areas such as room hire costs which are no longer funded by WHSSC, temporary additional security costs at the rear of the building, additional spend within molecular genetics for test kits, 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 £m | YTD Actual £m | YTD Variance £m | Full Year Budget £m | Full Year Forecast £m | Year End Projected £m |
|---|---|---|---|---|---|---|
| **Income** | **3.325** | **3.426** | **0.101** | **4.670** | **4.771** | **0.101** |
| Expenditure | | | | | | |
| Staff | 11.315 | 10.409 | 0.906 | 15.314 | 14.408 | 0.906 |
| Non Staff | 2.561 | 3.180 | (0.619) | 3.503 | 4.151 | (0.647) |
| **Sub Total** | **13.876** | **13.589** | **0.288** | **18.817** | **18.558** | **0.259** |
| **Total** | **(10.551)** | **(10.163)** | 0.389 | **(14.147)** | **(13.787)** | **0.360** |

### Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of December 2024 was an underspend of **£0.389m**. The Corporate division is currently expecting to achieve an outturn **underspend** position.

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** | **3.378** | **3.436** | **0.057** | **4.847** | **4.905** | **0.057** |
| Expenditure | | | | | | |
| Staff | 2.632 | 2.811 | (0.178) | 3.836 | 4.015 | (0.178) |
| Non Staff | 0.536 | 0.487 | 0.049 | 0.727 | 0.679 | 0.049 |
| **Sub Total** | **3.169** | **3.298** | **(0.130)** | **4.564** | **4.693** | **(0.130)** |
| **Total** | **0.210** | **0.137** | (0.072) | **0.284** | **0.212** | **(0.072)** |

### RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of December 2024 was an overspend of **(£0.072m)** 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.

## TCS – (Revenue)

| | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Budget £m | Full Year Forecast £m | Year End Projected Variance £m |
|---|---|---|---|---|---|---|
| **Income** | **0.028** | **0.028** | **0.000** | **0.028** | **0.028** | **0.000** |
| Expenditure | | | | | | |
| Staff | 0.517 | 0.450 | 0.067 | 0.706 | 0.639 | 0.067 |
| Non Staff | 0.032 | 0.024 | 0.008 | 0.042 | 0.034 | 0.008 |
| **Sub Total** | **0.549** | **0.474** | **0.075** | **0.748** | **0.673** | **0.075** |
| **Total** | **(0.521)** | **(0.446)** | 0.075 | **(0.720)** | **(0.644)** | **0.075** |

### TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of December 2024 is a **£0.075m** underspend with a forecast **surplus** outturn position now expected for 2024-25.

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** | **1.241** | **1.261** | **0.020** | **1.654** | **1.674** | **0.020** |
| Expenditure | | | | | | |
| Staff | 1.276 | 1.249 | 0.027 | 1.701 | 1.674 | 0.027 |
| Non Staff | 0.095 | 0.142 | (0.047) | 0.127 | 0.174 | (0.047) |
| **Sub Total** | **1.371** | **1.391** | **(0.020)** | **1.828** | **1.848** | **(0.020)** |
| **Total** | **(0.130)** | **(0.130)** | 0.000 | **(0.174)** | **(0.174)** | **0.000** |

### HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of December 2024 was **breakeven,** with a forecasted outturn position which will be managed to a **breakeven** position.

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

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

# TCS PROGRAMME
# FINANCE REPORT 2024-25

## Period Ending 31st December 2024

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DRAFT

## 1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2024-25, outlining spend against budget as at 31st December 2024 and the current year-end forecast.

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

## 2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2024-25 as at 31st December 2024 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

| Expenditure Type | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Capital | £4.990m | £7.096m | £7.098m | -£0.003m |
| Revenue | £0.474m | £0.749m | £0.741m | £0.008m |
| **Total** | **£5.464m** | **£7.845m** | **£7.840m** | **£0.005m** |

2.2 The overall forecast outturn for the Programme is an underspend of £0.005m for the financial year 2024-25 against a budget of £7.845m.

2.3 The nVCC FBC and the EW FBC Addendum were submitted to WG on the 3rd September 2024, and on the 18th November 2024 the Award of Funding was received in respect of nVCC Project Resources Funding 2024-2028. This provided further funding of £69.719m Capital and £2.412m Revenue for the nVCC activities between 2024 and 2028, and £8.943m Capital for the Enabling works relating to works between 2024 and 2027.

2.4 The Trust is finalising the profile of spend for each of the Financial Years for WG.

2.5 In addition, funding of £0.082m was provided by WG in November 2024 to cover the recurrent pay award for 2024-25.

2.6 There are no financial risks to report as at December 2024.

## 3. BACKGROUND

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

3.2 By 31st March 2024, the Welsh Government (WG) had provided a total of £63.295m funding (£60.246m capital, £3.049m revenue) to support the TCS Programme. In

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addition, the Trust had provided £0.264m from its discretionary capital allocation and £0.512m non-recurrent revenue funding.

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

3.4 The current funding provided to support the TCS Programme in 2024-25 is £0.749m revenue, with no capital funding allocated as yet. This is outlined in Appendix 2. The sources of funding changes are summarised below, with further detail in Appendix 3.

| Funding Source | Capital | Revenue | Total |
|---|---|---|---|
| Welsh Government | £7.096m | £0 | £7.096m |
| LHB Commissioners | £0 | £0.420m | £0.420m |
| Trust Reserves | £0 | £0.218m | £0.218m |
| Escrow Interest | £0 | £0.028m | £0.028m |
| **Total Funding** | **£7.096m** | **£0.666m** | **£7.762m** |

## 4. CAPITAL POSITION

4.1 The current capital funding for 2024-25 is outlined below:

- Enabling Works Project £3.500m
- nVCC Project £3.243m
- Whitchurch Hospital Site £0.353m

**Total £7.096m**

4.2 The capital position as at 31st December 2024 is outlined below, with a forecast overspend of £0.003m for 2024-25. Funding was provided by WG on 18th November 2024.

| Capital Expenditure | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Enabling Works Project | £3.045m | £3.500m | £3.501m | -£0.001m |
| nVCC Project | £1.915m | £3.243m | £3.244m | -£0.002m |
| Whitchurch Hospital Site | £0.030m | £0.353m | £0.353m | £0 |
| **Total** | **£4.990m** | **£7.096m** | **£7.098m** | **-£0.003m** |

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## 5. REVENUE POSITION

5.1 The revenue funding for 2024-25 is outlined below:

- PMO £0.332m
- Enabling Works Project £0.028m
- nVCC Project £0.065m
- SDT Project £0.320m

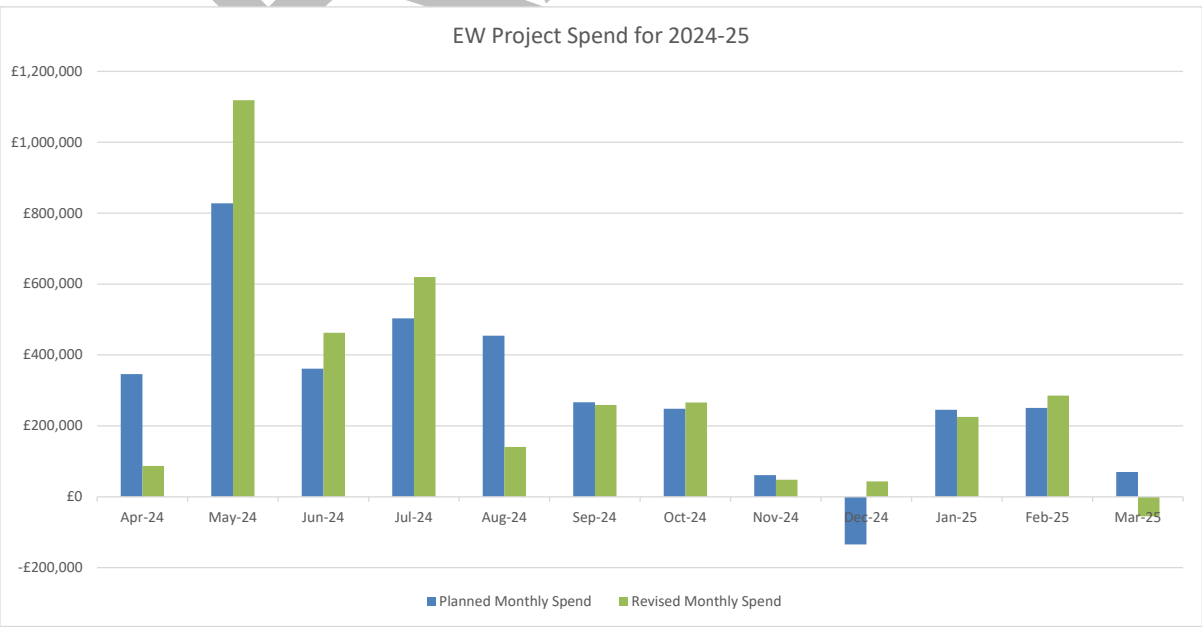
**Total £0.749m**

5.2 The revenue position as at 31st December 2024 is outlined below, with a forecast underspend of £0.008m for 2024-25 against a budget of £0.749m.

| Revenue Expenditure | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| PMO | £0.219m | £0.332m | £0.332m | £0.000m |
| Enabling Works Project | £0 | £0.028m | £0 | £0.028m |
| nVCC Project | £0.068m | £0.065m | £0.090m | -£0.024m |
| SDT Project | £0.187m | £0.323m | £0.320m | £0.003m |
| **Total** | **£0.474m** | **£0.749m** | **£0.741m** | **£0.008m** |

## 6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The actual capital spend to date is £3.045m, with a run rate to date similar to the planned spend.

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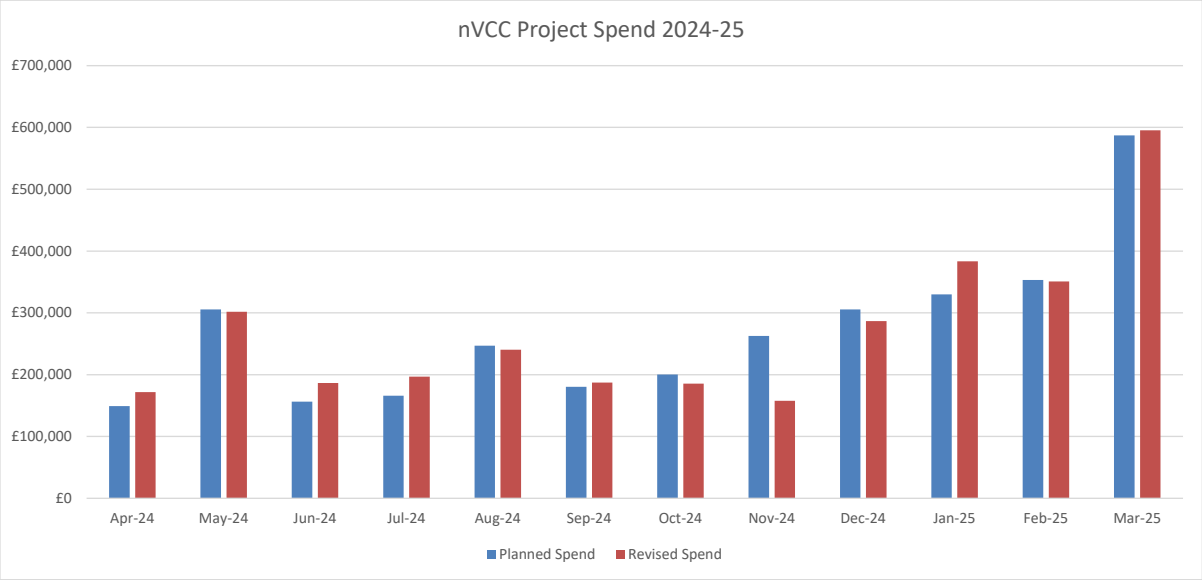
6.2 The capital cash flow for the **nVCC Project** is outlined below. The actual capital spend to date is £1.915m, with a run rate to date similar to the planned spend.




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

## 7. PROJECT FINANCE UPDATES

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

### Programme Management Office

7.2 The current revenue funding for the PMO for 2024-25 is £0.332m, with £0.240m of this provide from NHS Commissioners' funding, £0.078m from the Trust Reserves, and £0.014m from the WG Pay Award Funding.

7.3 There is no capital funding requirement for the PMO in 2024-25.

7.4 The revenue position for the PMO as at 31st December 2024 is shown below, with a forecast breakeven position for the year against a budget of £0.332m.

| PMO Expenditure | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £0.216m | £0.331m | £0.283m | £0.048m |
| Non Pay | £0.003m | £0.002m | £0.049m | -£0.047m |
| **Total** | **£0.219m** | **£0.332m** | **£0.332m** | **£0.000m** |

7.5 There are currently no financial risks associated with the PMO for 2024-25.

### Enabling Works Project

#### *Capital*

7.6 The EW FBC Addendum was submitted to WG on the 3rd September 2024 and on the 18th November 2024, the Award of Funding was received in respect of nVCC Project

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Resources Funding 2024-2028. This provided further funding of £8.943m Capital for the Enabling works relating to works between 2024 and 2027.

7.7 The Project's financial position for 31st December 2024 is shown below. The forecast position reflects an expected breakeven position for this financial year against a budget of £3.500m.

| Enabling Works Capital Expenditure | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £0.170m | £0.153m | £0.153m | -£0.000m |
| Non Pay | £2.875m | £3.347m | £3.348m | £0 |
| **Total** | **£3.045m** | **£3.500m** | **£3.501m** | **£0** |

7.8 The Project spend relates to the following activities:

**Enabling Works FBC Project Capital Budget & Spend Summary 2024-25**

| Description | Year to Date Budget Dec-24 £ | Year to Date Spend Dec-24 £ | Year to Date Variance Dec-24 £ | Financial Year Annual Budget £ | Financial Year Annual Forecast £ | Financial Year Annual Variance £ |
|---|---|---|---|---|---|---|
| **PAY** | | | | | | |
| Enabling Works Pay | 114,690 | 170,398 | -55,709 | 152,919 | 153,354 | -435 |
| **Pay Capital Total** | **114,690** | **170,398** | **-55,709** | **152,919** | **153,354** | **-435** |
| **NON-PAY** | | | | | | |
| 6MVA Supply - National Grid | 480,000 | 480,000 | 0 | 480,000 | 480,000 | 0 |
| Supply Chain Fees | 165,280 | 155,548 | 9,732 | 207,280 | 196,215 | 11,065 |
| Non Works Costs | 0 | -4,670 | 4,670 | 3,131 | -4,670 | 7,801 |
| Asda Works | 1,652,120 | 1,653,052 | -932 | 1,404,120 | 1,420,052 | -15,932 |
| Walters Design & Build | 481,200 | 481,188 | 12 | 481,200 | 481,188 | 12 |
| S278 works on Longwood Drive | 37,000 | 39,272 | -2,272 | 400,000 | 402,272 | -2,272 |
| Offsite Habitat Creation (SW Corner) | 47,050 | 47,052 | -2 | 356,050 | 336,052 | 19,998 |
| HV Intake Room | 13,300 | 13,300 | 0 | 200,300 | 195,300 | 5,000 |
| TCAR Extension Planning Application | 0 | 0 | 0 | 40,000 | 0 | 40,000 |
| Rural Path | 0 | 0 | 0 | 0 | 0 | 0 |
| TCAR Habitat | 0 | 0 | 0 | 0 | 0 | 0 |
| Revised Emergency Access | 0 | 0 | 0 | 0 | 0 | 0 |
| Enabling Works FBC Reserves | -56,250 | 9,921 | -66,171 | -225,000 | -158,829 | -66,171 |
| **Enabling Works FBC Project Capital Total** | **2,819,700** | **2,874,663** | **-54,963** | **3,347,081** | **3,347,580** | **-499** |
| **TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE** | **2,934,390** | **3,045,061** | **-110,672** | **3,500,000** | **3,500,934** | **-934** |

7.9 In addition to the funding award, a QRA has been established of c£1.4m that will be managed by WG. QRA will be reviewed on a quarterly basis with Welsh Government, supported by Technical Advisors so that risks are robustly assessed, quantified and appropriately revised. The Trust will request funding on a quarterly basis from the QRA when matters arise that require additional funding.

***Revenue***

7.10 There is currently revenue funding of £0.028m for the Enabling Works nVCC Project for 2024-25. This is provided from the interest earned from the Enabling Works Escrow bank Account for the ASDA works.

7.11 The revenue financial position for the Enabling Works Project for 31st December 2024 is shown below, reflecting a current underspend of £0.028m for the year.

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| Enabling Works Revenue Expenditure | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Non-Pay | £0 | £0.028m | £0 | £0.028m |
| **Total** | **£0** | **£0.028m** | **£0** | **£0.028m** |

7.12 There is a risk of an underspend of £0.028m for the revenue element of the Enabling Works Project this financial year.

## New Velindre Cancer Centre Project

### *Capital*

7.13 The nVCC FBC was submitted to WG on the 3rd September 2024 and on the 18th November 2024, the Award of Funding was received in respect of nVCC Project Resources Funding 2024-2028. This provided further funding of £69.719m Capital and £2.412m Revenue for the nVCC activities between 2024 and 2028.

7.14 The Project's financial position for 31st December 2024 is shown below. The forecast position reflects an expected overspend of £0.002m for this financial year.

| Enabling Works Capital Expenditure | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £1.120m | £1.827m | £1.808m | £0.019m |
| Non Pay | £0.795m | £1.416m | £1.437m | -£0.020m |
| **Total** | **£1.915m** | **£3.243m** | **£3.244m** | **-£0.002m** |

7.15 The Project spend relates to the following activities:

**nVCC FBC Project Capital Budget & Spend Summary 2024-25**

| Description | Year To Date Budget Dec-24 | Year To Date Spend Dec-24 | Year To Date Variance Dec-24 | Financial Year Annual Budget | Financial Year Annual Forecast | Financial Year Annual Variance |
|---|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ | £ |
| Project Management Office | 682,090 | 678,670 | 54,481 | 1,176,723 | 1,172,289 | 8,231 |
| Design & Construction | 507,861 | 408,867 | 98,994 | 731,782 | 642,534 | 89,248 |
| Equipment, Commissioning and Migration | 219,455 | 209,236 | 10,220 | 393,376 | 377,306 | 16,070 |
| Digital | 65,923 | 66,177 | -254 | 133,150 | 133,420 | -270 |
| Engagement & Communications Workstream | 74,724 | 71,536 | 3,189 | 116,144 | 116,023 | 122 |
| Commercial Activity Group | 422,475 | 480,328 | -57,853 | 691,703 | 802,923 | -111,221 |
| **TOTAL CAPITAL EXPENDITURE** | **1,972,529** | **1,914,814** | **108,775** | **3,242,877** | **3,244,495** | **2,180** |

7.16 In addition to the funding award, a QRA has been established of c£17.3m that will be managed by WG. QRA will be reviewed on a quarterly basis with Welsh Government, supported by Technical Advisors so that risks are robustly assessed, quantified and appropriately revised. The Trust will request funding on a quarterly basis from the QRA when matters arise that require additional funding.

### *Revenue*

7.17 £0.065m was allocated to the nVCC Project from the revenue pay award funding from WG provided in November 2023. There is currently no other revenue funding for the nVCC Project for 2024-25.

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7.18 The revenue financial position for the nVCC Project for 31st December 2024 is shown below, reflecting a current overspend of £0.024m for the year.

| nVCC Revenue Expenditure | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £0.047m | £0.065m | £0.065m | £0 |
| Non-Pay | £0 | £0 | £0.024m | -£0.024m |
| **Total** | **£0.047m** | **£0.065m** | **£0.090m** | **-£0.024m** |

7.19 There is a risk of an overspend of £0.024m for the revenue element of the nVCC Project this financial year.

## Whitchurch Hospital Site

7.20 WG have provided capital funding of £0.353m the Whitchurch Hospital Site Project for 2024-25.

7.21 The Project's financial position for 31st December 2024 is shown below. This spend relates mainly to legal fees associated with the Whitchurch Hospital Site. The forecast position reflects a breakeven position for the year against a budget of £0.353m.

| Whitchurch Hospital Site Expenditure | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Non-Pay | £0.030m | £0.353m | £0.353m | £0 |
| **Total** | **£0.030m** | **£0.353m** | **£0.353m** | **£0** |

## Service Delivery and Transformation Project

7.22 The revenue funding for the Project for 2024-25 is £0.323m from NHS Commissioners' funding, £0.140m from Trust reserves, and £0.003m from the WG Pay Award Funding. The resulting budget is £0.323m for this financial year.

7.23 There is no capital funding requirement for the Project in 2024-25.

7.24 The SDT Project revenue position for 2024-25 is shown below, with an underspend of £0.003m for this financial year.

| SDT Expenditure | Year to Date Spend | 2024-25 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £0.187m | £0.309m | £0.320m | -£0.010m |
| Non-Pay | £0.000m | £0.014m | £0.000m | £0.013m |
| **Total** | **£0.187m** | **£0.323m** | **£0.320m** | **£0.003m** |

7.25 There are currently no financial risks associated with the Project for 2024-25.

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## 8. KEY RISKS AND MITIGATING ACTIONS

8.1 The key financial risk to the TCS Programme at present is as follows:

- There is no expenditure against the Enabling Work Project revenue budget, whilst there is revenue overspend against the nVCC project.

## 9. TCS SPEND REPORT SUMMARY

9.1 At the end of 2019, a financial model was developed by the TCS Finance Team to provide a spend profile for the TCS Programme. The model allocates reported spend by year to defined deliverables and outputs within each project within the Programme. It also allocates spend to the various resources need to deliver the Programme, such as pay, advisors, suppliers, etc. The output for the model itself is an in-year report providing spend details on a quarterly basis. A cumulative report is also produced for the Programme for its inception to the end of the latest quarter.

9.2 Appendix 4 provides cumulative report to 31st March 2024. The report for 2024-25 is currently being developed and will be in line with the approved nVCC FBC.

9.3 The cumulative report shows a total spend for the TCS Programme of £68.635m (£63.443m Capital, £5.192m Revenue) to 31st March 2024. The total pay costs for this period were £15.239m.

9.4 The spend to 31st March 2024 for each Project within the Programme is summarised below.

| | |
|---|---|
| Programme Management Office | £2.187m |
| Project 1 Enabling Works | £34.735m |
| Project 2a nVCC | £26.221m |
| Project 2c Whitchurch Hospital Site | £0.051m |
| Project 3a Integrated Radiotherapy Solution | £0.1.049m |
| Project 3b Digital Strategy | £0.200m |
| Project 4 Radiotherapy Satellite | £0.393m |
| Project 5 SACT and Outreach | £0.002m |
| Project 6 Service Delivery and Transformation | £3.798m |
| Project 7 Decommissioning | £0m |

9.5 The spend to 31st March 2024 for each financial year is summarised below.

| | |
|---|---|
| 2014-15 | £0.328m |
| 2015-16 | £2.398m |
| 2016-17 | £6.168m |
| 2017-18 | £3.909m |
| 2018-19 | £4.267m |
| 2019-20 | £2.928m |
| 2020-21 | £3.924m |
| 2021-22 | £6.429m |
| 2022-23 | £17.365m |
| 2023-24 | £20.918m |

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

| | |
|---|---|
| Construction Costs | £19.842m |
| ASDA Works | £6.660m |
| Competitive Dialogue | £6.196m |
| Advanced Design and Works | £6.016m |
| Project Control | £5.198m |

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

**TCS Programme Budget & Spend 2024-25**

| CAPITAL | Year to Date Budget Dec-24 | Year to Date Spend Dec-24 | Year to Date Variance Dec-24 | Financial Year Annual Budget | Financial Year Annual Forecast | Financial Year Annual Variance |
|---|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ | £ |
| **Enabling Works Project** | | | | | | |
| Enabling Works Pay | 114,690 | 170,398 | -55,709 | 152,919 | 153,354 | -435 |
| Supply Chain Fees | 165,280 | 155,548 | 9,732 | 207,280 | 196,215 | 11,065 |
| Non Works Costs | 0 | -4,670 | 4,670 | 3,131 | -4,670 | 7,801 |
| Asda Works | 1,652,120 | 1,653,052 | -932 | 1,404,120 | 1,420,052 | -15,932 |
| Walters Design & Build | 481,200 | 481,188 | 12 | 481,200 | 481,188 | 12 |
| 6MVA Supply - National Grid | 480,000 | 480,000 | 0 | 480,000 | 480,000 | 0 |
| S278 works on Longwood Drive | 37,000 | 39,272 | -2,272 | 400,000 | 402,272 | -2,272 |
| Offsite Habitat Creation (SW Corner) | 47,050 | 47,052 | -2 | 356,050 | 336,052 | 19,998 |
| HV Intake Room | 13,300 | 13,300 | 0 | 200,300 | 195,300 | 5,000 |
| TCAR Extension Planning Application | 0 | 0 | 0 | 40,000 | 0 | 40,000 |
| Rural Path | 0 | 0 | 0 | 0 | 0 | 0 |
| TCAR Habitat | 0 | 0 | 0 | 0 | 0 | 0 |
| Revised Emergency Access | 0 | 0 | 0 | 0 | 0 | 0 |
| Enabling Works FBC Reserves | -56,250 | 9,921 | -66,171 | -225,000 | -158,829 | -66,171 |
| **Enabling Works Capital Total** | **2,934,390** | **3,045,061** | **-110,672** | **3,500,000** | **3,500,934** | **-934** |
| **nVCC Project** | | | | | | |
| Project Management Office | 682,090 | 678,670 | 3,420 | 1,176,723 | 1,172,289 | 4,434 |
| Design & Construction | 507,861 | 408,867 | 98,994 | 731,782 | 642,534 | 89,248 |
| Equipment, Commissioning and Migration | 219,455 | 209,236 | 10,220 | 393,376 | 377,306 | 16,070 |
| Digital | 65,923 | 66,177 | -254 | 133,150 | 133,420 | -270 |
| Engagement & Communications Workstream | 74,724 | 71,536 | 3,189 | 116,144 | 116,023 | 122 |
| Commercial Activities Group | 422,475 | 480,328 | -57,853 | 691,703 | 802,923 | -111,221 |
| **nVCC Capital Total** | **1,972,529** | **1,914,814** | **57,714** | **3,242,877** | **3,244,495** | **-1,618** |
| **Whitchurch Hospital Site** | | | | | | |
| Advisory Services | 204,750 | 30,147 | 174,603 | 273,000 | 180,890 | 92,110 |
| Preliminary Works | 0 | 800 | -800 | 80,000 | 80,800 | -800 |
| Whitchurch Hospital Site Reserves | 0 | -447 | 447 | 0 | 91,310 | -91,310 |
| **WHS Capital Total** | **204,750** | **30,500** | **174,250** | **353,000** | **353,000** | **0** |
| **CAPITAL TOTAL** | **5,111,668** | **4,990,375** | **121,293** | **7,095,877** | **7,098,429** | **-2,551** |

| REVENUE | Year to Date Budget Dec-24 | Year to Date Spend Dec-24 | Year to Date Variance Dec-24 | Financial Year Annual Budget | Financial Year Annual Forecast | Financial Year Annual Variance |
|---|---|---|---|---|---|---|
| | £ | £ | £ | £ | £ | £ |
| **Enabling Works Project** | | | | | | |
| Project Delivery Support Costs | 28,434 | 0 | 28,434 | 28,434 | 0 | 28,434 |
| **Enabling WorksRevenue Total** | **28,434** | **0** | **28,434** | **28,434** | **0** | **28,434** |
| **nVCC Project** | | | | | | |
| nVCC Pay Award | 46,865 | 46,865 | 0 | 65,082 | 65,082 | 0 |
| Project Delivery Support Costs | 0 | 21,044 | -21,044 | 0 | 24,454 | -24,454 |
| **nVCC Revenue Total** | **46,865** | **67,908** | **-21,044** | **65,082** | **89,536** | **-24,454** |
| **TCS Programme Management Office** | | | | | | |
| TCS PMO Pay | 242,116 | 216,028 | 26,088 | 330,695 | 283,161 | 47,534 |
| TCS PMO Non Pay | 1,500 | 2,746 | -1,246 | 1,500 | 48,746 | -47,246 |
| **PMO Revenue Total** | **243,616** | **218,774** | **24,842** | **332,195** | **331,907** | **288** |
| **Service Developmemnt, Transformation and Transition Project** | | | | | | |
| SDT Pay | 227,717 | 187,095 | 40,623 | 309,327 | 319,523 | -10,196 |
| SDT Non Pay | 9,862 | 259 | 9,603 | 13,754 | 259 | 13,495 |
| **SDT Revenue Total** | **237,579** | **187,353** | **50,226** | **323,081** | **319,782** | **3,298** |
| **REVENUE TOTAL** | **556,494** | **474,036** | **82,458** | **748,792** | **741,226** | **7,566** |

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# APPENDIX 2: TCS Programme Funding for 2024-25

| Description | Date | Funding Type | |
|---|---|---|---|
| | | Capital | Revenue |
| **Programme Management Office** | | **£0** | **£0.332m** |
| Commissioner's Funding | 01 April 2024 | £0 | £0.240m |
| Trust Revenue Funding | 01 April 2024 | £0 | £0.078m |
| WG Pay Award | 02 December 2024 | £0 | £0.014m |
| **Enabling Works FBC** | | **£3.500m** | **£0.028m** |
| WG Funding | 28 November 2024 | £3.500m | £0 |
| Escrow Bank Account Interest | 04 June 2024 | £0 | £0.028m |
| **New Velindre Cancer Centre FBC** | | **£3.243m** | **£0.065m** |
| WG Funding | 28 November 2024 | £3.243m | £0 |
| WG Pay Award | 02 December 2024 | £0 | £0.065m |
| **Whitchurch Hospital Site** | | **£0.353m** | **£0** |
| WG Funding | 28 November 2024 | £0.353m | £0 |
| **Radiotherapy Satellite Centre** | | **£0** | **£0** |
| No funding requested or provided for this project to date | - | £0 | £0 |
| **SACT and Outreach** | | **£0** | **£0** |
| No funding requested or provided for this project to date | - | £0 | £0 |
| **Service Delivery, Transformation and Transition** | | **£0** | **£0.323m** |
| Commissioner's Funding | 01 April 2024 | £0 | £0.180m |
| Trust Revenue Funding | 01 April 2024 | £0 | £0.140m |
| WG Pay Award | 02 December 2024 | £0 | £0.003m |
| **VCC Decommissioning** | | **£0** | **£0** |
| No funding requested or provided for this project to date | - | £0 | £0 |
| **Total** | | **£7.096m** | **£0.749m** |

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# Appendix 3: Sources of Funding and In Year Changes 2024-25

## Sources of Capital Funding

### *Initial Allocation (as at April 2024)*

| Project | WG Capital | Total Funding |
|---|---|---|
| Enabling Works Project | £0 | £0 |
| nVCC Project | £0 | £0 |
| Whitchurch Hospital Site | £0 | £0 |
| **Total** | **£0** | **£0** |

### *Overall Change to Allocation*

| Project | WG Capital | Total Funding |
|---|---|---|
| Enabling Works Project | £3.500m | £3.500m |
| nVCC Project | £3.243m | £3.243m |
| Whitchurch Hospital Site | £0.353m | £0.353m |
| **Total** | **£7.096m** | **£7.096m** |

### *Current Allocation (as at May 2024)*

| Project | WG Capital | Total Funding |
|---|---|---|
| Enabling Works Project | £3.500m | £3.500m |
| nVCC Project | £3.243m | £3.243m |
| Whitchurch Hospital Site | £0.353m | £0.353m |
| **Total** | **£7.096m** | **£7.096m** |

## Sources of Revenue Funding

### *Initial Allocation (as at April 2024)*

| Project | LHB Comm'rs | Trust Reserves | WG Pay Award | Escrow Interest | Total Funding |
|---|---|---|---|---|---|
| PMO | £0.240m | £0.078m | £0 | £0 | £0.318m |
| EW | £0 | £0 | £0 | £0 | £0 |
| nVCC | £0 | £0 | £0 | £0 | £0 |
| SDT | £0.180m | £0.140m | £0 | £0 | £0.320m |
| **Total** | **£0.420m** | **£0.218m** | **£0** | **£0** | **£0.638m** |

### *Overall Change to Allocation*

| Project | LHB Comm'rs | Trust Reserves | WG Pay Award | Escrow Interest | Total Funding |
|---|---|---|---|---|---|
| PMO | £0 | £0 | £0.014m | £0 | £0.014m |
| EW | £0 | £0 | £0 | £0.028m | £0.028m |
| nVCC | £0 | £0 | £0.065m | £0 | £0.065m |
| SDT | £0 | £0 | £0.003m | £0 | £0.003m |
| **Total** | **£0** | **£0** | **£0.082m** | **£0.028m** | **£0.111m** |

### *Current Allocation (as at May 2024)*

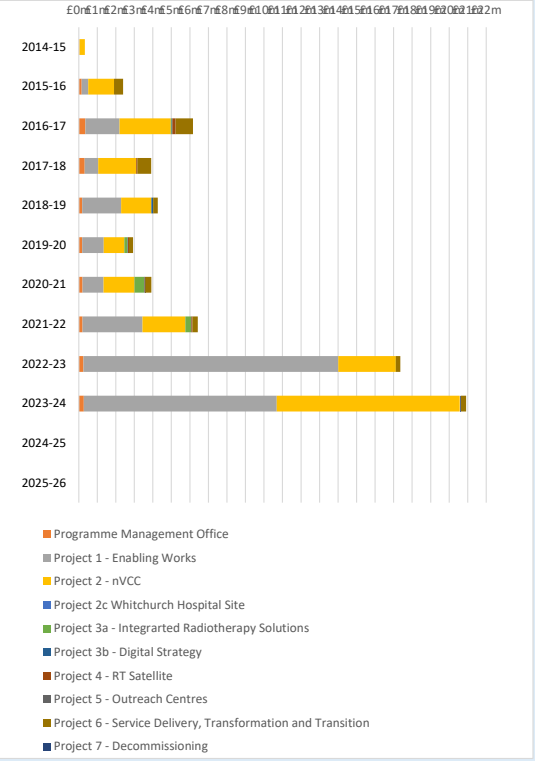
| Project | LHB Comm'rs | Trust Reserves | WG Pay Award | Escrow Interest | Total Funding |
|---|---|---|---|---|---|
| PMO | £0.240m | £0.078m | £0.014m | £0 | £0.332m |
| EW | £0 | £0 | £0 | £0.028m | £0.028m |
| nVCC | £0 | £0 | £0.065m | £0 | £0.065m |
| SDT | £0.180m | £0.140m | £0.003m | £0 | £0.323m |
| **Total** | **£0.420m** | **£0.218m** | **£0.082m** | **£0.028m** | **£0.749m** |

DRAFT

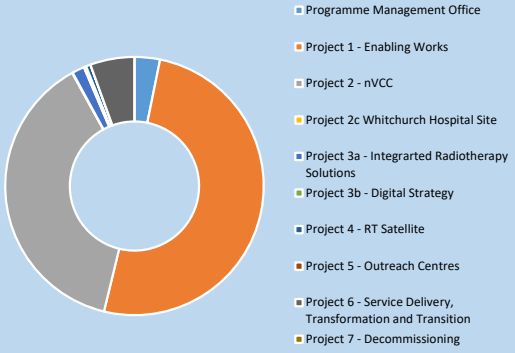
# APPENDIX 4: TCS Cumulative Spend Report to 31st March 2024

## SUMMARY OF CUMULATIVE TCS SPEND TO 31 MARCH 2024

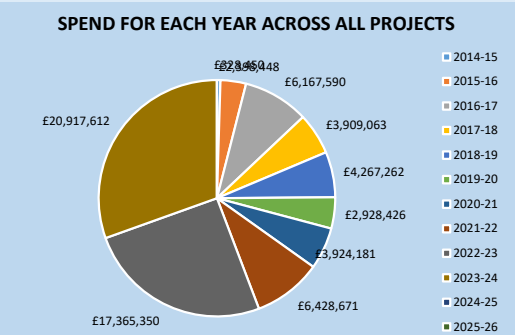
### SPEND PER PROJECT PER YEAR




### SPEND FOR EACH PROJECT ACROSS ALL YEARS




### SPEND FOR EACH YEAR ACROSS ALL PROJECTS




| TOTAL SPEND BY PROJECT TO DATE | £68,635,053 |
|---|---|
| Programme Management Office | £2,186,915 |
| Project 1 - Enabling Works | £34,734,803 |
| Project 2 - nVCC | £26,220,533 |
| Project 2c Whitchurch Hospital Site | £50,807 |
| Project 3a - Integrarted Radiotherapy Solutions | £1,049,425 |
| Project 3b - Digital Strategy | £199,786 |
| Project 4 - RT Satellite | £393,293 |
| Project 5 - Outreach Centres | £1,909 |
| Project 6 - Service Delivery, Transformation and Transition | £3,797,583 |
| Project 7 - Decommissioning | - |

### DELIVERABLES WITH HIGHEST EXPENDTITURE TO DATE

| | | |
|---|---|---|
| 1 | Construction Costs | £19,841,778 |
| 2 | Asda | £6,659,918 |
| 3 | Competitive Dialogue | £6,196,147 |
| 4 | Advanced Design and Works | £6,015,699 |
| 5 | Project Control | £5,198,999 |

### PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS

| TRUST BOARD | |
|---|---|
| **PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT** | |
| **DATE OF MEETING** | 30 January 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 |

## 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 16 January 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 16 JANUARY 2025

### *3.1 Triangulated themes*

The following triangulated themes were identified:

- ***Patient and Staff Wellbeing***: Discussions in respect of papers and the patient story highlighted the positive impact of psychological support on both patients and staff, emphasising the importance of enhancing patient and their families lives, maintaining staff resilience and reducing agency spend through improved recruitment and retention strategies.

- ***Demand and Capacity Planning / forecasting***: The need for robust demand and capacity planning featured as a theme, with examples of how effective demand and capacity management impacted on the blood service in respect of good stock levels after Christmas which is usually a challenging time in comparison to areas within Velindre Cancer Service where work remains ongoing in respect of robust capacity and demand mapping infrastructure so that it can effectively impact on service delivery and contingency plans...
- ***Policy Assurance***: Significant progress was noted in policy management, with improvements in compliance with renew dates and the need for ongoing updates and training to ensure policies are current and effective.

These themes were discussed in various contexts throughout the meeting, reflecting the ongoing efforts to improve service delivery and support across the organisation.

### *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-16012025/

### *3.3 Summary of Committee Highlights*

The following areas were highlighted for reporting to the Trust Board by the Committee:

| | |
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| **ALERT / ESCALATE** | There were no items to alert/escalate to Trust Board. |
| **ADVISE** | ***Bullying, Harassment and Discrimination Data Analysis***<br><br>The Committee received an overview of the data provided in relation to bullying, harassment and / or discrimination in the workplace, as reported in the 2023 staff survey. The report was discussed at length, as follows:<br>• An action plan was presented, focusing on eight areas, including improving the culture of speaking up safely and enhancing staff networks.<br>• Emphasis was placed on the importance of support mechanisms for staff, particularly in dealing with the psychological impact of bullying and discrimination.<br>• Leadership commitment: The WBS Director highlighted the service's commitment to addressing behavioural issues within the service, noting the impact of even a single incident on the wider team.<br>• Future actions - the need for ongoing discussions and actions to unpick the nuances between discrimination, harassment, and bullying, and to address the 'other' category in the survey data. |

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| | The Committee requested that a revised action plan is presented at the March meeting.<br><br>The applied **level of assurance of 3** was discussed and **agreed**, pending refinement of the action plan to sustain this level. |
| **ASSURE** | ***SACT Gold Close Down Report***<br><br>The Committee discussed the SACT Gold Close Down report which highlighted the improvements made since the November meeting. The Committee noted that due to improved performance and an improvement plan being in place there was no longer the requirement for continued management through business continuity. It had been agreed to transition to enhanced executive monitoring arrangements through a fortnightly SACT Steering Group chaired by the Executive Director of Nursing, AHP & Health Science.<br><br>However, the Committee were advised that the unvalidated performance data for December 2024 was showing a reduction in performance linked to increased demand and loss of one day of SACT delivery (Christmas Day). SACT Steering Group have requested that future plans are put in place to mitigate bank holiday capacity loss.<br><br>The proposed **level of assurance of 4** was discussed and supported by the Committee.<br><br>***Finance Report for the Period Ending 30th November 2024 (month 8)***<br><br>The Committee received the finance report and the following key points were highlighted:<br><br>• *Long Term Agreements (LTA*): The report highlighted that two LTAs were still outstanding at the time of writing, but they have since been received. Discussions with Health Boards indicated that the 1.77% uplift for the next year would be passed through, but no additional funds were expected beyond this, except for the SACT case which is still under consideration.<br>• *Pay Awards*: The pay awards for the year have been settled, and the modelling is being worked through. There is a small risk of a £300K shortfall in Welsh Government funding.<br>• *Agency Spend*: There has been a significant reduction in agency spend, with a forecasted reduction of £200,000, representing a 25% decrease from the previous year.<br>• *Savings*: The Committee discussed the achievement of savings targets, with some schemes needing replacement. The importance of realistic planning and understanding the impact on frontline services was emphasised. |

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| | The proposed **Level of assurance of 4** was discussed and **agreed** by the Committee.<br><br>***Policy Management Review and Compliance Status: as at December 2024***<br><br>The Committee discussed the Policy Management Compliance report which demonstrated an improved data set of information from which the Committee could take assurance regarding compliance with policy management review. The work undertaken on this was commended as a baseline going forward.<br><br>The **level of assurance of 3** was **agreed**, with a view to increasing to a level 4 following the Committee's receipt of the revised Policy on Policies.<br><br>***Freedom of Information Act / Environmental Information Regulation Report Quarter 1-Quarter 3 2024/2025***<br><br>The Freedom of Information (FOI) report which outlined that there had been an improvement in compliance with FOI requests from quarter one to quarter three. However, there was reduced performance in October 2024 and November 2024 impacted by staff absence. Assurance was provided in respect of increasing FOI request resilience to prevent staff absence impacting in the future.<br><br>The Committee **approved** the rating of **level 3 assurance.**<br><br>***Trust Risk Register***<br><br>The Trust Risk Register was received and discussed in detail.<br><br>The Committee discussed the work being undertaken to further enhance risk management processes as there were some similarities between long standing and newer reported risks. There are plans for further departmental level risk training.<br><br>Further detail was requested at the next Committee in respect of the Sarcoma Service risk, currently a rating of 16. Assurance was provided of the mitigation that has been put in place pending outcome of discussions across South Wales.<br>The proposed **level of assurance** was **Level 2**. The Committee noted the progress made but acknowledged that further improvements and actions are still required, particularly in terms of training, reviewing historical risks, and ensuring that actions are clearly defined and time focused.<br><br>***Annual Presentation of Nurse Staffing Levels***<br><br>The Committee received the Nurse Staffing Levels paper which provided assurance that the staffing levels are fully compliant with the Nurse |

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| | Staffing Levels Wales Act. The only outstanding work is to separate the establishment financially for the ward and the assessment and ambulatory care unit, which is planned to be completed by the end of quarter 4.<br><br>The Committee **ENDORSED** the nurse staffing levels report prior to onward Board approval and submission to Welsh Government. |
| **INFORM** | ***Velindre Cancer Service - Patient Story***<br><br>The Trust's Consultant Clinical Psychologist shared a powerful letter that had been written by a patient regarding the psychology support he had received. The story outlined how the sessions had had a far-reaching impact on the patient's family and had significantly improved the patient's resilience and ability to manage his condition. The Committee requested to extend both condolences and thanks to the family of the patient who has sadly passed away.<br><br>The Committee reflected on the importance of the wider patient / family support services such as psychology and how this support can make such a powerful impact during the most difficult of times in patients' lives.<br><br>***Performance Management Framework (PMF) Report and Supporting Analysis***<br><br>The Committee received the PMF report covering the period to the end of November 2024. The Committee were updated in respect of the nine work packages underway to further develop the framework and its reporting including the transition to exception reporting. The report now includes levels of assurance for each of the seven performance areas, as considered by the Executive Management Board.<br><br>The development of the Aria Insight project in radiotherapy was highlighted which will help to understand service productivity and capacity gains and is expected to be in place by March, with benefits rolling out in the first quarter of the next financial year.<br><br>Welsh Blood Service - Blood and blood product supply - the Committee were informed of the successful Christmas campaign and robust demand mapping which resulted in being in a strong stock position in January 2025, usually a difficult time in the post-Christmas period.<br><br>The Committee were advised of the key findings from the Welsh Blood Service (Medicines and Healthcare products Regulatory Agency (MHRA) inspection that was conducted in early December 2024. There were no critical findings. The Committee will receive the report and improvement plan at the next meeting. |

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| | The Committee extended congratulations to all staff involved in the work undertaken to recruit to the Welsh Donor Registry for STEM cells, as there has been a significant increase in numbers recruited.<br><br>Proposed **levels of assurance** for each element of the report were **supported** by the Committee, as follows:<br>• VCS - level **3**<br>• WBS - level **3**<br>• Workforce & Wellbeing - level **4**<br>• Digital Services - level **4**<br>• Estates, Infrastructure & Sustainability - level **3**<br>• Health & Safety - level **4**<br>• Financial Services - level **4**<br><br>***Assurance Report Medicines Management Group (including Medical Gases & CDs)***<br><br>The Committee received and discussed the Medicines Management Group report and **agreed** the proposed **level of assurance of 5**.<br><br>***Trust Policies and Procedures for Endorsement***<br><br>The Committee **ENDORSED** the following Trust Policies and Procedures for onward Board approval:<br><br>• Employing Ex-Offenders and People with a Criminal Record<br>• Annual Leave and Bank Holiday Policy and Procedure (Medical)<br>• Job Evaluation Policy and Procedure<br>• All Wales Pregnancy Loss Support Policy<br>• All Wales Recovery of Overpayments Procedure |
| **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 16 January 2025.

| Trust Board | |
|---|---|
| **Annual Presentation of Nurse Staffing Levels to the Board** | |
| **DATE OF MEETING** | 30th January 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** | Rhian Wright, Nurse Staffing Programme Lead |
| **PRESENTED BY** | Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science |
| **APPROVED BY** | Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science |
| **EXECUTIVE SUMMARY** | This paper is to provide an update on compliance with the Nurse Staffing Levels (Wales) Act 2016. This report provides the position from the 1st of October 2023 to the 30th of September 2024. The report highlights that:<br>• Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for the one Velindre Cancer Service 25B area: First Floor Ward. There are no financial concerns in relation to the staffing of this area.<br>• There has been no change in the planned roster since 2022.<br>• The First-Floor ward establishment includes the required 26.9% headroom, the ward manager remains supernumerary to the planned roster.<br>• ***There has been no reportable harm in relation to the quality indicators during the review period in respect of nurse staffing levels on the First Floor Ward.***<br>• All reasonable steps have been utilised to maintain the nurse staffing level in line with the |

| | |
|---|---|
| | requirements of the Act.<br>• Recent establishment reviews highlighted that first floor is fully established, however, there are some challenges with skill mix due to International Nurse and Student Streamlining recruitment and deployment of SACT trained nurses to support SACT day case delivery, however, this is an improving picture.<br>• VCS Team have provided assurance that the work to separate the Band 5 and Band 3 nursing workforce on the First Floor Ward roster from that of the Ambulatory and the Assessment Units will be completed by the end of Quarter 4. |

| | |
|---|---|
| **RECOMMENDATION / ACTIONS** | Trust Board is asked to ***NOTE*** the compliance in respect of the Nurse Staffing Levels Wales Act prior to the report being submitted to Welsh Government. |

| **GOVERNANCE ROUTE** | |
|---|---|
| **List the Name(s) of Committee / Group who have previously received and considered this report:** | **Date** |
| Professional Nurse Forum | 05/12/2024 |
| Executive Management Board | 08/01/2025 |
| Quality, Safety & Performance Committee | 16/01/2025 |
| **SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS**<br>Report discussed and endorsed by all three groups.<br>The Quality, Safety & Performance Committee requested assurance in respect of headroom being in place across all areas. Confirmation was provided that the required 26.9% headroom is included in all rosters with the exception of the Clinical Nurse Specialist (CNS) Team which is being worked through aligned with site specific team CNS reviews. | |
| **7 LEVELS OF ASSURANCE** | |
| **ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR** | Level 4 - Increased extent of impact from actions<br>***In respect of 25B area*** |

## 1. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

- Enable the provision of safe nursing care to patients at all times

- Improve working conditions for nursing and other staff
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Section 25B of The Nurse Staffing Levels (Wales) Act 2016 requires organisations to have sufficient staff to provide appropriate patient centred care. Section 25A places a duty on health boards/trusts to take due regard to have sufficient nurses to allow nurses time to care sensitively for patients wherever nursing services are provided or commissioned.

Section 25E of the Nurse Staffing Levels (Wales) Act 2016 requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward and paediatric inpatient wards.

There is only one area of the Trust that sits under the requirements of 25B of the Act, First Floor Ward at Velindre Cancer Service. This was re-classified in April 2021 as meeting the wider definition of a 'medical ward' as it is a specialist oncology medical ward and therefore, the ward and Trust are now required to meet the full reporting requirements of the Nurse Staffing Levels (Wales) Act (2016).

Bi-annual nursing establishment reviews of both 25A and 25B areas are carried out 6-monthly utilising a triangulated approach.

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

### *2.1 Nurse Staffing Levels Act Reporting*

National reporting is annually and 3 yearly, however following suit with the acuity and establishment reviews internally this update will be provided to the Trust Board for noting on progress. The Annual Presentation of Nurse Staffing Levels has been completed and the report (using the national reporting template) is attached in ***Appendix 1***. The required establishment figures for the last three establishment reviews are included in ***Appendix 2***. This report is laid out on a national template and will be reported to Welsh Government for onward assurance.

### *2.2 Establishment Reviews*

Following each national benchmarked acuity review (twice yearly) an establishment review is undertaken across all areas of the Trust that employs registered nurses. The establishment reviews include all front-line

care/treatment delivery (both Divisions) chaired by the Executive Director of Nursing, AHP & Health Science and relevant Head of Nursing. The establishment reviews are reported on a template for agreement at each level. Each establishment review includes an overview of:

2.2.1 Current funded establishments
2.2.2 Vacancies and staff in post
2.2.3 Datix Incidents – related to service delivery and staffing
2.2.4 Complaints relevant to establishment or staffing
2.2.5 Training compliance
2.2.6 PADR compliance
2.2.7 Review of Roster
2.2.8 Patient Feedback (CIVICA)
2.2.9 Audits (Tendable)
2.2.10 Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
2.2.11 KPI review
2.2.12 Quality Indicators (25b)
2.2.13 Service plans or Clinic Templates as applicable (not all areas)

### *2.3 Outcome of the establishment review of the First Floor Ward*

In line with the regulatory requirements of the Nurse Staffing Levels (Wales) Act 2016, the First Floor in-patient ward has been assessed against the requirements of section 25B of the Nurse Staffing Levels (Wales) Act 2016. Following the review undertaken, assurance can be provided that the ward is safely staffed with the correct nursing establishment in place, this includes the 26.9% headroom. Assurance can also be provided that the establishment is fully funded.

The establishment review highlighted that the First Floor Ward establishment requires separation from the Ambulatory and Assessment Unit establishments to ensure robust reporting and to facilitate reporting against rostering policy. Historically staff have rotated shift by shift from the ward to the units. In order to separate the establishments and budgets 6-month rotations will commence. Assurance has been provided that establishments will be separated and rotations commenced by the end of quarter 4.

### *2.4 Electronic Rostering*

Health roster is fully utilised in six nursing areas and for the nurse Bank. Rostering Key Performance Indicators (KPIs) are produced electronically which are scrutinised locally to assess rostering efficiency and effectiveness. An overview of these KPIs is also taken as part of establishment reviews. Health Roster also facilitates rapid and robust assurance that staffing levels are safe across all nursing areas. These rosters are legible, auditable and viewed in one centralised location for visibility of responsible staff.

The Nurse Rostering Policy is being finalised - this contains robust rostering

requirements e.g. number of requests, etc.

### *2.4 SafeCare*

The SafeCare module has assisted in facilitating automated Act reporting through Velindre University NHS Trust and to NHS Wales in line with National Nurse Staffing Act reporting requirements. Velindre University NHS Trust has completed its integration into the First Floor ward which is now recording acuity and staffing levels data twice a day in line with the All-Wales Standards of Practice for Safe Care.

## 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:<br>• Outstanding for quality, safety and experience ☒<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒<br>• A beacon for research, development and innovation in our stated areas of priority ☐<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐<br>• A sustainable organisation that plays its part in creating a better future for people across the globe ☐ | |
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)**<br>*For more information: STRATEGIC RISK DESCRIPTIONS* | 06 - Quality and Safety |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | **Select all relevant domains below** |
| | Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>Patient Centred ☒ |

| | |
|---|---|
| | The Nurse Staffing Levels (Wales) Act 2016 covers all aspects of safe, timely and effective care.<br>Rostering of staff against demand considers equitable and efficient care to deliver patient centred delivery. |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:**<br>*For more information:*<br>*https://www.gov.wales/socio-economic-duty-overview* | Not required |
| | Socio-economic disadvantage and inequality of outcome is not relevant to this paper |
| **TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT** | A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health |
| | To enable us to achieve a Healthier Wales and our organisational goals we need a sufficient workforce with the right skills and in the right place to be able to provide safe, timely and effective care to our patients and donors. |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| **EQUALITY IMPACT ASSESSMENT**<br>*For more information:*<br>*https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx* | Not required for this type of report |
| | There is no evidence to suggest that the information in this paper could benefit or disadvantage any particular group of people. |
| **ADDITIONAL LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny. |

## 4. RISKS

| | |
|---|---|
| **ARE THERE RELATED RISK(S) FOR THIS MATTER** | No |

Appendix 1

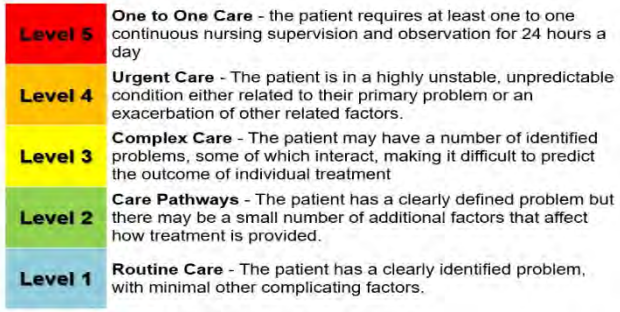
# Annual Presentation of Nurse Staffing Levels to the Board

| | | | | | | |
|---|---|---|---|---|---|---|
| **Health Board/Trust** | Velindre NHS University Trust | | | | | |
| **Date of annual presentation of Nurse Staffing Levels to Board** | 30/01/2025 | | | | | |
| **Period Covered** | **01 October 2023 to 30 September 2024** | | | | | |
| **Number and identity of section 25B wards during the reporting period.**<br>• **Adult acute <u>medical</u> inpatient wards (inclusive of Oncology & Haematology inpatient wards)**<br>• **Adult acute <u>surgical</u> inpatient wards**<br>• **<u>Paediatric</u> inpatient wards** | Section 25B of the Nurse Staffing Levels (Wales) Act applies to one ward (First Floor) in Velindre Cancer Centre. There has been no primary change to the ward structure during the last year. Bed capacity has remained at full capacity of 32 beds during the last 12-month period.<br><br>The bi-annual acuity and nurse staffing levels audit cycle took place as planned in both January and June 2024. Establishment reviews were held in October 2023, June 2024 and October and November 2024. There have been no changes to the wards planned roster in the last 12 months. | | | | | |
| | **Adult acute <u>medical</u> inpatient wards** | | **Adult acute <u>surgical</u> inpatient wards** | | **Paediatric inpatient wards** | |
| | 1 | | | | | |
| **Required establishment (WTE) calculated (October 2022)** | **RN** | **HCSW** | **RN** | **HCSW** | **RN** | **HCSW** |
| | 28.42 | 14.21 | | | | |
| **WTE of required establishment funded (October 2022)** | 28.42 | 14.21 | | | | |
| **Staffing requirements following Spring Cycle (May 2023)** | **Adult acute medical inpatient wards** | | **Adult acute surgical inpatient wards** | | **Paediatric inpatient wards** | |
| **Required establishment (WTE) calculated (May 2023)** | **RN** | **HCSW** | **RN** | **HCSW** | **RN** | **HCSW** |
| | 28.42 | 14.21 | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **WTE of required establishment funded (May 2023)** | 28.42 | 14.21 | | | | |
| **Staffing requirements at end of reporting period (September 2023)** | **Adult acute medical inpatient wards** | | **Adult acute surgical inpatient wards** | | **Paediatric inpatient wards** | |
| **Required establishment (WTE) calculated (September 2023)** | **RN** | **HCSW** | **RN** | **HCSW** | **RN** | **HCSW** |
| | 28.42 | 14.21 | | | | |
| **WTE of required establishment funded (September 2023)** | 28.42 | 14.21 | | | | |
| **WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but excluded from planned roster)** | 1 | | | | | |
| **Required establishment (WTE) calculated and WTE of required establishment funded** | The required establishment is fully funded. Due to the recent challenges in recruiting staff over the last 18 months a recruitment drive was initiated which has included the recruitment of internationally educated nurses and the commencement of student streamlining. The First Floor ward is now fully established as a result of the recruitment drive. | | | | | |
| **Using the triangulated approach to calculate the Nurse staffing level on section 25B wards** | The triangulated approach as documented in the Welsh Levels of Care (WLOC) Toolkit has been utilised to inform the calculation of the nurse staffing levels on the First Floor ward. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. There have been no reportable incidents (quality indicators) in relation to nurse staffing during this period Establishment reviews have taken place bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. | | | | | |

Patient acuity is scored twice a day using the Welsh Levels of Care Tool. The ward manager and band 6 nurses measure patient acuity using the approved Welsh Levels of Care Tool. Further refresher training on SafeCare and the WLOC tool is scheduled in December to aid consistency in scoring of acuity levels. Compliance with SafeCare from the 1st of October to the 30th of September 2024 was 92.62%.

| | The percentage of patients assigned to each level as a proportion of the total data captured | | | |
|---|---|---|---|---|
| WLOC Level | 2022- 2023 | 2023-2024 | Last 6 months | Trend |
| Level 5 | 6.5% | 0.40% | 0.60% | ↑ |
| Level 4 | 46.7% | 22.08% | 12.95% | ↓ |
| Level 3 | 43.8% | 51.62% | 57.61% | ↑ |
| Level 2 | 3.1% | 22.08% | 28.50% | ↑ |
| Level 1 | 0.02% | 1.20% | 0.34% | ↓ |




SafeCare has assisted in avoiding the over or under use of staff and helps in assuring that there is an appropriate and safe nursing skill mix. SafeCare has brought together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients at Velindre Cancer Centre. All reasonable steps are taken to maintain the nurse staffing level.

**Finance and workforce implications**

The nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor including the 26.9% headroom. There are no financial concerns in relation to the staffing of first floor. All reasonable steps are taken to maintain the nurse staffing level, including, redeployment of staff, utilisation of staff who sit outside of the planned roster and the use of appropriate bank or overtime. Agency is occasionally utilised for support work staff.

First floor is sufficiently staffed however there are challenges with skill mix due to recent international recruitment and student streamlining. The skill mix is improving, and support is available from the co-ordinator role and practice educator team. The recent establishment review highlighted that the establishment and roster for the First-Floor ward continues to be amalgamated with that of the Ambulatory Unit and the Assessment Unit, and plans are in place to address this. The establishment

| | |
|---|---|
| | review concluded that the current establishment allows nurses time to deliver care to patients sensitively on first floor ward and no additional resource is required. |
| **Conclusion & Recommendations** | |
| | • The First floor ward is currently fully established which includes 26.9% headroom.<br>• The skill mix has been challenging due to the introduction of international recruitment and student streamlining. However, this is an improving as experience is gained with ongoing support from the practice education team<br>• There have been no instances of reportable quality indicators/harm to patients during this period and no harm reported due to nurse staffing levels<br>• All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Nurse Staffing Levels (Wales) Act 2016.<br>• There are no financial concerns in the funding of the establishment for first floor ward<br>• Acuity continues to be scored twice a day on the ward. Data reporting from SafeCare remains a challenge, the All-Wales Nurse Staffing Group is working with the digital team from the NHS Executive to develop dashboards to improve the data retrieval and reporting process.<br>• The current establishment allows nurses time to deliver care to patients sensitively on first floor ward and no additional resource is required. |

**Appendix 2: Annual Presentation of the Nurse Staffing Level to the Board report**

| | |
|---|---|
| **Health board/trust:** | **Velindre University NHS Trust** |
| **Period of the report** | **1st Octover 2023 to 30th of September 2024** |
| **adult acute surgical wards** | 1 |

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report [INSERT HYPERLINK] on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

**Adult Acute Surgical inpatient wards**

| | Autumn 2022 Cycle | | | | | | Spring 2024 Cycle | | | | | | Autum 2024 cycle | | | | | | | Biannual calculation cycle reviews, and any changes made & rationale during the spring & autumn calculation cycles | | | Any reviews outside of biannual calculation, if yes, provide rationale for any changes made | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Planned roster as stated within the annual | | Required Establishment as stated within the annual | | | | Planned roster calculated by the designated person during the spring | | Required Establishment as calculated by the designated perons during the spring cycle | | | | Planned roster calculated by the designated person during the autumn cycle | | Required Establishment as calculated by the designated perons during the autumn cycle including uplift 26.9% | | | | | | | | | | |
| Name of Ward | SHIFT | RN (band 5 &6) | HCSW (bands 2,3 &4) | TOTAL WTE RN (bands 5 &6) | TOTAL WTE HCSW (bands 2,3 &4) | TOTAL WTE Band 7 supernumerary ward sister/Charge nurse | SHIFT | RN (band 5 & 6) | HCSW (bands 2,3 &4) | TOTAL WTE RN (bands 5 &6) | TOTAL WTE HCSW (bands 2,3 &4) | TOTAL WTE Band 7 supernumerary ward sister/Charge nurse | Date designated person calculated the nurse staffing level | SHIFT | RN (band 5 &6) | HCSW (bands 2,3 &4) | TOTAL WTE RN (bands 5 &6) | TOTAL WTE HCSW (bands 2,3 &4) | TOTAL WTE Band 7 supernumerary ward sister/Charge nurse | Date designated person calculated the nurse staffing level | Completed (Yes/No) | Changed | Rationale | Completed (Yes/No) | Date | Changed | Rationale |
| First Floor Velindre Cancer Centre | Long Day | 5 | 3 | 28.42 | 14.21 | 1 | Long Day | 5 | 3 | 28.42 | 14.21 | 1 | 17/06/2024 | Long Day | 5 | 3 | 28.42 | 14.21 | 1 | 13/11/2024 | Yes | No | No changes to the planned roster or required establsihment in the review period. The additional ward co-ordinator role is supernumerary to the planned roster | No | | | |
| | Night | 5 | 2 | | | | Night | 5 | 2 | | | | | Night | 5 | 2 | | | | | | | | | | | |

# Health Technology Wales Annual Report 2023-24

## Velindre University NHS Trust

## Public Board Meeting 30th Jan 2025


**Professor Peter Groves**

**Chair HTW**

**Dr Susan Myles**

**Director HTW**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Health Technology Wales

Ariennir gan
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# ANNUAL REPORT 2023/24

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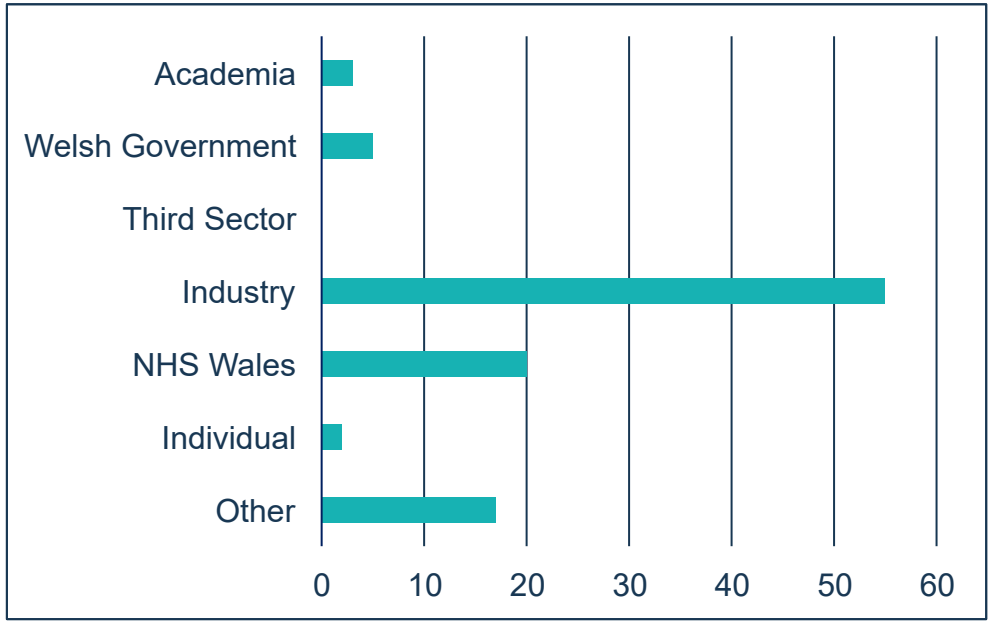
Health Technology Wales

# IDENTIFICATION

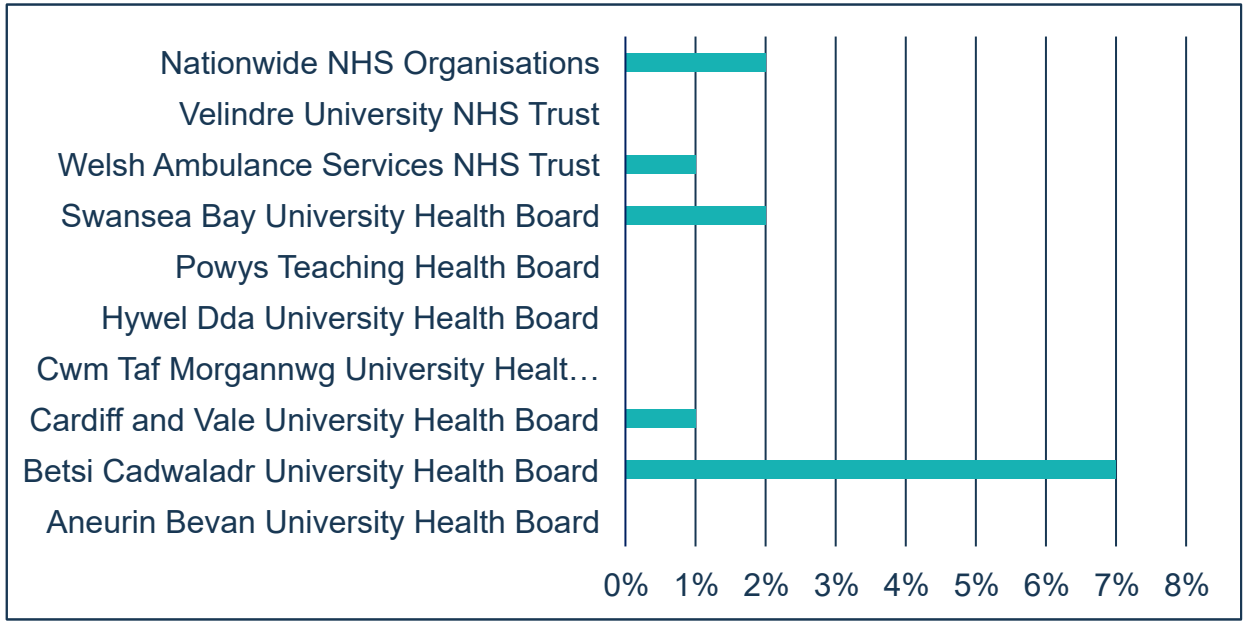
**66**
Topics proposed to HTW in 2023/24

**493**
Topics proposed to HTW since 2017

**Source of topic referrals in 2023/24**




**Breakdown of topics referred from the NHS in 2023/24**



# APPRAISAL: HTW NATIONAL GUIDANCE

**493**
Topics proposed to HTW since 2017

**65**
Topics progressed to evidence appraisal

**44**
Pieces of Guidance published

**Routine adoption**

The evidence supports the adoption of that technology for a general population

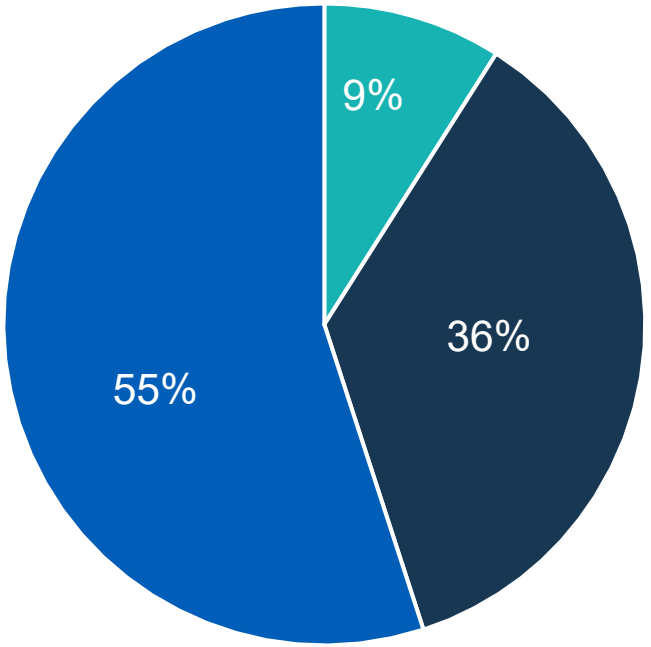
**Selective adoption**

The evidence supports the adoption of that technology in specific subset of the general population

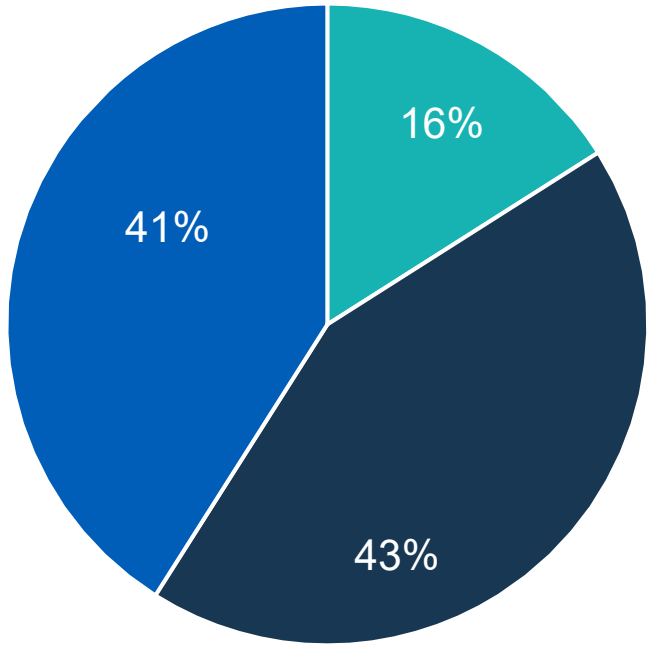
**Insufficient evidence to support adoption**

There Is not enough evidence to support the adoption of that technology

**2023-2024**




**2017-2024**

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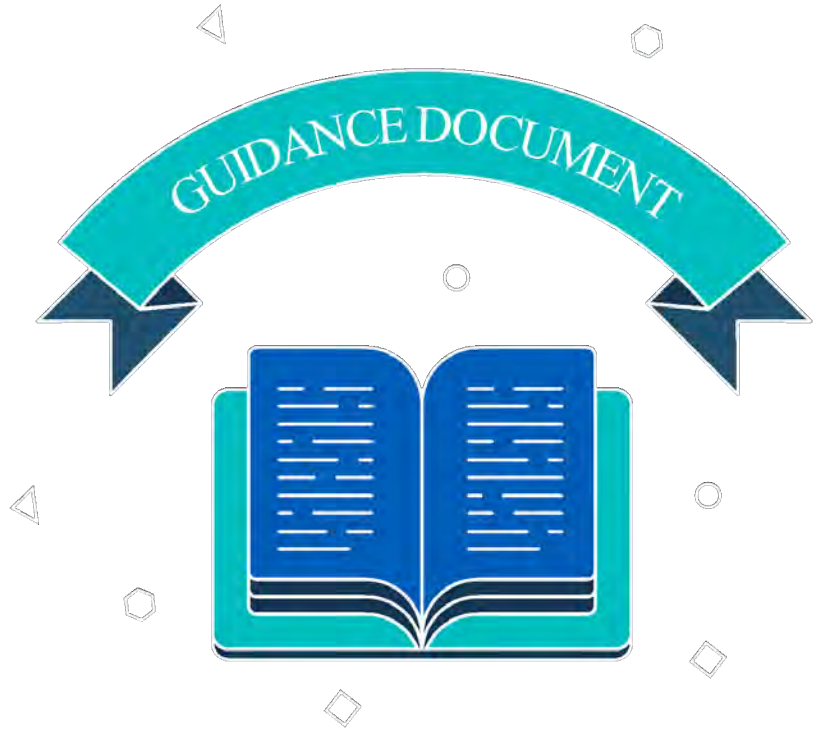
Welsh Government

# APPRAISAL: HTW Guidance Published in 2023/24

- Liposuction for the treatment of chronic lymphoedema
- Video feedback interventions
- Intensive family preservation programmes
- Digital wound management tools
- Low energy contact x-ray brachytherapy
- Robot-assisted thoracic surgery
- Solution-focused assessment tools (DIALOG+)
- Percutaneous implantation of pulmonary artery sensors
- Multi-grip upper limb prosthetics
- Myopia control contact lenses and spectacles
- Wearable cardioverter defibrillator



# Adoption Audit 23/24 - Key Findings

***Process***

- 11 HTW & 3 NICE
- Minor changes to 23/24 process to help with clarity and analysis
- Best response rate so far. Full responses from 4/7 LHBs, NWJCC, WAST & Velindre. Partial responses from 2/7 LHBs
- Procurement provided all requested data
- Audit able differentiate levels of adoption & impact

***Awareness, clarity & impact of guidance***

- **Awareness** good **79%**
- **Clarity** very good **96%**
- **Impact** high **72%**
- Useful **feedback** on barriers & enablers

# ADOPTION AUDIT 23/24 - KEY FINDINGS

## *Themes*

- Still some uncertainty of the remit of HTW guidance (does not cover implementation or funding)
- Recommendations "partially supporting" adoption insufficient for changing clinical practice/commissioning
- Differences in opinion on what makes guidance relevant

## *Barriers to adoption*

- Funding and resources
- Small patient numbers
- Concerns about the evidence / more convincing evidence for other technologies
- Organisations and relevant people still sometimes not aware of guidance

# Adoption Audit - Key Findings Over 3 Years

| | 2021/2022 | 2022/2023 | 2023/24 |
|---|---|---|---|
| **Awareness** | 68% | 70% ↑ | 79% ↑ |
| **Clarity** | 68% | 83% ↑ | 96% ↑ |
| **Impact** | 68% | 72% ↑ | 72% — |

**Process is suitable and acceptable**

- Works well for HTW and NICE guidance
- Suitable for different commissioning organisations within NHS Wales

**Research recommendations**

- Often a lack of action in response to these
- Clarity of research recommendations mentioned as an issue

**Misunderstanding of the remit of HTW guidance**

- Lack of information on implementation and sources of funding often mentioned
- The above are frequently mentioned as barriers to adoption

**Barriers to adoption**

- Funding initially not a barrier, now frequently mentioned as a barrier
- Small patient numbers limit ability to implement

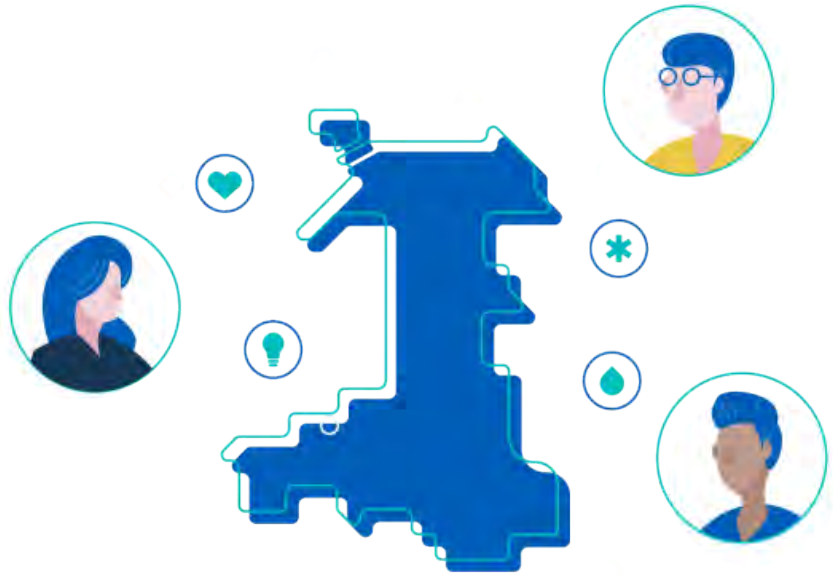
# HTW Evidence-based MedTech Report to Welsh Government

Spring 2024, HTW Commissioned by WG to prepare an evidence-based MedTech Advisory Report

A collaborative project that involved engagement with more than 180 stakeholders from Wales and other parts of the UK

The final advisory report was submitted to WG on 20th December 2024 with 22 recommendations for future direction for MedTech assessment and use in Wales

Recommendations around topics such as collaborative working, impactful topic identification, patient safety, patient and public involvement, equality and diversity, sustainability



# HTW More Information

- Website - https://healthtechnology.wales/
- Annual Report 2021/22 - https://healthtechnology.wales/health-technology-wales-2021-annual-report-is-published/
- 5 Year Review Report - https://healthtechnology.wales/five-year-progress-review-highlights-prospects-for-future-development/
- Pilot adoption Audit Report - https://healthtechnology.wales/htw-publishes-pilot-adoption-audit-report/

**HTW Animations – Youtube**

- About us - https://youtu.be/lQml9QTTxzU
- Scientific Advice Service - https://youtu.be/hEGznWG5s_c
- Suggest a Topic - https://youtu.be/JCgIrk_GJkA
- Digital Open Topic Call - https://youtu.be/bUXVpM5oL5M
- Patient and Public Involvement (PPI) - https://youtu.be/nPbCZOq4tMI
- 5-Year Anniversary - https://youtu.be/z6pEFTouv1g
- Topic Appraisal Process - https://youtu.be/38OuhQp0S04

- **Annual Report 23/24 imminent. Share asap**

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Health Technology Wales

# Diolch | Thank you

Healthtechnology@wales.nhs.uk

Healthtechnology.wales

@HealthTechWales

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Health Technology Wales

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

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Our partners:

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

Ariennir gan Lywodraeth Cymru Funded by Welsh Government


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# FOREWORD

**Welcome to the Health Technology Wales (HTW) Annual Report which describes the work that we have done during 2023-24.**

This year we have balanced our commitments to selecting, appraising and promoting the adoption of novel, evidence-based, non-drug technologies, with taking on new roles to support the innovation and medtech ecosystem in Wales and beyond.

During 2023-24, we considered 66 new topic referrals and published 11 new HTW national guidance documents, which addressed topics that ranged from digital assessment tools to robot-assisted surgery and intensive family preservation programmes. Since 2017, HTW has published 44 pieces of evidence-based guidance and 245 Topic Exploration Reports. The 2022-23 audit report indicates that there is a high level of awareness of HTW guidance within NHS Wales and that HTW guidance is having a significant impact on decision-making.

To support the delivery in NHS Wales of the six ministerial priorities, HTW evolved its topic identification and prioritisation processes during 2023-24 and focused on searching for technology topics that are being addressed by HTA organisations internationally and may be relevant and of interest to the Welsh health and care sectors. Through engagement with clinical networks and policy leads, we have identified those most relevant to the ministerial Priorities and will now pursue more detailed selection and assessment of these.

During 2023-24, HTW contributed, as a collaborating partner, to the development and implementation of the Innovative Devices Access Pathway (IDAP) pilot, a national venture that aims to promote transformative medical technologies that address unmet clinical needs in the NHS.

In order to support decision-making around the full lifecycle of medical technologies, HTW engaged with the newly formed All-Wales Clinical Effectiveness Group (AWCEG). AWGEG is tasked with identifying interventions that are undertaken in Wales but which, evidence suggests, are low value interventions in terms of clinical and cost effectiveness. HTW provides evidence reviews and summaries to the group to ensure that they have access to the most robust and up-to-date published information on which to base their decisions.

Public and Patient Involvement (PPI) is central to all aspects of our work. During 2023-24, 13 non-drug technology topics were considered by the HTW PPI Standing Group. Meanwhile, the impact of the HTW PPI Group continues to spread beyond Wales through its involvement in the work of the International Network of Agencies for Health Technology Assessment (INAHTA).

Engaging with local, national and international stakeholders remained key to the success of HTW during 2023-24. Local engagement through the HTW Stakeholder Forum helped to guide the work of HTW to ensure that it continues to be of greatest relevance and value to the communities it serves. We have continued to work closely with partners in the Health and Care Research Wales (HCRW) Evidence Centre to ensure that the decisions made by NHS and social care leaders and Ministers are supported by the best available evidence. We have continued to build on already established links with the life sciences industry through the work of our Industry User Group and collaborations with the Life sciences Hub Wales and the Bevan Commission.

During 2023-24, HTW was able to successfully deliver the objectives outlined in the five-year Strategic Plan published in 2021 and continued to develop its vision to become a world class HTA organisation. We hope that you enjoy reading this annual report and we look forward to continuing to work with you in realising our vision.

**Professor Peter Groves**
Chair
Health Technology Wales

**Dr Susan Myles**
Director
Health Technology Wales

# STRATEGIC PLAN 2021-2025

**Better Health - Evidence Driven**

The HTW Strategic Plan 2021-2025 sets out the organisation's immediate, medium and long-term strategic goals and objectives.

**VISION:** To develop a world-class HTA organisation that facilitates the identification, appraisal and adoption of health technologies that offer most promise to deliver improved health outcomes and value for the people of Wales.

**MISSION:** To drive improvements in population health and care services by applying the best available evidence to inform decisions on the appropriate use of health technologies in Wales.

Key achievements in delivering our 2023/24 priority objectives are set out below:

**Expand HTW's topic identification, prioritisation and selection efforts**

- Reviewed the International HTA Database to identify health technologies which align with Welsh Government's six ministerial health and social care priorities
- Shortlisted 10 relevant publications from the INAHTA database which were classified into ministerial priority areas
- Worked in close partnership with clinical and policy networks across Wales to identify new topics for evidence appraisal

**Maintain increased HTW evidence appraisal and guidance output**

- 11 pieces of guidance published in 2023/24
- 10 topics progressed to evidence appraisals
- 30 Topic Exploration Reports (TERs) published

**Support time-critical health and social care policy decision making**

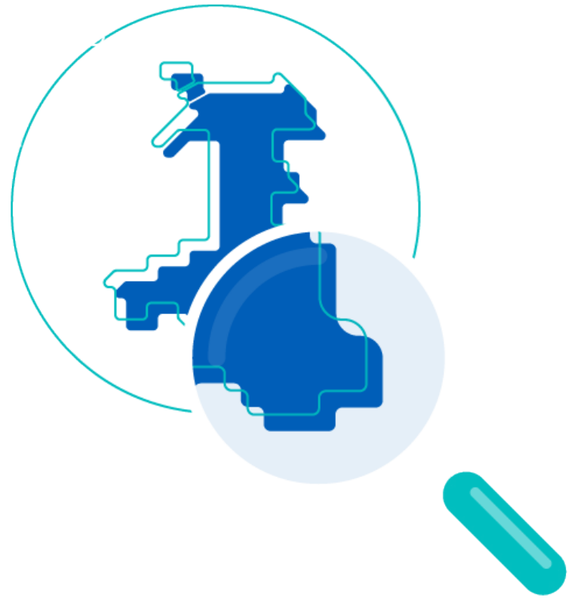
- Continued to conduct rapid evidence reviews as a Collaborating Partner of the Health and Care Research Wales Evidence Centre
- Participated as part of a Technology Specific Evaluation Team (TSET) in the NHS Artificial Intelligence Award evaluating research for two AI technology projects
- Provided a key evidence support role to the All-Wales Clinical Effectiveness Group (AWCEG) in reviewing current Interventions Not Normally Undertaken (INNU) policies held by Welsh health boards

**Roll-out technology adoption audit function and pilot the adoption audit process for NICE medical technologies guidance**

- 11 pieces of HTW guidance and three pieces of NICE guidance audited as part of the 2022/23 HTW Adoption Audit
- Encouraging response rates with participation by 6 local health boards and the Welsh Health Specalised Services Committee
- Responses indicate that awareness of HTW guidance is high (70%), clarity of HTW guidance recommendations is good (83%), and HTW guidance is having some form of impact in the majority of cases (72%)

**Improve and publish HTW's methods and processes**

Publication of HTW Appraisal Process Guide and summary document

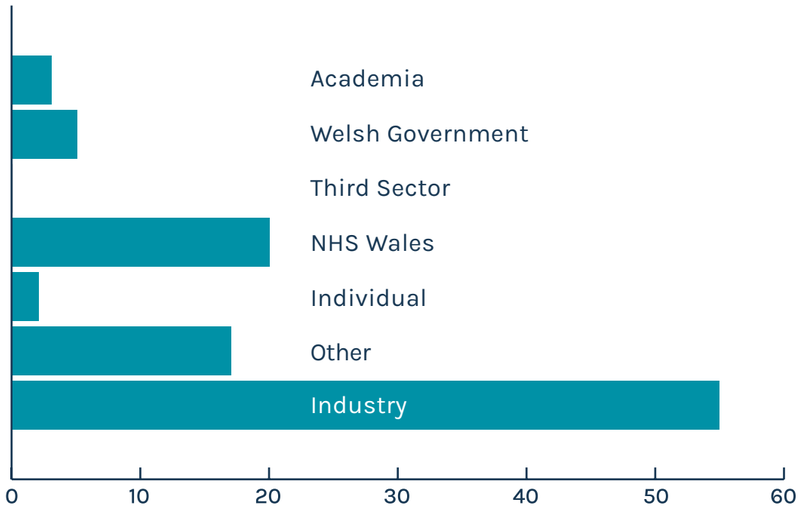


# TOPIC IDENTIFICATION

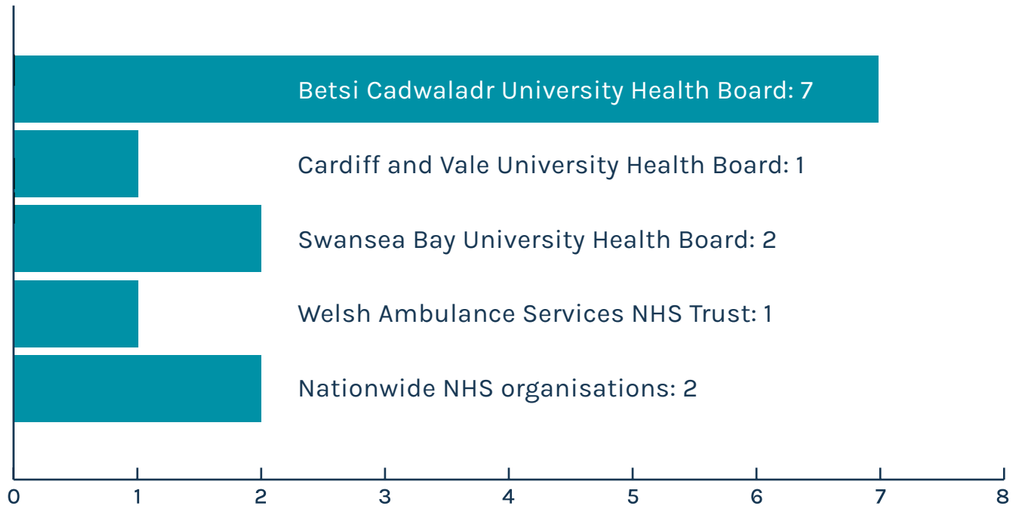
**66**
**Topics proposed to HTW in 2023/24**

**493**
**Topics proposed to HTW since 2017**

## Source of topic referrals in 2023/24




## Breakdown of topics referred from the NHS in 2023/24




We have produced an animation to explain the criteria required for submitting a topic for appraisal. To find out more watch our animation **here.**

# A ROADMAP FOR INNOVATION

**The Innovative Devices Access Pathway (IDAP) aims to bring transformative medical technologies to market to address unmet clinical needs within the NHS.**

It has been delivered by a UK-wide collaboration of partner organisations that includes Health Technology Wales, the Department of Health and Social Care, Medicines and Healthcare products Regulatory Agency, NHS England, Office for Life Sciences, National Institute for Health and Care Excellence and Scottish Health Technologies Group.

The aim of IDAP is to create a roadmap to support innovators in generating the evidence they need to achieve regulatory approval, health technology assessment and facilitate patient access.

In September 2023, the IDAP pilot initiative was launched and innovators were invited to submit expressions of interest for access into the pathway. The pilot attracted strong interest receiving 81 applications.

All eligible applicants were evaluated by the partner organisations alongside NHS clinicians and patient and public representatives. In assessing the applications multiple factors were considered including the potential to fulfil an unmet clinical need and address one of the Life Sciences Vision Healthcare Missions, the transformational and innovative nature of the device and the likelihood of it delivering a solution that will be widely adopted.

Eight technologies were invited to join the IDAP pathway, ranging from a device that aims to identify and destroy liver cancer tumours using focused ultrasound waves, to a blood test for Alzheimer's Disease and a Multiple Sclerosis fatigue app.

IDAP partners will now work with the companies to develop a Target Development Profile which provides a bespoke pre-market roadmap for the technology including engagement with other IDAP support tools.

You can find out more about the eight technologies selected to join IDAP here.

The aim of the IDAP pilot was to test the main elements of the pathway and to provide informative learning and feedback that will be used to help build the future IDAP.

Insights gained during the pilot phase will be crucial in shaping the future direction of the new IDAP pathway.

> This provides a game changing opportunity for health technologies to reach patients and clinicians faster. I look forward to seeing the impact these technologies will have as they address unmet clinical needs in Wales and across the UK.
>
> We believe Wales has a key role to play in supporting this new pathway and I hope this forward-thinking project will pave the way for the adoption of more innovative technologies to the benefit of the people of Wales.
>
> Llywodraeth Cymru Welsh Government
>
> **Eluned Morgan MS**
> Minister for Health and Social Services in Wales

# DRIVING INNOVATION IN ARTIFICIAL INTELLIGENCE

**HTW is working in collaboration with partners across the health, social care and innovation sectors to support the development of innovative AI technologies for use in Wales.**

It is at the forefront of developing frameworks for the appraisal of AI health and care technologies and is working on several projects aimed at identifying the challenges and opportunities the AI technology presents.

These include:

**The AI in Welsh Health and Social Care Commission**

The newly formed commission was set up by Welsh Government with the following aims:

- Deepen our understanding of AI needs
- Improve the organisational understanding of the requirements that exist across the health and social care sector in Wales so that we are using AI as a tool to answer the right questions:
  - What has prevented greater adoption of AI?
  - What can we deliver that supports effective adoption of AI?
  - What are the big issues than need solving?
- Map the current ecosystem

  Develop a better understanding of the wider architecture that can support and enable the delivery of ethical AI.
- Enable safe and ethical AI

  Ensuring the safe and ethical adoption of AI is core to the purpose of the commission.

HTW was invited to join the commission in 2023 and is part of a technical working group that supports its work. We are currently working with Welsh Government and other partners on the assessment and adoption of AI in health and care in Wales.

**AI rapid review**

As part of a Public Health Wales Evidence Service project, HTW's Principal Researcher Dr David Jarrom collaborated with the Public Health Wales Evidence Review to carry out research entitled: "A rapid review exploring the effectiveness of artificial intelligence for cancer diagnosis". Dr Jarrom and his team peer-reviewed the evidence review and worked with PHW's reviewers to develop methods for evaluating research specifically on AI.

**AI Appraisals**

HTW is due to undertake two pilot appraisals of AI technology. As part of this work, we have developed an internal checklist on AI-specific considerations for HTA. This has generated interest from other HTA bodies and this work will be presented at the HTAi 2024 Annual Meeting in Seville.

IDENTIFICATION CASE STUDY

# EVALUATION FOR AI IN HEALTH AND CARE AWARD

### What did we do?

In 2021 HTW joined a consortium supporting the testing and evaluation of artificial intelligence technologies in health and care, to support the work of the Evaluation for Artificial Intelligence (AI) in Health and Care Award (known as the AI Award). The AI Award aimed to accelerate the testing and evaluation of promising AI technologies that could be used in health and care. Over two years, we have supported and evaluated evidence generation on two specific AI technologies as part of this work.

### Who with?

We joined a consortium with academic researchers from Swansea University Computational Foundry and research staff at TEC Cymru, and applied to join the AI Award's Evaluation Partner Group. This group works with AI technology developers to deliver robust empirical evaluations of their technologies, and assist with further research. There are 15 Evaluation Partner Group members, of which this consortium is the only one based in Wales.

Throughout 2022 and 2023, we worked with two AI technology developers on separate projects. One, known as a 'Phase 3' evaluation, involved peer reviewing existing evidence and advising on ongoing evidence collection. A second, more in-depth 'Phase 4' evaluation, has involved advising on rollout of the technology to a number of test sites, where a pilot study was carried out. The consortium then evaluated the results and made recommendations for further research.

### What were the reactions?

Dr Matthew Roach, Senior Lecturer in Computer Science at Swansea University, said: "Health Technology Wales have been a vital part of our consortium. Their work on evidence evaluation and health economics has been essential, and they have helped us understand the needs and expectations of AI adopters in the health and care."

### What did people learn?

The consortium includes expertise in computational science, AI safety and user-centred research on digital technologies. HTW staff were involved in advising on developing and evaluating evidence on the effectiveness and cost effectiveness of AI technologies and how these need to be adapted for AI specifically. We have also learned about the work conducted by other members of the Evaluation Partner Group, allowing us to share innovative solutions and learnings with each other.

### What difference has this made?

Dr David Jarrom, Principal Researcher, said: "Working on the AI Award has put us at the cutting edge of research on using AI technologies in health and care, and best-practice methods of evaluating this research, as part of a truly multi-disciplinary project. We have learned a lot that can be applied to our own appraisals of artificial intelligence, and we are already putting these learnings into practice."

IDENTIFICATION CASE STUDY

# TOPIC IDENTIFICATION USING AN INTERNATIONAL DATABASE

**What did we do?**

On February 7, 2023, the Minister for Health and Social Services outlined six priorities for care services in Wales, aimed at addressing immediate pressures and building a sustainable service. HTW reviewed the International HTA Database to identify suitable health technologies being appraised internationally which align with ministerial priorities.

The database provides free access to information about ongoing and published health technology assessments commissioned or undertaken by health technology assessment organisations internationally. We concluded that a review of the database would provide a streamlined route to identify suitable topics for consideration.

The initial work focussed on reviewing publications of complete health technology assessments published in the last two years. We filtered publications according to the following criteria:

- At least an abstract in English
- A technology not recently reviewed by the National Institute for Health and Care Excellence (NICE). Older topics reviewed by NICE were included if the NICE review made research recommendations
- The publication included a rapid or systematic evidence synthesis that compared the technology to a comparator
- The publication included consideration of health economics
- The publication included evidence-based recommendations, or the agency involved in the work has a clear process for how evidence is used in decision making

This process produced a shortlist of 10 relevant HTA publications which were classified into Welsh ministerial priority areas:

| Ministerial Priority | Number of Topics |
|---|---|
| A closer relationship between the NHS and local government | 0 |
| Improving access to general practice, dentistry, optometry and pharmacy | 1 |
| Urgent and emergency care | 0 |
| Planned care and recovery | 5 |
| Cancer services | 3 |
| Mental health and child and adolescent mental health services | 0 |
| None | 1 |
| TOTAL | 10 |

We needed support from subject experts who could give us advice about whether the topic was likely to be of importance in Wales. We classified the identified topics into ‘speciality areas’ which assisted us in finding relevant subject experts.

**Who with?**

We consulted with Welsh Government on all 10 of the relevant topics identified. We also consulted with clinical networks for seven of the topics, including the Cancer Clinical Network, Mental Health Network, Social Care Network, and Women’s Health Network.

**What were the reactions?**

Welsh Government and experts from the clinical networks suggested that all 10 of the topics should be subject to further exploration in the form of a HTW Topic Exploration Report.

**What did people learn?**

Using resources to identify international reviews that other HTA organisations have prioritised and conducted, may result in topics that are potentially relevant to NHS Wales that we would not have otherwise considered.

# APPRAISAL

**10** Topics progressed to evidence appraisals in 2023/24

**11** Pieces of HTW guidance published in 2023/24

**44** Pieces of HTW guidance published since 2017

Find out more

Would you like to find out more about the Health Technology Wales topic appraisal process? To raise awareness about how the process works we have created an animated video: https://www.youtube.com/watch?v=38OuhQp0S04&t=5s

## GET INVOLVED

Do you know about a technology or model of care and support in health or social care that Health Technology Wales could appraise?

Anyone can suggest a topic and we are keen to receive suggestions from people with a wide range of backgrounds, including the general public.

To suggest a topic complete our online form here.

> It was really helpful to see HTW's processes in moving from an initial research question, to a comprehensive evidence synthesis, to the development of guidance.
>
> **Patricia Harrington, Deputy Director, Health Technology Assessment, Health Information and Quality Authority (HIQA)**

> As a junior doctor interested in the evaluation of healthcare technologies, I joined the assessment group meeting to observe the discussions on evidence assessment. The meeting was insightful hearing from various experts from HTW and independent advisors on the technology. I enjoyed listening to experts' thoughts on the evidence available from a cost-effective point of view and clinical effectiveness, giving me a deeper understanding of how health technologies we use in practice are scrutinised before their recommendation for NHS wide use.
>
> **Alexander Coombs, Foundation Year 2 Doctor**

> I just wanted to say a huge thank you for letting me observe today's meeting. It was an excellent opportunity to understand the process, key discussion points, expert feedback, and the importance of patient involvement/experience – as well as the breadth of topics covered. It has really helped me move from a theoretical understanding of the theory of how health technology is implemented into the NHS, to a much more practical understanding, which is helpful for me as I progress in my public health training.
>
> **Dr Emily Clark, Specialist registrar in Public Health, Public Health Wales**

# DEMYSTIFYING TOPIC APPRAISAL: THE HTW APPRAISAL PROCESS GUIDE

**One of our core aims is to ensure that our work can be clearly understood by our stakeholders. This includes; clinicians, health and care providers, people receiving health and social care, technology manufacturers and members of the public.**

To achieve this, we have created a range of tools and resources, including guides and animations, that are available in accessible formats which can be clearly understood by a wide audience.

In 2023 we published an Appraisal Process Guide which describes how we carry out health and social care appraisals.

The aim of the guide is to provide a summary of our methods and processes in an accessible format, for anyone who is interested in our work.

It explains the process we use for appraisals including:

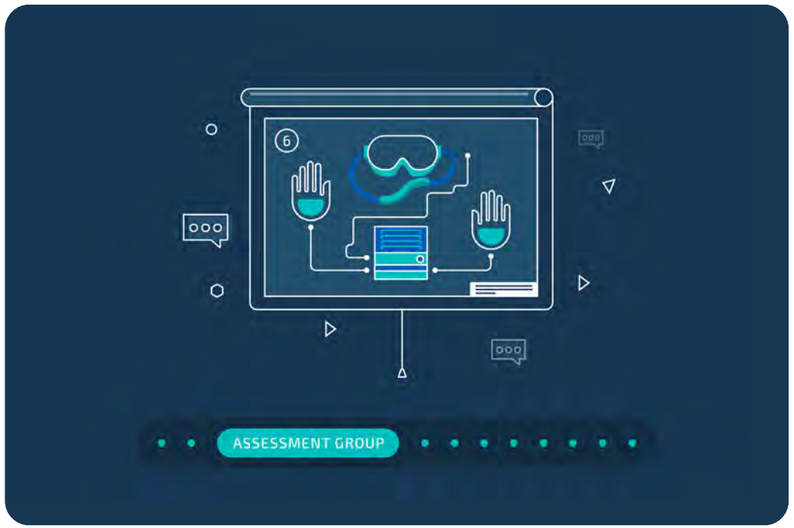
- Initial topic submission and selection
- Production of a Topic Exploration Report
- Selection of topics for further work, in the form of an Evidence Appraisal Report
- Production of an Evidence Appraisal Report
- Production of guidance

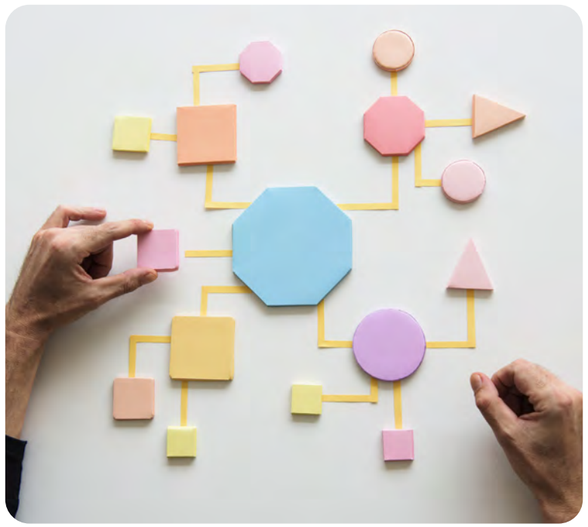
The guide also describes what happens after an appraisal has taken place, how we monitor the impact and adoption of our guidance and the circumstances under which we might change or update guidance.

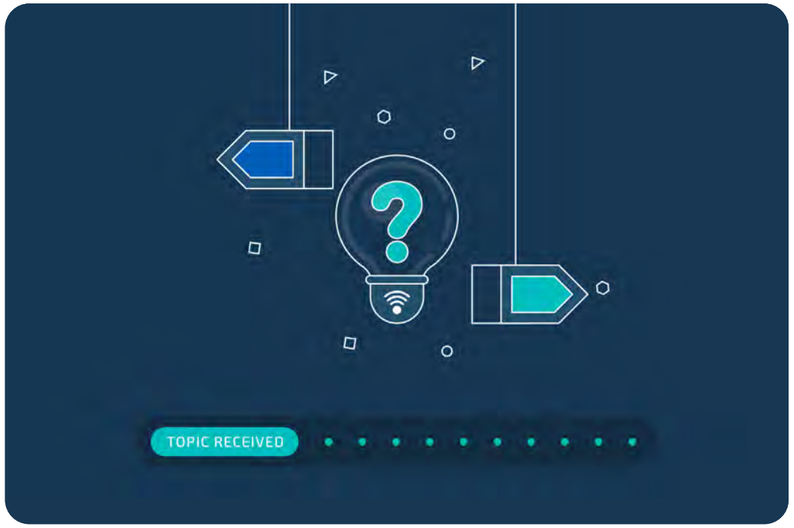
Before publishing the guide, we carried out a consultation survey and invited stakeholders to provide feedback on the draft version of the guide which we then incorporated into the final version.

A shorter plain language summary of our appraisal process can also be found on our website.

For more information about our health technology appraisal process watch our topic appraisal animation video here.





# GUIDANCE IMPACT

**493**
**Topics proposed to HTW since 2017**

**65**
**Topics progressed to evidence appraisal**

**44**
**Pieces of national guidance published**

## OUR RECOMMENDATIONS

Our national guidance recommendations fall into three main categories:

Routine adoption:

The evidence supports the adoption of that technology for a general population.

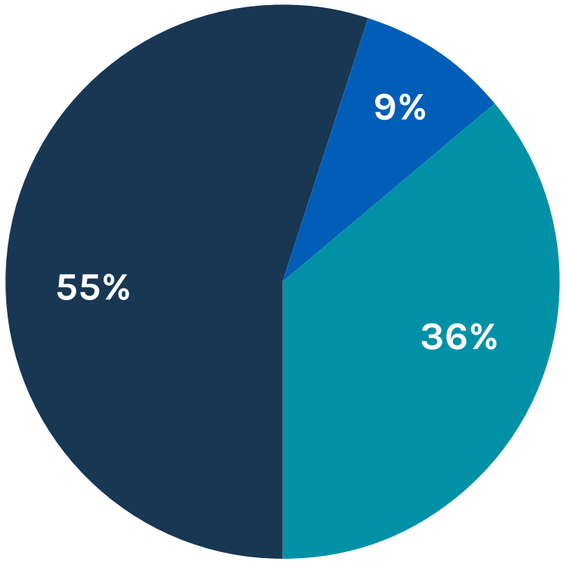
Selective adoption:

The evidence supports the adoption of that technology in a specific subset of the general population.

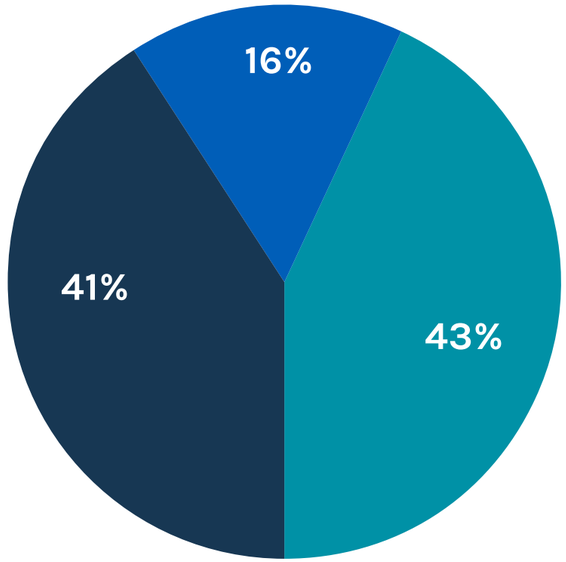
Insufficient evidence to support adoption:

There is not enough evidence to support the adoption of that technology.

## 2023/24




## 2017-2024



# OUR GUIDANCE

**MARCH 2024 | LIPOSUCTION FOR THE TREATMENT OF CHRONIC LYMPHOEDEMA**

The use of liposuction for the treatment of chronic lymphoedema is promising, however current evidence does not support its routine adoption in Wales.

**MARCH 2024 | VIDEO FEEDBACK INTERVENTIONS**

The evidence supports the adoption of video feedback interventions to support children and their families who are at risk of or suffering from harm. Improvements in parental sensitivity, parent-child interaction and attachment have been identified using video feedback interventions.

**MARCH 2024 | INTENSIVE FAMILY PRESERVATION PROGRAMMES (IFPP)**

The evidence supports the adoption of intensive family preservation programmes for families in crisis. The use of intensive family preservation programmes reduces the risk of out of home child placement.

**JANUARY 2024 | DIGITAL WOUND MANAGEMENT TOOLS**

The current evidence suggests that some integrated digital wound management systems can accurately measure surface area, but not depth or volume, for some but not all wounds. There is, however, insufficient evidence on how these technologies impact on clinical management and patient outcomes.

**JANUARY 2024 | LOW ENERGY CONTACT X-RAY BRACHYTHERAPY**

The evidence supports the routine adoption of contact x-ray brachytherapy (CXB) in addition to chemoradiotherapy for people with early-stage rectal cancer who are suitable for surgery. The use of CXB boost increases treatment response rates and organ preservation and reduces the need for subsequent surgery compared with external beam radiotherapy boost.

**JANUARY 2024 | ROBOT-ASSISTED THORACIC SURGERY**

The evidence does not support the routine adoption of robot-assisted thoracic surgery. The current evidence suggests equivalent clinical outcomes but uncertainty about any improvement in short and long term clinical effectiveness of robotic thoracic surgery as compared to standard of care (open or video-assisted thoracic surgery).

# OUR GUIDANCE

## DECEMBER 2023 | SOLUTION-FOCUSED ASSESSMENT TOOLS (DIALOG+)

The evidence supports the routine adoption of DIALOG+ for people receiving treatment for psychosis and schizophrenia in a secondary mental health setting. The use of DIALOG+ is shown to improve overall quality of life when compared with standard care but its impact on psychological symptoms, treatment satisfaction and addressing health and social needs remain uncertain.

## DECEMBER 2023 | PERCUTANEOUS IMPLANTATION OF PULMONARY ARTERY SENSORS

The evidence supports the routine adoption of percutaneously implanted pulmonary artery pressure sensors to monitor the treatment of people with New York Heart Association class III chronic heart failure and/or a hospitalisation for heart failure within the previous 12 months.

## NOVEMBER 2023 | MULTI-GRIP UPPER LIMB PROSTHETICS

The evidence on the use of multi-grip myoelectric upper limb prosthetics by people with upper limb difference remains insufficient to support their routine adoption. The benefits of multi-grip myoelectric upper limb prosthetics compared with other types of prosthetics for upper limb difference is uncertain, and their current use should be determined by individual patient requirements.

## SEPTEMBER 2023 | MYOPIA-CONTROL CONTACT LENSES AND SPECTACLES

The evidence supports the routine adoption of orthokeratology and multifocal soft contact lenses to slow the progression of myopia in children and adolescents. Evidence shows that orthokeratology and multifocal soft contact lenses significantly reduce spherical equivalent refraction progression and axial length elongation over at least two years of follow up.

## JUNE 2023 | WEARABLE CARDIOVERTER DEFIBRILLATORS

The evidence supports the adoption of wearable cardioverter-defibrillators, in some but not all, adult patients at high risk of sudden cardiac death. For patients who require an implantable cardioverter-defibrillator to be explanted and there is a delay to re-implantation, the use of wearable cardioverter-defibrillators is considered clinically and cost effective, and HTW supports their use for this indication.

# EVIDENCE APPRAISAL ON MYOPIA-CONTROL SPECTACLES AND CONTACT LENSES TO SLOW THE PROGRESSION OF SHORT-SIGHTEDNESS IN CHILDREN AND ADOLESCENTS

### What did we do?

HTW considered the use of myopia-control spectacles and contact lenses to slow the progression of short-sightedness in children and adolescents. We appraised the clinical and economic evidence on this topic, published an Evidence Appraisal Report, and published HTW Guidance in September 2023.

### Who with?

This topic was proposed by a clinical advisor to the NHS. We engaged with several different stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from Welsh Government, numerous optometrists, and national clinical advisors for optometry.

### What were the reactions?

Stakeholders believed the review to be of high quality. They felt that the appropriate evidence had been reviewed and conclusions reflected the evidence. The College of Optometrists welcomed HTW's guidance. Experts involved in the appraisal process subsequently co-developed a scientific journal article with HTW describing the health economic analysis.

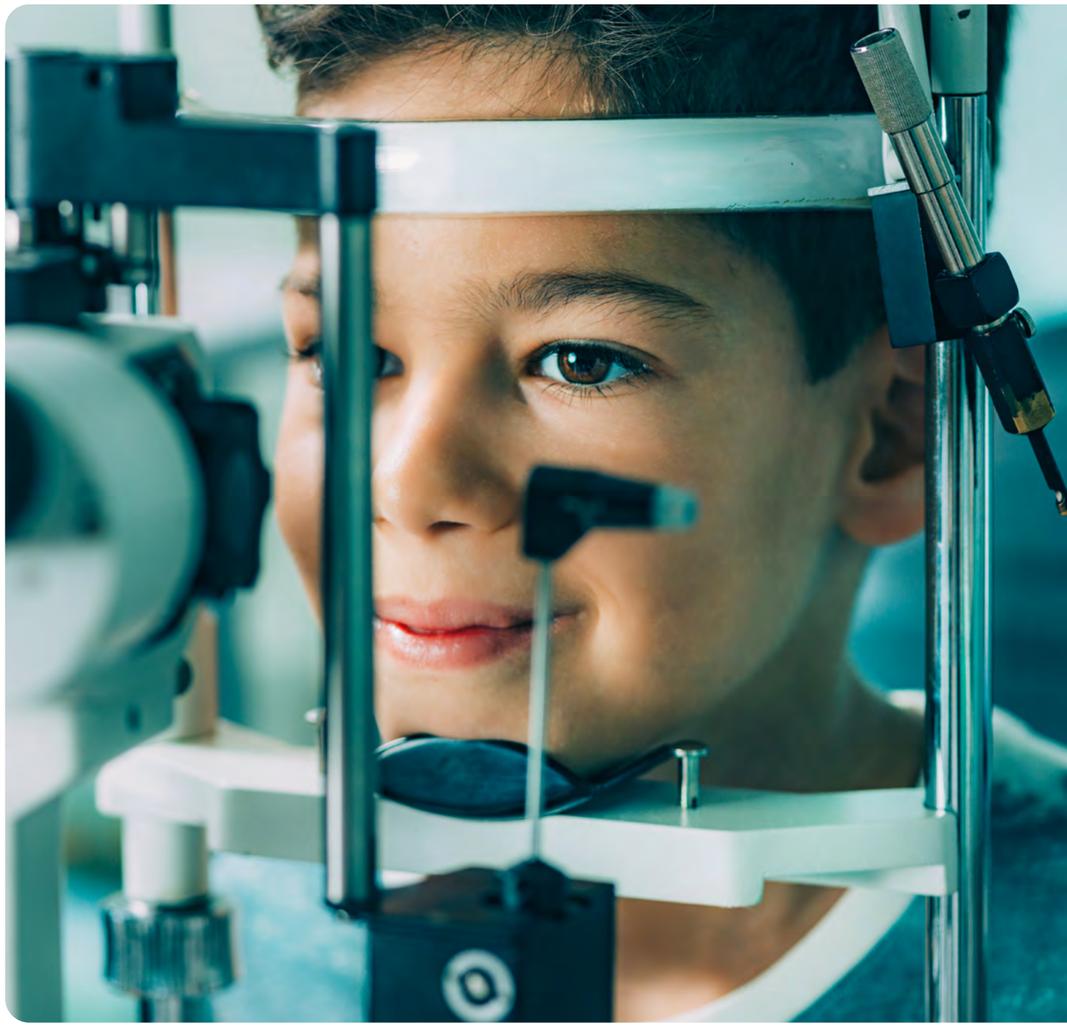
Andy Britton, a Specialist Optometrist who provided expert clinical input into the appraisal, reported that *"The Health Technology Wales process on Myopia Control was a robust appraisal of the current evidence regarding the effectiveness of the various interventions. As someone who was involved in the initial paper that gave rise to this report, it was rewarding to see the whole process performed so diligently and professionally. The opportunity to be involved as an expert witness towards the end of the process was also valuable... all-in-all a great process delivering a great conclusion that will ultimately benefit the children of Wales."*

### What did people learn?

Orthokeratology and multifocal soft contact lenses may reduce spherical equivalent refraction progression and axial length elongation over at least two years of follow up. Economic modelling estimates that orthokeratology and multifocal soft contact lenses may be cost-effective compared with single-vision correction, driven by the assumption of quality-of-life gains from a reduction in long-term progression of short-sightedness and its complications.

### What difference did this make?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of two types of lenses, orthokeratology and multifocal soft contact lenses, to slow the progression of short-sightedness in children and adolescents.



# EVIDENCE APPRAISAL ON PERCUTANEOUSLY IMPLANTED PULMONARY ARTERY PRESSURE SENSORS TO MONITOR TREATMENT OF PEOPLE WITH CHRONIC HEART FAILURE

### What did we do?

HTW considered the use of percutaneously implanted pulmonary artery pressure sensors to monitor treatment of people with chronic heart failure. We appraised the clinical and economic evidence on this topic, published an Evidence Appraisal Report, and HTW Guidance in October 2023.

### Who with?

This topic was identified following a search of National Institute for Health and Care Excellence (NICE) interventional procedures guidance. We engaged with several different stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from consultant cardiologists working in NHS Wales.

### What were the reactions?

Ross Wardle, Head of Market Access UK and Ireland for Abbott Medical, stated that *"Our experience of working with HTW on the development of the guidance on percutaneous implantation of pulmonary artery pressure sensors has been a very positive one. Regular and transparent communication from the outset enabled us to seamlessly feed into the process where necessary and ensure all relevant information was considered."*

### What did people learn?

Percutaneously implanted pulmonary artery pressure sensors may reduce hospitalisations for heart failure and the length of stay in hospital, and may improve quality of life. Experts suggested that the baseline rate of hospitalisations in Wales may have been underestimated in the HTW cost-utility analysis, and it is therefore plausible that percutaneously implanted pulmonary artery pressure sensors are cost effective in NHS Wales.

### What difference did this make?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of percutaneously implanted pulmonary artery pressure sensors to monitor the treatment of people with New York Heart Association class III chronic heart failure and/or a hospitalisation for heart failure within the previous 12 months. The Appraisal Panel also advised that the use of percutaneously implanted pulmonary artery pressure sensors in NHS Wales should be associated with the gathering of real-world evidence of clinical and cost effectiveness.

# EVIDENCE APPRAISAL ON SOLUTION-FOCUSED ASSESSMENT TOOLS (DIALOG+) FOR IMPROVING THE TREATMENT OF PEOPLE WITH PSYCHOSIS AND SCHIZOPHRENIA WITHIN SECONDARY MENTAL HEALTH SERVICES

**What did we do?**

HTW considered solution-focused assessment tools to improve the treatment of people with psychosis and schizophrenia in secondary mental health services. We appraised the clinical and economic evidence on the topic, produced an Evidence Appraisal Report, and published HTW Guidance in December 2023.

**Who with?**

This topic was proposed by a consultant nurse at Cardiff and Vale University Health Board. We engaged with several stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from nurses and clinical psychologists, the manager of the Royal College of Psychiatrists Wales and a health economist with experience in this area.

**What were the reactions?**

Stakeholders believed the review to be of high quality and had confidence in the HTW appraisal method. Stakeholders felt the appropriate evidence had been reviewed and that the process was robust.

The topic proposer, Norman Young, Nurse Consultant, Clinical Service Lead for Early Intervention in Psychosis, Headroom said: *"DIALOG+ is a tool that effortlessly merges patient-reported experiences and outcomes with a solution-focused therapeutic approach. Developed over two decades, DIALOG+ not only has robust psychometric properties but also demonstrates enhanced clinical outcomes when utilised in routine practice. Recognising its potential, I put forward DIALOG+ for an independent evaluation when Health Technology Wales (HTW) invited topics. The HTW team agreed and carried out a comprehensive economic and clinical appraisal. As a topic proposer, I was actively involved in all key stages and in reviewing the final report. I wholeheartedly recommend that anyone with a suitable topic should take the opportunity to put it forward."*

**What did people learn?**

The evidence review showed that the use of a particular solution-focused assessment tool, DIALOG+, can improve subjective quality of life compared with standard care. The economic evidence also indicated that DIALOG+ is unlikely to increase overall health and social care costs compared to standard care.

**What difference did this make?**

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of DIALOG+ for people receiving treatment for psychosis and schizophrenia in a secondary mental health setting.

# EVIDENCE APPRAISAL ON LOW ENERGY CONTACT X-RAY BRACHYTHERAPY (CXB) FOR THE TREATMENT OF EARLY-STAGE RECTAL CANCER

### What did we do?

HTW considered the use of contact x-ray brachytherapy (CXB) for the treatment of early-stage rectal cancer. CXB is a form of radiotherapy boost, given alongside standard radiotherapy or chemoradiotherapy. It is locally delivered via a tube inserted into the rectum. It aims to improve quality of life and reduce the need for surgery and stoma. We appraised the clinical and economic evidence on the topic, publishing an Evidence Appraisal Report and HTW Guidance in January 2024.

### Who with?

This topic was proposed by a Consultant Clinical Oncologist at Swansea Bay University Health Board. We engaged with the Papillon Patient Support group, Tenovus and the All-Wales Cancer Network to explore patient perspectives on the diagnosis of rectal cancer and available treatments. During the consultation period, we received feedback from clinical oncologists, surgeons and radiotherapy physics professionals. The topic proposer stated the process was *'very diligent and thorough'* and that they found *'communication excellent throughout'*.

**We joined forces with experts who took part in our appraisal of low energy contact X-ray brachytherapy (CXB) to develop an academic journal article which can be read here.**

### What were the reactions?

Stakeholders believed the review to be of high quality and felt that the appropriate evidence had been reviewed and conclusions drawn. Clinical experts involved in the appraisal process welcomed the guidance and developed a journal article with HTW to present the appraisal findings to a wider audience. They also plan to share the guidance with clinical colleagues at international meetings in 2024.

### What did people learn?

The evidence review showed that the use of CXB boost increases treatment response rates and organ preservation compared with external beam boost for people with rectal cancer who are suitable for surgery. Economic modelling suggested that CXB boost is also cost-effective compared with external beam boost in this population.

### What difference did this make?

The HTW Appraisal Panel recommended that the evidence supports the routine adoption of CXB in addition to chemoradiotherapy for people with early-stage rectal cancer who are suitable for surgery. Dr Craig Barrington, Consultant Clinical Oncologist at Swansea Bay UHB said *"I feel the conclusions of the report to be practise changing for the population of Wales and I hope it enables our patients to have access to all potential opportunities for treating their rectal cancer"*.

APPRAISAL CASE STUDY

# EVIDENCE APPRAISAL ON MULTI-GRIP UPPER LIMB PROSTHETICS

### What did we do?

We carried out an appraisal of multi-grip upper limb prosthetics. HTW originally produced guidance on this technology in 2019. The topic was proposed by the Welsh Health Specialised Services Committee, which has now become the NHS Wales Joint Commissioning Committee. We appraised the clinical and economic evidence on the use of multi-grip myoelectric upper limb prosthetics for people with upper limb difference, published an Evidence Appraisal Report, and re-issued HTW guidance in September 2023.

There was a lot of new evidence available since we first appraised this topic, with evidence comparing multi-grip prosthetics to other types now available.

### Who with?

We engaged with several different stakeholder groups during the development of this appraisal. During the consultation period, we received feedback from clinicians involved in prosthetics and rehabilitation from across Wales and from Scotland, as well as prosthetics researchers.

### What were the reactions?

Dr Rachel Gemine, Assistant Director of Evidence, Evaluation and Effectiveness, Welsh Health Specialised Services Committee, said *"The report from HTW provided a comprehensive evidence review which enabled us to prioritise resources and ensure the best outcomes and experiences for the people of Wales who are requiring upper limb prosthetics. This guidance supported the decision to continue to individually assess those who would potentially benefit from multi-grip myoelectric."*

### What did people learn?

The HTW Appraisal Panel recommended that the evidence remains insufficient to support the routine adoption of multi-grip myoelectric upper limb prosthetics. The benefits of multi-grip myoelectric upper limb prosthetics compared with other types of prosthetics are uncertain, as there is often little difference in reported outcomes, and their current use should be determined by individual patient requirements.

Evidence on cost-effectiveness was limited and we were unable to perform our own economic modelling. However, economic evidence from the Netherlands suggested multi-grip myoelectric upper limb prosthetics are unlikely to meet NHS cost-effectiveness thresholds.

# EVIDENCE APPRAISAL ON INTENSIVE FAMILY PRESERVATION PROGRAMMES

### What did we do?

HTW considered the evidence on intensive family preservation programmes (IFPP) for families in crisis where there is an imminent risk of children entering care. These programmes are short-term intensive interventions where a social worker works directly with families to resolve crises and provide support to improve skills and resilience. They also provide connections to available services in Wales, with the ultimate aim of preventing children from being taken into care.

We appraised the effectiveness and economic evidence on this topic, published an Evidence Appraisal Report, and published HTW guidance in March 2024.

### Who with?

We engaged with several different stakeholder groups during the development of this appraisal including representatives from the College of Arts, Humanities and Society Sciences in Cardiff.

During the consultation period, we received feedback from academics in social care research, educational psychologists, research fellows, and early years practitioners.

### What did people learn?

The HTW Appraisal Panel concluded that the evidence supports the adoption of IFPP for families in crisis. The use of IFPP reduces the risk of out-of-home child placement. Parent and children's perspectives support the view that IFPP are beneficial and can address crises that may risk a child's entry to care. While the evidence leaves some uncertainty about the impact of this on child emotional and behavioural wellbeing, there seems to be no evidence of harm. The economic analysis was associated with uncertainty but indicates the potential for cost savings of up to £12,171 per child through the use of IFPP, largely due to the avoidance of out-of-home placement.

### What difference will this make?

Families at the point of crisis should be offered IFPP, which findings suggest are associated with reductions in out-of-home placement and can keep children within the family unit. Evidence also suggests that IFPP could be associated with a reduction in distress and substance misuse in parents. Parents and children's perspectives support the idea that IFPP are beneficial and can help address crises that may risk a child's entry to care. However, parents do raise concerns about the coercive nature of IFPP and question why more intensive services could not be provided prior to crises occurring. It is also recognised that there are capacity constraints in social services and that this is a potential barrier to the implementation of the intervention.

APPRAISAL CASE STUDY

# EVIDENCE APPRAISAL ON VIDEO FEEDBACK INTERVENTIONS

### What did we do?

Health Technology Wales appraised the evidence and produced guidance supporting the adoption of video feedback interventions (VFI) to support children and their families who are at risk of, or suffering from, harm. Child maltreatment has a profound impact on children's wellbeing and a potentially lifelong effect on the child's social, emotional, and cognitive development. Parental home visiting programmes, including VFI for families at risk may decrease the prevalence and risk of maltreatment. VFI is an umbrella term that refers to the use of recorded video feedback during several sessions. The intervention has other names, including but not limited to Video Interaction Guidance (VIG) and Video Feedback Intervention to Promote Positive Parenting (VIPP).

We appraised the effectiveness and economic evidence on this topic, published an Evidence Appraisal Report (EAR), and issued HTW guidance in March 2024.

### Who with?

We engaged with several different stakeholder groups during the development of this appraisal including representatives from the Swansea Bay University Health Board, CASCADE and Cardiff Council.

During the consultation period, we received feedback from academics in social care research, educational psychologists, research fellows, and early years practitioners.

### What did people learn?

The HTW Appraisal Panel recommended that the evidence supports the adoption of video feedback interventions to support children and their families who are at risk of, or suffering from, harm. Improvements in parental sensitivity, parent-child interaction and attachment have been identified using video feedback interventions. The impact of video feedback interventions on out of home placement and longer-term outcomes are uncertain. Parents who used video feedback interventions report improvements in family relationships and parental confidence. Uncertainty in the effect of video feedback interventions on out of home placement translates into uncertainty in the costs of video feedback interventions compared with standard care. The Appraisal Panel concluded, however, that the evidence to support the benefits of video feedback interventions justifies any possible increase in costs, and that the economic evidence does not preclude adoption.

### What difference will this make?

Early interventions in the form of parenting home visiting programmes that are aimed at improving outcomes for children and preventing the escalation of risk, are highlighted in national safeguarding guidance across the UK. Identifying and addressing a family's needs early on can decrease risk factors that may be impacting a child's life negatively. The adoption of VFI in social care can have a positive impact on parental sensitivity, parent-child interaction, attachment, and child placement decisions. VFI could also potentially contribute to the reduction in out of home placements, although HTW appraisal panel would encourage further data accumulation to support this intervention.

"It's important that we understand the most effective ways of supporting children and families who are at risk of harm, so I was delighted to be invited to contribute to the appraisal of Video Feedback Interventions in social care. In many ways Health Technology Wales adopt the central tenets of Video Feedback Interventions as working with them is a strengths-based, rewarding experience. I hope their appraisal will lead to increased use of Video Feedback Interventions, especially as children, families and professionals like this strengths-based approach."

**Nina Maxwell Speciality Co-Lead for Social Care, Assistant Director and Principal Research Fellow, CASCADE, Cardiff University**

# AUDITING THE ADOPTION OF HTW GUIDANCE

**We carry out an annual adoption audit to find out whether adoption of our national guidance recommendations has taken place across Wales.**

The adoption audit is carried out in collaboration with partners across health and social care and focuses on HTW and NICE Medical Technologies Evaluation Programme (MTEP) guidance.

Each adoption report summarises how HTW guidance has been used and any facilitators and barriers to adoption.

Our 2023 audit revealed that awareness and impact of HTW guidance is high and that is having an impact across Wales.

The audit focused on 11 pieces of HTW guidance and three pieces of NICE MTEP guidance.

Response rates to the audit were encouraging with responses from six of the seven health boards and from the Welsh Health Specialised Services Committee (WHSSC).

**Key findings from the Adoption Audit Report 2022/23 included:**

- Responses from organisations where the guidance is relevant indicate that awareness of HTW guidance is high (70%), clarity of HTW guidance recommendations is good (83%), and HTW guidance is having some form of impact in the majority of cases (72%).
- In some cases, responses clearly show that HTW guidance was adopted and had a clear impact on decision-making.
- For guidance recommending the routine adoption of a technology, this was most evident for FreeStyle Libre flash glucose monitoring.
- There were some cases where HTW guidance appears not to have been adopted. For guidance recommending the use of a technology, this was most evident for ClearGuard™.
- Adoption of guidance was hindered in some cases by resource limitations (positive HTW guidance is not accompanied by additional funding) and other factors such as small patient numbers, the capabilities of existing technology and the current use of other products.

The audit report concluded that local health boards, WHSCC and the specialist health boards should continue to work with HTW to support future adoption audit reports and that Welsh Government should continue to encourage participation in the process. It also suggests that HTW should consider how the adoption audit process can be extended to cover social care guidance.

Professor Peter Groves, Chairman of HTW, said: *"I would like to take this opportunity to thank the local health boards, commissioners, and specialist health boards for engaging with us so closely throughout the audit process."*

Dr Susan Myles, Director of HTW, added: *"We are proud to be leading the way in the UK and internationally in the way we monitor the impact of our national guidance.*

*"This important work will enable us to support the ambitions set out in the health and social care agenda for Wales."*

**Collaborating with partners on topic selection:**

As part of the 2023 adoption audit we included three pieces of NICE MTEP guidance.

For the 2024 adoption audit we have further developed our process for selecting the NICE guidance to be audited in partnership with Wales NICE Health Network (WNHN) members.

The selection process has involved the WNHN members selecting three pieces of guidance from a shortlist of six pieces of NICE medtech and diagnostic guidance.

ADOPTION CASE STUDY

# SHOWCASING THE USE OF AMaT SOFTWARE TO AUDIT GUIDANCE

### What did we do?

In 2021 we provided funding that enabled local health boards across Wales to access the AMaT (Audit Management and Tracking) system. The software can be used by health boards to disseminate and monitor the adoption of Health Technology Wales and NICE guidance. This enables the health boards to provide information on the adoption of that guidance for the annual HTW adoption audit.

### Who with?

Hywel Dda University Health Board (HDUHB) is one of seven health boards in Wales to use AMaT . As HDUHB covers three counties, Pembrokeshire, Carmarthenshire, and Ceredigion, it was particularly important to ensure that there was equality of access to the best available care across the health board area. We worked closely with HDUBH's clinical effectiveness team for two years to support the implementation of AMaT.

**To find out more about how HDUHB used AMaT to monitor the adoption of HTW and NICE guidance watch our video case study here.**

### What did people learn?

The use of AMaT by HDUHB's clinical effectiveness team has enabled the health board to ensure compliance with HTW and NICE guidance. Donna Edwards, Clinical Effectiveness Co-ordinator at HDUBH said this means they can be *"reassured as a health board that the patients and the people we serve are receiving the best evidence-based care".*

She went on to say that AMaT enabled the health board to: *"Provide safe and effective care in each of the counties, with limited variation."*

The health board now hopes to develop its use of AMaT so that it is better able to understand which health boards have implemented HTW and NICE guidance. It is also planning to enable clinicians to input information directly into the system.

### What difference has this made?

By working in collaboration with HDUBH we have gained greater insight into the health board's user experience. This has enabled us to further develop the audit process to ensure it meets the needs of those taking part.

# HTW EVIDENCE SUPPORT FOR NATIONAL GROUPS

### Individual Patient Funding Requests (IPFR)

HTW aims to support the IPFR process across Wales by developing evidence summaries for non-medicine IPFR treatment requests. The evidence summaries provide a high-level overview of the clinical evidence available to support the use of the intervention requested and contain a summary of the economic considerations. The production of evidence summaries ensures that best practice is consistently considered when IPFR panels across Wales are considering the clinical and cost effectiveness of IPFR applications for the funding of non-medicine interventions.

> It's great that individuals are now recognising how IPFR, INNU (Interventions not normally undertaken) and prior approval requests link in with the work of Health Technology Wales and the All Wales Therapeutics and Toxicology Centre. Sophie's input to the IPFR group, and the wider work such as quality assurance and the annual training event, has been extremely valued.
>
> **Ann-Marie Matthews,**
> ***Lead for Clinical Commissioning, Aneurin Bevan University Health Board***

### All Wales Clinical Effectiveness Group (AWCEG)

AWCEG was established in November 2023 to ensure that a national approach to quality improvement takes place across Wales. It aims for best practice to be spread across the healthcare system and to ensure equity of access to evidence-based procedures.

AWCEG bases its work on the concept of value-based healthcare which promotes co-production, equity and reducing unwarranted variation through evidence-based practice.

The group draws on expertise from HTW who provide rapid evidence reviews to support decision-making by the national group.

Part of this work involves reviewing current Interventions Not Normally Undertaken (INNU) policies held by Health Boards across Wales and the NHS England Evidence Based Interventions (EBI) list with the aim of developing an All-Wales list.

HTW is providing a key evidence support role during this process, evaluating the best available evidence, to inform AWCEG recommendations on procedures to be added or removed from the new national list.

It is hoped that removing access to inappropriate or unnecessary interventions will free up valuable resources which can be put to better use in the NHS.

> It is great to see that we now have a clinically led group in Wales that seeks to reduce unwarranted variation in care using the most up-to-date evidence base. HTW play a pivotal role in supporting this work through evidence synthesis, ensuring that there is an All-Wales approach.
>
> **Dr Sally Lewis,** ***Director of the Welsh Value in Health Centre***

# 2023/24 PPI HIGHLIGHTS

**HTW's Patient and Public Involvement (PPI) work continues to grow. This year has seen HTW engage with new patient networks and organisations, undertake original events, lead with partners in PPI activities across the UK and internationally and grow and expand HTW's PPI remit. Current tools and processes continue to prove to be effective and relevant and we continue to gather feedback and improve.**

Summary of PPI work undertaken:

- PPI undertaken for 13 topics
- Six literature reviews, one patient submission, two patient surveys, one patient testimonial and two focus groups
- PPISG meetings held to determine PPI mechanisms, oversight of ongoing PPI activities, plain language summaries and evolving PPI processes and tools
- HTW continue to input into INAHTA's (International Network of Agencies for Health Technology Assessment) Patient and Citizen Interest Group (PCIG) sessions. Current work involves the creation of a checklist for organisations looking to start PPI
- HTW's PPI Manager has contributed expertise to IDAP's (Innovative Devices Access Pathway) patient engagement on the trial of their pathway for innovative technologies
- Presentation of PPI work as posters at the virtual HTAi conference 2023
- Engagement with Cardiff University presenting a panel on how to conduct good patient engagement in research

This year four of our longstanding PPI members left the PPI Standing Group group, Kiana Collins, Alan Meudell, Catherine Evans-O'Brien and Louise Baker. We would like to take this opportunity to thank them for their invaluable contributions to our PPI work and for the commitment they have shown to championing and developing our processes further.

PPI CASE STUDY

# HTW AND VELINDRE CANCER CENTRE PPI FOCUS GROUPS ON THE USE OF AI IN HEALTHCARE

### What did we do?

HTW partnered with the Velindre Cancer Centre to run focus groups for two appraisals in which the health technology incorporated Artificial Intelligence (AI). Two focus groups were held, one virtual and one in-person at the Velindre Cancer Centre. Attendees were current or former cancer patients of varying ages, ethnicities and backgrounds. The focus groups had two aims; to establish a baseline understanding of patients' views, experiences and expectations around the use of AI in healthcare and to gather patient feedback on the two technologies being appraised.

### Who with?

Velindre Voices patient network and Velindre's Patient Experiences team.

### What were the reactions?

The focus groups proved popular and were well attended. Participants informed HTW that they enjoyed the sessions and were keen to partake in feedback sessions upon completion of the relevant evidence appraisals. The sessions were positively received and have helped to strengthen relationships between HTW and Velindre, educate patients on health technology assessment and HTW and encourage patient participation in ongoing and future appraisals.

### What did people learn?

HTW gained valuable insights from patients which were used to inform the PPI reports in the evidence appraisal reviews for both topics. We were able to establish that patients have vastly different ideas of what constitutes AI in healthcare. Patients expect to be informed of, and consent to, innovations such as AI being used in procedures, tests, processes and structures that they will be subject to during any course of treatment. Good communication is of particular importance as the majority of patient fears and concerns around the use of AI in healthcare can be alleviated if time is taken to explain how it functions, where responsibilities lie and what they can expect. Many patients are unaware of encountering AI and where AI technologies are currently being used in healthcare services. All participants expressed that they would be happy to have both technologies in questions used during their treatments once the technologies and the role of the AI was adequately explained to them.

### What difference has this made?

HTW were able to gain patient experiences and evidence for the two appraisals that otherwise would have been difficult to obtain. It has ensured that patient voices, opinions, experiences and concerns inform decision making in healthcare in Wales.

> Working with Health Technology Wales in hosting patient focus groups was an efficient and enjoyable process throughout. This was our first time in partnership with an external organisation for a project like this and we are pleased to say it was a huge success. With clarity on roles and expectations from the outset, we thoroughly enjoyed working alongside Alice and her team to deliver two engaging, thought provoking and efficient focus groups.
>
> Our patients felt valued through both sessions and were encouraged to share their views, questions and challenges freely. We would love to work with the HTW team again in the future and welcomed the opportunity to offer our patients such an exciting and interesting topic to review.
>
> **Lucesca Walters, Patient Engagement and Volunteer Support Officer, Velindre University NHS Trust**

# PPI PUBLICATIONS

**In 2023/24 HTW's PPI team contributed to the following publications:**

- The role of HTW's Patient and Public Involvement Standing Group (PPISG) and Public Partners was featured in an article looking at how HTA bodies across the globe include patient representatives at the organisational level. HTW's PPI manager and a public partner were interviewed and provided written oversight of the role of the PPISG and public partners in HTW's core work program, including the running of Assessment Group and Appraisal Panel. The article was published with the International Journal of Technology Assessment in Health Care and can be located here. Karen Facey, PPI Advisor, HTW PPI Standing Group said: *"This paper has generated much interest in the HTA community which shows that HTW's work is again world leading."*
- An article written as poster presentations for the HTAi 2023 conference on HTW's PPI work has been published in the International Journal of Technology Assessment entitled: *"The Importance Of Flexible PPI Approaches: Case Study On Flash Glucose Monitoring"*. The article can be located here.
- HTW's PPI Manager contributed to the production of INAHTA'S (International Network of Agencies for Health Technology Assessment) position statement on patient and public involvement. The position statement was published and can be viewed here. An article on the international production of this position statement through the work of the PCIG is due for publication with the International Journal of Technology Assessment.
- HTW were invited to write a chapter for the second book on conducting PPI in HTA which is due for publication in the summer of 2025. Covering HTW's unique approaches to undertaking PPI, the chapter will look at the role of the PPISG in conducting a PPI mechanism tool for every topic, HTW's flexible and responsive process for adapting PPI activities during the course of an appraisal and HTW's model for evaluation and implementing changes from feedback. The chapter will be one of several jurisdictional chapters featuring PPI approaches from across the globe.

# COLLABORATING WITH PARTNERS IN 2023/24

We engage with stakeholders across health, social care, innovation and academia to identify and appraise topics that address key health and care priorities in Wales.

Throughout 2023/24 we continued to work in collaboration with regional, national, and international partners to raise awareness about health technology innovation and appraisal.

Projects we engaged with our partners on included:

## IDAP

HTW is part of the UK-wide partnership that launched IDAP – the Innovative Devices Access Pathway - in September 2023.

The project, which received £10million of government funding, is run by HTW, the Medicines and Healthcare products Regulatory Agency (MHRA), the National Institute for Health and Care Excellence (NICE), NHS England and the Scottish Health Technologies Group.

We worked in collaboration with our IDAP partners to launch the IDAP pilot, sharing content across our website, social media channels and with Welsh stakeholders. Once eight technologies had been chosen to join the pilot, we issued a joint press release and agreed content for social media posts.

## Learn 2 Innovate

As part of our ongoing HTA capacity building work, we worked in collaboration with the Learn 2 Innovate student health care innovation programme to deliver training on health technology appraisal.

Alexander Coombs, founder and programme director of Learn 2 Innovate Programme said: “At Learn 2 Innovate we collaborated with Health Technology Wales to deliver an interactive workshop on validation of health technologies. The programme is designed to support and inspire students to become future innovators in healthcare. The session from HTW provided students the understanding that new technologies should aim to improve patient outcomes and be cost-effective, both of which ought to be considered in the early phases of a health technology idea. The students enjoyed the session with excellent feedback, and we hope to continue our relationship with HTW in the future.”

## Health and Care Research Wales Evidence Centre

We have continued to produce rapid evidence reviews on priority health and care topics as a collaborating partner of the Health and Care Research Wales Evidence Centre. HTW was appointed a collaborating partner of the centre, having previously worked as a collaborating partner of the Wales COVID-19 Evidence Centre.

### Spreading the word

As part of our ongoing work to increase understanding about our role and the health technology assessment process, we produced a series of resources aimed at explaining what we do and why.

These have included:

- A series of animations explaining the topic appraisal process and the criteria for submitting a topic for appraisal
- Case study videos about guidance we have published
- A Frequently Asked Questions document about our work and the criteria for submitting a topic
- An Appraisal Process Guide that is also available in a plain language format

**Advisory committee meetings hosted**

| | |
|---|---|
| 6 | Appraisal Panels |
| 13 | Assessment Groups |
| 2 | Stakeholder Forums |
| 1 | Industry User Group |
| 4 | Executive Groups |
| 4 | PPI Standing Groups |

**Website**

| | |
|---|---|
| 15132 | Webpage views |
| 9334 | Visitors |

**Social media**

| | |
|---|---|
| 2736 | Followers |
| 208 | LinkedIn posts and tweets |
| 1307 | Engagements |
| 42,616 | Impressions |
| 365 | Link clicks |
| 489 | Likes and retweets |

# OUR ROLE AS COLLABORATING PARTNER OF THE HEALTH AND CARE RESEARCH WALES EVIDENCE CENTRE

**Throughout 2023/24 we have continued to conduct rapid evidence reviews as a Collaborating Partner of the Health and Care Research Wales (HCRW) Evidence Centre.**

The centre, which is funded by Welsh Government, was set up to ensure that decisions about health and social care policies in Wales are made using findings from the most up to date research.

Its aim is to focus on the following priorities:

- Identifying information gaps relating to health and social care policy and practice in Wales
- Answering research questions that address the information gaps quickly and with robust methodology
- Establishing a network between the Centre and key policy and practice organisations such as Welsh Government, Social Care Wales and the NHS
- Working closely with the Welsh public
- Reviewing available research evidence where possible
- Conducting new research where evidence is lacking

As a Collaborating Partner, HTW conducts rapid evidence reviews on a wide range of health and social care topics on behalf of the Evidence Centre. In 2023/2024 HTW worked on the following rapid evidence reviews in collaboration with the Wales Evidence Centre:

- **Prognostic factors for a change in eye health or vision: A rapid review**
- **Measuring mental health in a cost-of-living crisis: A rapid review**
- **Factors associated with childhood obesity or overweight in children under five years old: A Rapid Review**

  The team were working on the Childhood Obesity Report at the time of publication. Over one-quarter of children in Wales aged four-to-five years old are either overweight or obese. Children who are overweight or obese may experience health issues during childhood or adolescence. They are also more likely to be overweight or obese through to adulthood, which can cause associated health problems. The aim of this work is to inform future policy decisions relating to the factors associated with obesity or overweight in children under five years old.

Collaborating partners work in close collaboration with leaders in Welsh Government, the NHS and social care to ensure that the Evidence Centre addresses key evidence gaps and priorities for health and social care in Wales.

The centre builds on the success of the Wales COVID-19 Evidence Centre which was vital in informing pandemic management and recovery and showed how essential research evidence is to supporting decision making about health and social care. It draws on the skills, networks and methods developed by the Wales COVID-19 Evidence Centre to carry out its work.

The latest Evidence Centre work programme can be seen here.

The latest information about the Health and Care Research Wales Evidence Centre can be found by signing up to the Health and Care Research Wales bulletin.

Wales COVID-19 Evidence Centre
Canolfan Dystiolaeth COVID-19 Cymru

> As a Centre, we provide research evidence to NHS and Social Care Wales leaders and to Ministers to tackle health and social care challenges in Wales. Health Technology Wales, as a collaborating partner, has a fundamental role in delivering this research to inform policy and practice needs in Wales.
>
> **Professor Edwards,**
> ***Director of the Health and Care Research Wales Evidence Centre***

# RAISING OUR PROFILE

We exhibited at conferences and events throughout the UK and internationally in 2023/24, meeting with stakeholders and potential topic proposers and spreading the word about our work.

Events we have taken part in during 2023/24 include:

**June 2023: Social Care Roadshow**

We exhibited at the Social Care Research Roadshow which was organised by Social Care Wales in partnership with Health and Care Research Wales. The event focused on care and support of older people and it was an important opportunity to raise awareness of our work in appraising non-medicine care technologies among social care professionals.

**June 2023: HTAi**

Our Health Services Researcher Charlotte Bowles attended HTAi 2023 in Adelaide, Australia, where she presented a paper on HTA Adaptation: Pharyngolaryngeal Biopsies (OLB) for People with Suspected Head and Neck Cancer in the Outpatient Setting.

**June 2023: MediWales Connects 2023**

HTW hosted an exhibition stand at the event and Principal Researcher Matthew Prettyjohns gave a presentation. MediWales Connects, an all-Wales NHS collaboration conference, featured a key note speech by Judith Paget CBE, Chief Executive of the NHS in Wales and Director of Health and Social Services. NHS colleagues from across Wales met with industry sector representatives to share ideas on clinical innovation.

**July 2023: Bevan Commission Conference - Transforming the Future of Health and Care Together**

This event run by Bevan Commission, which was held to mark the 75th anniversary of the NHS, focussed on creating a sustainable model for health and care and featured talks from eminent national and international speakers. We exhibited at the event alongside health and social care organisations from across Wales.

**October 2023: MediWales Showcase**

We exhibited at the annual MediWales Showcase where members of Wales' thriving life sciences sector gathered to share news of their latest projects.

**October 2023: ABHI UK HealthTech Conference**

We were delighted to take part in the Association of British Health Tech Industries annual conference. During the event we met with health tech manufacturers and potential topic proposers and took the opportunity to raise awareness about the Scientific Advice Service offered by HTW.

**November 2023: NICE Conference**

The one-day National Institute for Health and Care Excellence (NICE) conference brought together frontline staff and leaders from health and social care together with the life sciences, health tech and digital sectors. It focused on revealing how NICE is transforming to deliver more relevant, timely and usable guidance.

**March 2024:**

The Wales Health Science Conference, organised by the Welsh Scientific Advisory Committee provided us with a chance to showcase our work to a diverse audience of health science experts, practitioners, professors and students.

# A GLOBAL PERSPECTIVE

**Throughout 2023/24 we have continued to collaborate with our international partners to share knowledge and insights on health technology assessment and the identification of topics for appraisal.**

## EXPANSION OF INTERNATIONAL HTA COLLABORATION

In September 2023 we announced the expansion of a collaboration between six HTA bodies from across the UK, Australia, and Canada.

Institut national d'excellence en santé et en services sociaux (INESSS), Quebec and Pharmac, New Zealand joined the collaboration which now includes:

- National Institute for Health and Care Excellence (NICE)
- Canadian Agency for Drugs and Technologies in Health (CADTH)
- Australian Government Department of Health and Aged Care
- Healthcare Improvement Scotland , Scottish Medicines Consortium (SMC) and Scottish Health Technologies Group (SHTG)
- Health Technology Wales (HTW)
- All Wales Therapeutics & Toxicology Centre (AWTTC)
- Institut National D'Excellence En Santé Et En Services Sociaux (INESSS)
- Pharmac, New Zealand

It is estimated that the collaboration could benefit more than 134 million people worldwide. Together the partner organisations focus on three key areas of work:

**Work sharing:** Exploring the feasibility of work sharing to support HTA decision making

**Horizon scanning:** Identifying and preparing for the opportunities and challenges of the future

**Sciences and methods development:** Collaborating on sciences and methods to make best use of skills and expertise within the partner organisations.

## INISA

In October we were pleased to announce that our Director Dr Susan Myles had been appointed to join the board of directors of INSIA (International Network for Social Intervention Assessment). This reinforces HTW's commitment to identifying and appraising innovative technologies and models of care to support the social care sector in Wales. As part of our partnership with INISA we have joined a group of international colleagues which will plan INSIA's communications strategy and activities.

# OUR TEAM

**The work in this annual report has been delivered by the Health Technology Wales team.**

Our team comprises of 28 people including health services researchers, health economists, information specialists, communication specialists, project managers and administrators.

During the 2023/24 financial year we were pleased to welcome two new Senior Health Services Researchers and a Senior Health Economist to our team.

We come from a broad range of backgrounds and skillsets and collectively have extensive experience in both the public and private sectors.

The team is supported by the invaluable contributions of our external committee members who continue to ensure our work meets the needs of the health and social care sectors in Wales.

**Professor Peter Groves**
Chair

**Dr Susan Myles**
Director

**Lisa King**
Senior Programme Manager

**June Price**
Business Operations Manager

**Katie McDermott**
Project Manager

**Rebecca Shepherd**
Project Support Manager

**Alice Evans**
Patient and Public Involvement Manager

**Elise Hasler**
Information Specialist

**Jenni Washington**
Information Specialist

**Matthew Prettyjohns**
Principal Researcher, Health Economics

**Dr David Jarrom**
Principal Researcher, Health Services Research

**Jessica Williams**
Health Services Researcher

**Dr Claire Davis**
Health Services Researcher

**Dr Clare England**
Health Services Researcher

**Leona Batten**
Health Services Researcher

**Hayley Bennet**
Health Economist

**Sophie Hughes**
Senior Health Economist

**Mafalda Gordo**
Business Support and Communications Assistant

**Dr Greg Hammond**
Health Services Researcher

**Antonia Needham**
Health Services Researcher

**Charlotte Bowles**
Health Services Researcher

**Rebecca Boyce**
Health Economist

**Diana Milne**
Communications Manager

**Llinos Jones**
Welsh Language Translator

**Caron Potter**
Executive Assistant

**Dr Sian Cousins**
Senior Health Services Researcher

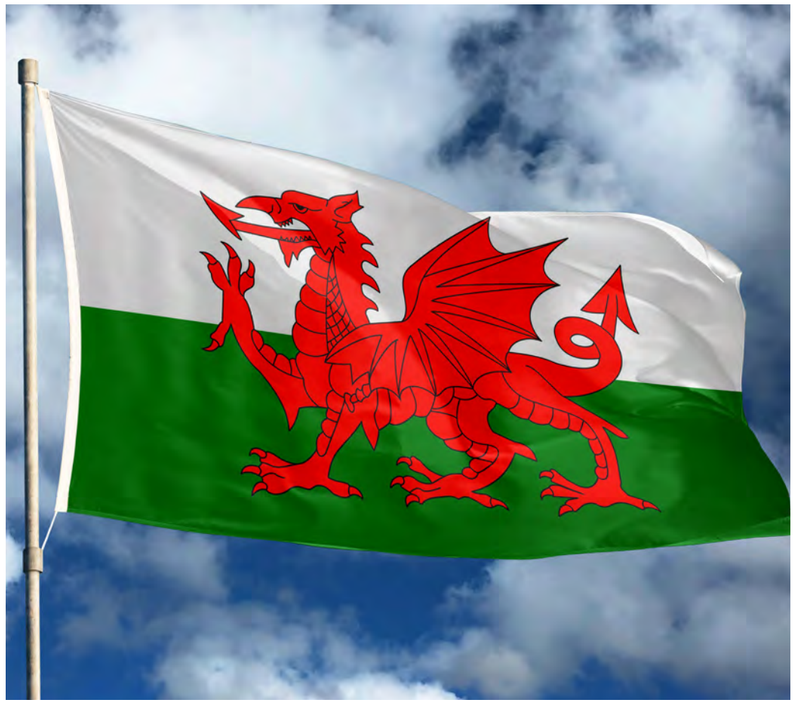
**Ryan Miller**
Senior Health Economist

**Nathan Bromham**
Senior Health Services Researcher

# BUDGET DELIVERY

**HTW is successfully delivering against its Strategic Plan for 2021–2025 which sets out our immediate and medium-term strategic goals and objectives.**

The Welsh Government awarded us £1.5million for 2023-2024 to fund our core work. HTW secured additional income of £130,000 to fund it's work as a collaborating partner of the Health and Care Research Wales Evidence Centre and two years of grant funding to support its involvement in an NHS Artificial Intelligence Award as part of a Technology Specific Evaluation Team (TSET).



Reporting modest underspend to date, due to recruitment delays. On target to deliver within budget during FY 24/25.

Supporting **25.3** full-time equivalent posts and a headcount of **28**.

Allocating our budget to **87%** staff costs and **13%** non-staff costs.

A **five-year award** secured in FY23/24 to act as a collaborator in the new Welsh Evidence Centre.

**Do you know about a technology or model of care and support in health or social care that HTW could appraise? Anyone can suggest a topic for appraisal. To take part visit our website.**

Technoleg Iechyd Cymru
Health Technology Wales

**healthtechnology.wales**

Health Technology Wales (HTW), Velindre University NHS Trust Headquarters, Unit 2 Charnwood Court, Park Nantgarw, CF15 7QZ, United Kingdom

| TRUST BOARD | |
|---|---|
| **STRATEGIC PLANNING UPDATE** | |
| **DATE OF MEETING** | 30.01.25 |
| **PUBLIC OR PRIVATE REPORT** | PUBLIC |
| **IF PRIVATE PLEASE INDICATE REASON** | NOT APPLICABLE - PUBLIC REPORT |
| **REPORT PURPOSE** | NOTE |
| **IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?** | NO |
| **PREPARED BY** | LAUREN FEAR, TRANFORMATION DIRECTOR (INTERIM) |
| **PRESENTED BY** | LAUREN FEAR, TRANFORMATION DIRECTOR (INTERIM) |
| **APPROVED BY** | LAUREN FEAR, TRANFORMATION DIRECTOR (INTERIM) |
| **EXECUTIVE SUMMARY** | This paper provides a regular bi-monthly update on key Strategic Planning matters for Strategic Development Committee and Trust Board Members. |
| **RECOMMENDATION / ACTIONS** | The Trust Board is asked to note the update. |

## 1. BACKGROUND

As introduced in the September Board meeting, this paper will provide an overview of key strategic planning matters bi-monthly.

For this reporting period, the paper will therefore provide an overview across:

- Trust Integrated Medium Term Plan
- Regional Cancer Programme Board

## 2. ASESSMENT

### Trust Integrated Medium Term Plan

**2.1.1** The national planning guidance was issued over the course of late December to early January. The Trust's Integrated Medium Term Planning framework has been updated to include all the requirements and guidance. Key documents include:

- NHS Wales Planning Framework
- Key Ministerial Expectations and Performance Metrics
- Cabinet Secretary's Enabling Actions
- Minimum Data Set
- Financial Allocation Circular and associated Cabinet Secretary and Director General letters
- Healthier Wales refresh
- Ministerial Cancer Summit Report

**2.1.2** The shape and approach to the Trust's Integrated Medium Term Plan was discussed in the Strategic Development Committee in December. It was discussed that the plan would include:

- Strategic context – now updated as per 2.1.1
- Delivery of core clinical standards, including current key outcome KPIs, and projected performance based on actions.
- How the plan responds to patient, donor and staff experience and feedback
- Delivery of corporate/ enabling services, including current key outcome KPIs, and projected performance based on actions.
- Change portfolio
- Financial Plan
- Implementation, communication and assurance

**2.1.3** The first draft of the full plan is being produced for end of January, for discussion in Executive Management Board on 10th February and in Strategic Development Committee 18th February. It will be presented to the Trust Board for approval on 27th March, following endorsement at Strategic Development Committee on 20th March. The approach to reviewing drafts, particularly for any Independent Members not able to make the Strategic Development Committee session, can be arranged.

## 2.2 Regional Cancer Planning Update

**2.2.1** As context, and as per previous update, in 2020 a South East Wales regional planning partnership was established for specific programmes of work:

Ophthalmology, Diagnostics, Orthopaedics and Stroke. The Trust joined the partnership in August 2023 marking the creation of a fifth regional programme – *cancer.*

**2.2.2** The Cancer Programme is hosted by Aneurin Bevan University Health Board and, following the initial Cancer Programme Board in September 2024, it was agreed by the regional group that the Trust will take on a key leadership role in this work.

**2.2.3** Each of the Directors of Planning have been sharing a summary report across the programmes of work with their Boards in public domain so that each Board has a common report. This is attached as ***Appendix 1***. The status of the Cancer Programme has been agreed through the Regional Oversight Board to improve from Red to Amber to reflect the progress made since October.

**2.2.4** The Trust has coordinated the work packages agreed in the first meeting of the Regional Cancer Board in October and these were presented and discussed in the meeting in November. The three work packages were:

- **Cancer strategies** - A summary of key areas, common themes and mapping to national priorities and improvement plan - in order to inform further regional strategic planning.
- **Baseline review of regional cross-organisational work relating to cancer services** – To agree scope of regional portfolio reporting into the regional governance going forward to support collective leadership of the programmes of work and addressing any key issues.
- **Developing the Regional Cancer Programme** – To agree approach to agreeing the first tranche of the collective programme of work. There were a number of initial priorities agreed, with Trust Officers taking a leading role in a number of areas

**2.2.5** In the November meeting, initial programmes of work were agreed as part of third work package above. Assigned leads were agreed to progress the following work prior to the next meeting in early February:

- Task and Finish Group and develop an initial Project Brief for a Regional Data / Shared Patient Tracker List Project.
- Task and Finish Group and develop an initial Project Brief for a Regional Cancer Workforce Development Project.

- Task and Finish Group and develop an initial Project Brief for a Regional Multi-Disciplinary Team Resourcing and Governance Project.
- Task & Finish Group and develop an initial Project Brief for a Haemato-oncology Project.

## 3. IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:<br>YES - Select Relevant Goals below | |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety and experience ☒<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒<br>• A beacon for research, development and innovation in our stated areas of priority ☒<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒<br>• A sustainable organisation that plays its part in creating a better future for people across the globe ☒ | |
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)**<br>*For more information: STRATEGIC RISK DESCRIPTIONS* | 09 - Future Direction of Travel |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | Yes -select the relevant domain/domains from the list below. Please select all that apply |
| | Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>Patient Centred ☒ |
| | All strategic planning matters will require a Quality Impact Assessment and this will be included in the Trust IMTP Framework. |

| | |
|---|---|
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:**<br>*For more information:*<br>*https://www.gov.wales/socio-economic-duty-overview* | All strategic planning matters will require a Socio-economic duty assessment and this will be included in the Trust IMTP Framework. |
| **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** | Financial Planning core to Trust IMTP Framework |
| | Yes (Include further detail below) |
| **EQUALITY IMPACT ASSESSMENT**<br>*For more information:*<br>*https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx* | All strategic planning matters will require an Equality Impact Assessment and this will be included in the Trust IMTP Framework |

# November/December 2024 board update: South East Wales Region

GIG CYMRU NHS WALES
Rhanbarth De-ddwyrain Cymru
South East Wales Region

| Programme & purpose | Overview | Need to Know | What's new | RAG |
|---|---|---|---|---|
| **Regional Portfolio:**<br>Acts as the central 'hub' of intelligence for the design, delivery and assurance of all regional programmes of work.<br>The portfolio seeks to;<br>• Ensure standardisation in approach<br>• Identify, manage and mitigate portfolio levels risks<br>• Identify new opportunities for regional working | Overall portfolio position provides limited assurance, with work to realign programmes, their status, relative priorities and future opportunities to follow | • **Transition of Orthopaedics Programme:** Oversight Board have agreed the recommendation that the Regional Orthopaedics Programme transitions into a clinical network. It was agreed some regional aspects of the former Orthopaedics Programme related entirely to the development of the LHP now move into the Llantrisant Health Park (LHP) Programme. This will have implications for revised governance arrangements and the scope/accountability for LHP, with discussions ongoing<br>• **Realignment of Diagnostic Programme:** January Oversight Board will conduct a deep dive into the Diagnostic Programme. This will likely (a) reshape the purpose of the current programme to reflect key packages of work having bene completed and (b) identify areas of this programme which might likewise also better sit within the governance of the LHP programme. | • **South Wales Vascular Network:** agreed to bring the South Wales Vascular Network into the scope of the portfolio, recognising the current challenges and opportunities facing some of the networks<br>• **High Level Risk Profile:** new issue identified related to the short-term focus on 24/25 year end position - particularly around Ophthalmology and Endoscopy. This has been necessitated by the focus from Welsh Government. This is usurping nearly all available time and resource to consider the longer term. Mitigation to identify what 'support' for the short term looks like so that capacity for longer term strategic planning can be retained | Limited assurance |

# November/December 2024 board update: cont/…

| Programme & purpose | Overview | Need to Know | What's new | RAG |
|---|---|---|---|---|
| **Ophthalmology:**<br>• Sustainable Services<br>• Regional Centre of Excellence Network Model<br>• Workforce<br>• Clinical Research Facility<br>• Modernised IT<br>• Reduce waste and clinical variation. | Reasonable assurance. Programme is currently focused on managing the spend of the additional short term non-recurrent funding awarded by WG | • **Funding:**<br>  • Additional non-recurrent year end funding provided from WG to tackle wait lists to the end of the reporting year. Initial commitment to £3m has been raised up to £7.5m<br>  • Activity has, therefore, focused on short term planning to quantify, identify options and complete a market exploration of providers. This will inform the commissioning of additional capacity<br>  • Rapid tendering process underway. Recognition by the Programme that there is insufficient time and market capacity to eradicate 104-week waits<br>• **Planning:** Short term focus from WG is on reducing wait times overall | • **Programme Risk:** new short term programme risk associated with reprofiling the programme activity in order to spend the additional funding allocation by the end of the financial year, including identifying additional booking and scheduling team capacity | Reasonable Assurance |
| **Orthopaedics:**<br>• High quality equitable care and interventions<br>• Best outcomes and experience for patients<br>• Balanced orthopaedic demand, capacity, productivity and efficiency | Reasonable assurance | • **Transition to network:** options being developed to transition to a network from a managed programme, with elements of the workstream would likely be moving into the Llantrisant Health Park (LHP) programme. Clinical Directors are supportive of the proposal, pending discussion at Programme Board on 22/11<br>• **Terms of Reference:** Joanne Hill is developing a ToR and framework for the clinical network, and a critical path to ensure a smooth transition from the current programme | • **Programme Risk:** no new risks or changes in risk scores | Reasonable assurance |

# November/December 2024 board update: cont/…

| Programme & purpose | Overview | Need to Know | What's new | RAG |
|---|---|---|---|---|
| **Stroke:**<br>• Transform stroke outcomes<br>• Deliver evidence-based, innovative and sustainable care<br>• Achieve best-in-class at all stages of our clinical pathways | Limited assurance | • **Critical path and governance:** new critical path and governance structure presented and agreed at Programme Board on 08/10, with ToR document being refreshed. Review at next programme board in December<br>• **Clinical Advisory Group:** Nick Gidman meeting with Medical Directors and senior clinical and operational colleagues on 09/12, to discuss membership of the Clinical Advisory Group<br>• **Future service model:** Clinical task & finish group to be established to identify the potential options for delivering a regional model | • **System pressure:** CTM's stroke services are currently under pressure with relocation due to the damaged roof at POW Hospital<br>• **Llais Regional Directors:** Briefing held on 27/11<br>• **Programme Risk:** Programme SRO role vacant from January with a need to identify a suitable replacement as soon as possible | Limited assurance |
| **Cancer:**<br>• Design, develop and articulate the desired future state for the cancer system for SE Wales<br>• Adopt best practice<br>• Reduce inequalities<br>• Improve outcomes | Limited assurance / no assurance given as programme in development | • **Initial work completed:**<br>  • Analysis of each organisation and nationally agreed strategies and priorities to identify key themes and requirements.<br>  • Mapping of existing regional and bi-lateral programmes and initiatives to ensure appropriate join up<br>• **Initial work programme with assigned leads agreed at Programme Board in November 2024 to establish:**<br>  • Task & finish Group and develop an initial Project Brief for a Regional Data / Shared PTL Project (enabler)<br>  • Task & finish Group and develop an initial Project Brief for a Regional Cancer Workforce Project (enabler)<br>  • Task & finish Group and develop an initial Project Brief for a Regional MDT Resourcing & Governance Project (Immediate Issue)<br>  • Task & finish Group and develop an initial Project Brief for a Haemato-oncology Project (Immediate Issue) | • **Informed decision-making:** Framing completed to inform decision, based on initial work as described<br>• **Programme Risk:** risk score associated with appropriate resources to support the development of the workstream, has reduced, from 20 to 16. No new risks identified | Limited assurance |

# November/December 2024 board update: cont/…

| Programme & purpose | Overview | Need to Know | What's new | RAG |
|---|---|---|---|---|
| **Diagnostics – Endoscopy:**<br>• Regional service model<br>• JAG accreditation across all services<br>• Shared PTL<br>• Collaborative training<br>• Common IM&T system<br>• Shared understanding and common approaches and definitions of D&C data | Limited assurance | • **Endoscopy Academy and integration with Llantrisant Health Park (LHP):** Clinical Summit on 11/11 reviewed the concept of the Endoscopy Academy and started building the case for change into a regional unit service model. As per the Tri Exec meeting, the bulk of the program will align to LHP, with ongoing work to agree how to proceed with non-LHP elements<br>• **Formal review of the endoscopy programme:** has commenced, to appraise the optimal future model. The bulk of the program will now align to LHP – ongoing work to agree how to proceed with non LHP elements. HBs were requested to feed back on appraisals to inform discussion at December Endoscopy Project Board.<br>• **Business case:** discussions are progressing. HB DoPs, DoFs, and COOs met on 10/12 to discuss next steps to refine the business case to facilitate HB approvals | • **Project Risk:** risk to delivery of the may change as the project structure is reconsidered | No rating provided |
| **Diagnostics – Pathology:**<br>• Regional pathology solutions in South East Wales<br>• Create a sustainable patient-focussed service | Limited assurance | • **Future model:** under active consideration for the pathology workstream to become a separate programme. A SitRep to capture this remains under development<br>• **Programme Manager:** Joanne Hill will be moving to support the emerging pathology workstream | • **Project Risk:** no change since last period | No rating provided |

# November/December 2024 board update: cont/…

| Programme & purpose | Overview | Need to Know | What's new | RAG |
|---|---|---|---|---|
| **Diagnostics – Radiology:**<br>• Collaborative regional approach<br>• Provide additional regional capacity<br>• Improve access to services in areas of social deprivation | Limited assurance | • **Community Diagnostic Hubs:** noted that progressing CDHs is likely to sit within the LHP Programme for CTM. CAV is not looking to utilise the emerging framework agreement<br>• **Closure report:** the CDH Project Board will receive a closure report and formal proposals for legacy work structures in January 2025. Confirmed that:<br>  • CTM will proceed with developing a CDH at the LHP site<br>  • AB will proceed with developing a CDH at YYF<br>  • CAV is re-appraising options for CDHs | • **Project Risk:** the risk associated with the delivery of the programme may change as the project structure is reconsidered | Limited assurance |
| **Llantrisant Health Park (LHP):**<br>• Cutting-edge diagnostics and treatment centre<br>• Improve care and access to services with CTM and the wider region | N/a – different reporting structure to Regional Programme Delivery Board | • **Infrastructure:**<br>  • CTM was proceeding at risk, with partner Execs invited to the IIB meeting.<br>  • Welsh Government funding letter followed from IIB, setting out a list of requirements conditional on releasing funds to close the RIBA 2 and deliver RIBA 3 phases. This has since been confirmed.<br>• **Clinical:**<br>  • Working through implications and requirements for the transition of certain elements of the Regional Orthopaedic Programme into the LHP Programme. | • **Programme Risk:** no risk information provided | No status provided |

| TRUST BOARD | |
|---|---|
| **CHAIR'S URGENT ACTION MATTER REPORT** | |
| **DATE OF MEETING** | 30 January 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 **22/11/2024 – 23/01/2025.**<br><br>There was one (1) urgent item of business for the Trust Board that was considered via Chairs Urgent Action during this period:<br><br>1. High Voltage Intake Building.<br><br>No objections to approval were received in respect of the items of business considered. |
| **RECOMMENDATION / ACTIONS** | To **RATIFY** the Chairs Urgent Action taken between the **22/11/2024 – 23/01/2025.** |
| **GOVERNANCE ROUTE** | |
| **Trust Board Members – Via Email** | **08/01/2025**: High Voltage Intake Building. |
| **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 **21/11/2024 – 23/01/2025.**

## 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 November 2024:

### 3.1 High Voltage Intake Building

The Trust Board were sent an email and Chair's Urgent Action Report on the **8th January 2025** in relation to the **High Voltage Intake Building** that required urgent approval.

The Trust Board is asked to **APPROVE:**

- The submission of a bid for draw down of funds from QRA contingency to fund increased cost to delivering the High Voltage (HV) intake room

- An increase delegation limit from £331,000 conditional on Welsh Government funding by £63,540 to allow appointment of the contractor, and a further £70,000 to cover provisional sums and contingency.

Should this funding not materialise from the QRA, a further round of executive governance will be required to request funding from the Trust's discretionary capital funds.

**Recommendation Approved by:**

- Donna Mead, Chair
- David Donegan, CEO
- Stephen Harries, Vice Chair
- Andrew Westwell, Independent Member
- Gareth Jones, Independent Member
- Carl James, Executive Director of Strategic Transformation, Planning & Digital

## 3 IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:<br>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** | **Select all relevant domains below** |
| | Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>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

## BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 22 NOVEMBER 2024 TO 23 JANUARY 2025

| | |
|---|---|
| **DATE OF MEETING** | 30 January 2025 |
| **PUBLIC OR PRIVATE REPORT** | Public |
| **IF PRIVATE PLEASE INDICATE REASON** | NOT APPLICABLE - PUBLIC REPORT |
| **REPORT PURPOSE** | FOR APPROVAL |
| **IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?** | NO |
| **PREPARED BY** | Kay Barrow, Corporate Governance Manager |
| **PRESENTED BY** | Matthew Bunce, Executive Director of Finance |
| **APPROVED BY** | Appendix 1: Alan Prosser, Director Welsh Blood Service |
| **EXECUTIVE SUMMARY** | This report details the Trust Board decisions required for Commitment of Expenditure exceeding the Chief Executive's Limit (£100k), for the period 22/11/2024 – 23/01/2024.<br><br>There is one (1) items of expenditure is required for Trust Board Approval during this period:<br><br>• Appendix 1: Courier Services for Samples at Welsh Bone Marrow Donor Registry (WBMDR) and National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics (H&I) |
| **RECOMMENDATION / ACTIONS** | The Trust Board is requested to:<br>• **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. |

| **GOVERNANCE ROUTE** | |
|---|---|
| Finance and Procurement Planning Group (FPPG) | 06/12/2024 |
| WBS Senior Leadership Team | 11/12/2024 |
| Extraordinary Executive Management Board | 08/01/2025 |

**SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS**

The Executive Management Board **ENDORSED** for Trust Board Approval the following Commitment of Expenditure exceeding £100k:

- **Appendix 1**: Courier Services for Samples at Welsh Bone Marrow Donor Registry (WBMDR) and National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics (H&I)

**7 LEVELS OF ASSURANCE –** N/A

**APPENDICES**

**Appendix 1**: Courier Services for Samples at Welsh Bone Marrow Donor Registry (WBMDR) and National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics (H&I)

## 1. SITUATION/ BACKGROUND

1.1 Velindre University NHS Trust (VUNHST) has a Scheme of Delegation, as set out in its Standing Orders, together with its Standing Financial Instructions (SFIs), which ensures that there are effective governance arrangements in place for the delegation of financial authority.

1.2 Financial limits apply to the commitment of expenditure. If expenditure is greater than an individual's financial limit and is more than the limit delegated to the VUNHST Chief Executive, the planned expenditure will require VUNHST Board approval. For extensions of existing contracts in place, this only applies if the provision for extension was not included in the original approval granted by the Trust Board.

1.3 The decisions expected during the period 22/11/2024 – 23/01/2024.are highlighted in this report.

1.4 In line with the process for Commitment of Expenditure over the Chief Executive's Limit, all reports are received by the Executive Management Board to ensure Executive oversight and scrutiny, to provide the Trust Board with supporting recommendations and additional assurance.

## 2.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to Appendix 1 for the detailed appraisal undertaken of the expenditure proposal that the Trust Board is asked to **ENDORSE** for VUNHST Board **APPROVAL**.

2.2 The table below provides a summary of the decisions sought from the January 2025 meeting of the Trust Board:

| **Appendix No.** | **Division** | **Scheme / Contract Agreement Title** | **Period of Contract** | **Total Expected Maximum Value of Contract £** |
|---|---|---|---|---|
| **Appendix 1** | Welsh Blood Service | Courier Services for Samples at Welsh Bone Marrow Donor Registry (WBMDR) and National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics (H&I) | Start: 09/03/2025<br>End: 09/03/2027<br>Option to extend: plus 12 months | £375,000 (inc. VAT) |

## 3 IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:<br>YES - Select Relevant Goals below | |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety and experience ☒<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒<br>• A beacon for research, development and innovation in our stated areas of priority ☒<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒<br>• 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 ☒<br>Timely ☒<br>Effective ☒ |

| | |
|---|---|
| | Equitable ☒<br>Efficient ☒<br>Patient Centred ☒ |
| | Due authority is being sought in advance of expenditure to ensure the compliant provision of goods/services to meet operational requirements. |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:** | *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** | Yes - please Include further detail below, including funding stream |
| | Further details are provided in each individual appendix enclosed with this report. |
| **EQUALITY IMPACT ASSESSMENT** | Not required, undertaken on a case by case basis, as part of the procurement process. |
| **ADDITIONAL LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | If applicable, as identified in each individual appendix as part of the service design/ procurement process. |

## 4 RISKS

| | |
|---|---|
| **ARE THERE RELATED RISK(S) FOR THIS MATTER** | If applicable, as identified in each individual appendix as part of the service design/ procurement process. |

# COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

| | |
|---|---|
| **SCHEME TITLE** | Courier Services for Samples at WBMDR and NEQAS H&I |
| **DIVISION / HOST ORGANISATION** | WBMDR and NEQAS sections of WBS |
| **DATE PREPARED** | 29/11/2024 |
| **PREPARED BY** | Chris Harvey |
| **SCHEME SPONSOR** | Deborah Pritchard |

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

## 1. DESCRIPTION OF GOODS / SERVICES / WORKS

*WBMDR: The Welsh Bone Marrow Donor Registry (WBMDR), hosted by the Welsh Blood Service (WBS), supports stem cell transplantation programmes in the UK and globally. This includes the transport of donor samples from the WBS to laboratories worldwide as well as the transport of samples from GPs/Hospitals/Donors addresses within the UK to WBS.*

*The exact number of shipments per year is impossible to predict due to the nature of the samples but based on 2023-2024 financial year, we would expect around 600-700 sample transportations with over half of these destinations within the UK. Samples are packaged to comply with UN3373 specifications.*

*NEQAS:* The UK National External Quality Assessment Service for Histocompatibility and Immunogenetics (UK NEQAS for H&I) provides an External Quality Assessment (EQA) Service for medical laboratories (our customers). We operate from the Welsh Blood Service, part of Velindre University NHS Trust.

We offer a number of EQA 'schemes', which are available to laboratories both in the UK and internationally. The EQA service necessitates the regular distribution of blood samples to our customers to allow us to check the quality of their medical tests. These samples need to delivered swiftly to avoid deterioration. It is estimated that we send 2140 shipments per year.

***Please note that all sample courier costs are recovered through the fee charged for the service provided.***

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

| **1.2 Period of contract including extension options:** | |
|---|---|
| **Expected Start Date of Contract** | 09/03/2025 |
| **Expected End Date of Contract** | 09/03/2027 |
| **Contract Extension Options**<br><br>**(E.g. maximum term in months)** | +12 months |

**2. STRATEGIC FIT** (*Host organisations are not required to complete Section 2)*

| **2.1 OUR STRATEGIC PILLARS**<br>This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme. | |
|---|---|
| **Goal 1:** Be recognised as a pioneer in blood and transplantations services across Europe. | ☒ |
| **Goal 2:** Be a recognised leader in specialist cancer services in Europe. | ☒ |
| **Goal 3:** Be recognised as a leader in stated priority areas of research, development and innovation. | ☐ |
| **Goal 4:** An established 'University' Trust which provides highly valued knowledge and learning for all. | ☒ |
| **Goal 5:** An exemplar of sustainability that supports global well-being and social value. | ☒ |

| **2.2 INTEGRATED MEDIUM TERM PLAN** | | |
|---|---|---|
| Is this scheme included in the Trust Integrated Medium Term Plan? | **Yes** | **No** |
| | ☒ | ☐ |

| |
|---|
| If not, please explain the reason for this in the space provided.<br><br>Provision of stem cell product to for patient transplant is included in the IMTP. |

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

**FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED**

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Prevention | ☐ | Long Term | ☐ | Integration | ☐ | Collaboration | ☒ | Involvement | ☒ |

## 3. OPTIONS CONSIDERED

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

| **3.1 Please state alternative options considered and reasons for declining** |
|---|
| *Do nothing:* |

| |
|---|
| • *WBMDR would be unable to facilitate transport of donor samples from the WBS to laboratories worldwide as well as the transport of samples from GPs/hospitals/Donors addresses within the UK to WBS.*<br>  • *Impact on ability to complete stem cell collections for patients that require a stem cell transplant.*<br>• *UK NEQAS would be unable to provide the EQA service which customers had paid for.*<br>  • *Impact on customer's laboratory accreditation and ability to provide services*<br>  • *Impact on UK NEQAS service provision and business continuity*<br>• *National and International reputational damage*<br>• *Significant financial impact to WBMDR and UK NEQAS, WBS and the wider Trust.* |
| |

**4. BENEFITS (Quantifiable / Non-Quantifiable)**

| **4.1 Outline benefits of preferred option** |
|---|
| *Continue with tender process:*<br><br>*Benefits of this option:*<br><br>• *Ability to maintain WBMDR and NEQAS sample Courier services.*<br>• *Ability to comply with the requirements of the Human Tissue Authority (HTA), Foundation for the accreditation of cellular therapy joint accreditation committee (FACT-JACIE) and the World Marrow Donor Association (WMDA).*<br>• *Sustainable business model*<br>• *Complies with Procurement Regulations. The Current contract was tendered for in 2022, therefore, by completing a new tender process, we will implement a compliant contract, while testing the market for Value for Money.* |

**5. RISKS & MITIGATION**

| **5.1 Please state risks of not proceeding with the scheme** | **5.2 Please state any mitigation to reduce the risk if the scheme is not approved** |
|---|---|
| • *WBMDR would be unable to facilitate transport of donor samples from the* | *None exist* |

| | |
|---|---|
| *WBS to laboratories worldwide as well as the transport of samples from GPs/hospitals/Donors addresses within the UK to WBS.*<br>• *Impact on ability to complete stem cell collections for patients that require a stem cell transplant.*<br>• *UK NEQAS would be unable to provide the EQA service which customers had paid for.*<br>• *Impact on customer's laboratory accreditation and ability to provide services*<br>• *Impact on UK NEQAS service provision and business continuity*<br>• *National and International reputational damage*<br>*Significant financial impact to WBMDR and UK NEQAS, WBS and the wider Trust*<br>*Unable to facilitate transport of donor samples from the WBS to laboratories worldwide as well as the transport of samples from GPs/hospitals/Donors addresses within the UK to WBS.* | |

## 6. PROCUREMENT ROUTE

| **6.1 How is the contract being procured?** Please mark with a (x) as relevant. | | | |
|---|---|---|---|
| **Competition** | | **Single source** | |
| 3 Quotes | ☐ | Single Quotation Action | ☐ |
| Formal Tender Exercise | ☐ | Single Tender Action | ☐ |
| Mini competition | ☐ | Direct call off Framework | ☐ |
| Find a Tender<br>(replaces OJEU Public Contract regulations 2015 still apply) | ☒ | All Wales contract | ☐ |

| |
|---|
| **Click here for link to Procurement Manual for additional guidance** |
| **6.2 Please outline the procurement strategy** |
| Given the value of this contract, it will be procured through a Find a Tender / OJEU tender procedure. The opportunity will be advertised on Sell2Wales and published on Bravo/eTender as an open competition, with a minimum advertisement period of 30 days. While a framework exists for this requirement, a recent costing exercise with suppliers on the framework did not receive any responses. Taking this into consideration, the procurement team determined that an open competition would be the most effective route to market, enabling us to engage with a broader pool of potential suppliers. |
| **6.3 What is the approximate time line for procurement?** |

| | |
|---|---|
| 10 December 2024 | Tender Issued on Bravo Solutions e-tending portal and Sell2Wales |
| 13 January 2025 | ITT Closes |
| 14 January 2025 | Evaluations |
| 27 January 2025 | Contract Award Preparation & Authorisation from Health Board |
| TBC | Board Approval Submitted |
| TBC | Board Approval Received |
| 09 February 2025 | Contract Award Submitted to Welsh Government |
| 23 February 2025 | Approval of Contract Award returned by Welsh Government |
| 26 February 2025 | Start of Alcatel Period |
| 08 March 2025 | Conclusion of Alcatel Period |
| 09 March 2025 | Contract Award |
| TBC | Contract Start |

****Please confirm board dates**

### 6.4 PROCUREMENT ROUTE APPROVAL

| |
|---|
| The Head of Procurement / Delegated Authority has approved the preferred procurement route |

| | |
|---|---|
| **Head of Procurement Name:** | pp. Ian Emptage |
| **Signature:** | I.Emptage |

| | |
|---|---|
| **Date:** | 3/12/2024 |

## 7. FINANCIAL ANALYSIS

| | | |
|---|---|---|
| **Maximum expected whole life cost relating to the award of contract** | **Excluding VAT (£k)** | **Including VAT (£k)**<br><br>**£375,000** |
| **The nature of spend** | **Capital** ☐ | **Revenue** ☒ |
| **How is the scheme to be funded?** Please mark with a (x) as relevant.<br><br>Existing budgets ☒<br>Additional Welsh Government funding ☐<br>Other ☐ | | |
| **If you have selected 'Other' – please provide further details below:** | | |

### PROFILE OF EXPENDITURE

| EXPENDITURE CATEGORY | Year 1 (exc. VAT) £k | Year 2 (exc. VAT) £k | Year 3 (exc. VAT) £k | Total Future Years (exc. VAT) £k | Total (exc.VAT) £k | Total (inc. VAT) £k |
|---|---|---|---|---|---|---|
| Courier Cost | 125,000 | 125,000 | 125,000 | | | 375,000 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| **Overall Total** | 125,000 | 125,000 | 125,000 | | | 375,000 |

## 8. PROJECT MANAGEMENT (if applicable)

| | |
|---|---|
| **What are the management arrangements associated with this scheme?** E.g. PRINCE 2 | *Not required – managed by WBMDR and UK NEQAS staff* |

## 9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

| | |
|---|---|
| The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file. | |
| **Lead Director Name:** | Alan Prosser |
| **Signature:** | |
| **Service Area:** | Director Welsh Blood Service |
| **Date:** | 05/12/2024 |

## 10. APPROVALS RECEIVED

*List and include date of approvals received in support of this scheme.*

| **Divisions** | **Date of Approval:** |
|---|---|
| Finance & Procurement Planning Group (FPPG) | 06/12/2024 |
| Senior Leadership Team (SLT) | 11/12/2024 |
| Executive Management Board (EMB Run) | |
| Trust Board Meeting | |

| **Host Organisations** | **Date of Approval:** |
|---|---|
| NWSSP /<br>NHS Wales Shared Services Partnership Committee | |
| HTW – Senior Management Team | |

| TRUST BOARD | |
|---|---|
| **BUDGETARY DELEGATION – AMENDMENT TO THE DELEGATED FINANCIAL LIMITS OF THE CHIEF EXECUTIVE AND FRAMEWORK FOR OFFICER FINANCIAL LIMITS** | |
| **DATE OF MEETING** | 30 January 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** | 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** | This paper seeks Trust Board **APPROVAL** to increase the delegated financial limit of the Chief Executive Officer from £100k to £500k, and formally sets out the delegated financial limits for officers at the Trust below the CEO subject to Board approving the CEO financial limit, which underpins the budgetary delegation as set out in the Trust SOs and SFIs. |
| **RECOMMENDATION / ACTIONS** | Trust Board is asked to:<br>• to **APPROVE** increasing the delegated financial limit of the Chief Executive Officer (CEO) from **£100k** to **£500k.**<br>• to **NOTE** 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. |

| **GOVERNANCE ROUTE** | |
|---|---|
| **List the Name(s) of Committee / Group who have previously received and considered this report:** | **Date** |
| Executive Management Board Shape | 09/12/2024 |
| Audit Committee | 12/12/2024 |

**SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS**

*EMB and Audit Committee endorsed for Trust Board approval the recommendation to increase the Chief Executive Officer Financial Limit from £100k to £500k.*

*EMB approved the delegated financial limits to be provided to officers below the CEO, subject to:*

- *Trust Board approving the increase to the CEO Delegated Financial Limit to £500k*
- *Trust Board reconfirming the delegation to the CEO to set Financial Limits below £500k*
- *Further review and amendment of Officer delegated Financial Limits by the CEO to reflect the increase in CEO limit to £500k*
- *Removal of the WBS Assistant Director of Operations from the Officer Scheme of Delegation and replacement with Head of Transfusion Laboratory Services*
- *Separation of Chief Executive or Executive Director of Finance Financial Limit up to £25k for Charitable Funds from the Chief Executive Financial Limits for Revenue and Capital*

| **7 LEVELS OF ASSURANCE** |
|---|
| N/A – Report for Discussion and Approval |

## 1. SITUATION / BACKGROUND

1.1 The Velindre University NHS Trust Standing Orders (SOs) and Standing Financial Instructions (SFIs) 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.

1.2 All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

1.3 The Trust Board role is to establish and uphold the organisation's governance and accountability framework, including its values and standards of behaviour. As outlined in section 1.2.2 of the Trust SFIs, ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.

1.4 This report seeks **APPROVAL** to increase the Chief Executive Officer (CEO) financial limit from **£100k** to **£500k** and aims to set out a structure for delegation of financial limits to officers below that of the Chief Executive which is defined within the Trust SOs and SFIs.

## 2. ASSESSMENT

2.1 The table below sets out the current delegated Financial Limits of the CEO and officers within section 5 of the Trust SFIs – Financial Limits

**FINANCIAL LIMITS**

(All values exclude VAT)

| Financial Limits | Revenue £'000 | Capital £'000 | Charitable Funds £'000 |
|---|---|---|---|
| **Corporate Services:** | | | |
| Trust Board | No Limit | No Limit | 0 |
| Charitable Funds Committee | 0 | 0 | >25 |
| Delegated Charitable Fund Holders | 0 | 0 | 5 |
| Chief Executive or Executive Director of Finance | 100 | 100 | 25 |
| **Cancer Services:** | | | |
| Director of Cancer Services, Director of Operations & Chief Pharmacist – for Pharmaceuticals | 150 | 0 | 0 |
| **Blood Wholesale Products**<br>Chief Executive<br>Executive Director of Finance<br>WBS Director<br>WBS Medical Director<br>WBS Deputy Director<br>WBS Assistant Director of Operations | 800 | 0 | 0 |

Further delegated financial limits which are **less than £100k** will be agreed by the Chief Executive and the Executive Management Board.

The financial limits delegated for expenditure on Pharmaceuticals and Blood Wholesale Products are exceptional allowed delegations and authority to approve expenditure to these financial limits relate specifically and only for these purposes as set out in the Trust SFIs.

**Increase Chief Executive Limit to £500k**

2.2 The current financial limit of the Chief Executive Officer of £100k is disproportionately low when compared to other NHS bodies in Wales. Increasing the Chief Executives limit to £500k aligns the Trust with other similar size (Comparing income, expenditure) NHS Wales bodies, namely Welsh Ambulance Service Trust (WAST) and Public Health Wales Trust (PHWT) who have a delegated financial limit of £500k for their respective Chief Executive Officers.

2.3 Under the current financial limits any request for expenditure that is over £100k will require Trust board approval via the completion of the Commitment of Expenditure Exceeding Chief Executive limit / Business Justification template. Subject to approval by the Trist Board of the recommended revision to £500k, the Business justification template would be updated and used for expenditure exceeding £500k.

2.4 The Trust SOs and SFIs are clear in paragraphs 11.17.5 and 11.17.6 that in the case of contract extension or renewals, further approvals are required where a contract value is increased beyond the delegated threshold under which the original contract value was approved. In the case of an increase that takes the total value of the contract over £500k (subject to approval of the CEO limit), whole life cost over its entire period, then this would still require approval from the Trust Board.

**Proposed Structure for Delegation of Financial Limits to Officers below that of the Chief Executive**

2.5 In March 2019 the Trust Board approved an amendment to the Financial limits contained within section 5 of SFIs which details the requirements for budgetary control. The proposal gave the Chief Executive as Chief Accountable officer and the Executive Management Board the authority to further delegate expenditure control limits below their threshold as they deem appropriate.

Table B below sets out a proposed structure for delegation of financial limits to officers below that of the Chief Executive to ensure that limits are set consistently across the core Trust.

Table B

| **Financial Limits** | **Band** | **Revenue £'000** | **Capital £'000** | **Charitable Funds £'000** |
|---|---|---|---|---|
| Executive Director of Finance | Exec Director | 100 | 100 | 25 |
| Executive Director / Divisional Directors (VCS & WBS) | Exec / Director | 60 | 60 | 5 |
| Deputy Director | 9 / 8d | 40 | 40 | 0 |
| Heads of Department | 8c / 8b | 20 | 20 | 0 |
| Senior Managers | 8b / 8a | 10 | 10 | 0 |
| Delegated Budget Holders | Various | 5 | 0 | 0 |
| Delegated Charitable Fund Holders | Various | 0 | 0 | 5 |

Table B sets out the framework and initial delegation of financial limits below that of the Chief Executive which will underpin section 5 of the Trust SFIs. The Chief Executive will undertake a review of the framework and financial limits in light of the proposed increase to the Chief Executive limit to £500k.

2.6 Setting financial approval limits at a suitable level will ensure that purchase orders are raised both appropriately and efficiently, supporting the day to day running of the Trust business and ensuring that supplier invoices are processed in a timely manner.

2.7 It ensures consistency of budget holder responsibilities across the Trust that will enable effective communication and understating of their respective financial delegated limits.

2.8 Any proposed amendment to financial limits which is outside of that set out in the table above will require formal approval as set out in the Trust SFIs.

## 3. SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The **TRUST BOARD** is asked to:

- to **APPROVE** increasing the delegated financial limit of the Chief Executive Officer from **£100k** to **£500k.**

- to **NOTE** 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.

3.2 **Next Steps & Future Reporting**

Subject to **APPROVAL** by the Trust Board to increase the Chief Executive limit:

- Section 5 of the Trust SOs and SFIs will be updated increasing the Chief Executive Officers limit to £500k.
- The Commitment of Expenditure Exceeding Chief Executive limit / business justification template will be updated and used for expenditure over £500k.
- For a period of 12 months all items approved by the CEO in the range of £250k to £500 will be reported through the Trust finance report to ensure that the Board is sighted on the range and types of items that have been approved.
- Oracle Finance Ledger will need to be updated to reflect changes in line with Table B above ensuring consistency of delegated Financial Limits is applied across the Trust systems and processes.

## 4. IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** |
|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:<br>YES - Select Relevant Goals below |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety, and experience ☒ |

| | |
|---|---|
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)** | 08 - Trust Financial Investment Risk<br>Financial Sustainability and Long-Term Value. |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>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: | |
| If yes select the relevant goals:<br>• A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities. ☒ | |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| | **Source of Funding**:<br>Other (please explain)<br><br>Please explain if 'other' source of funding selected:<br><br>As outlined in Appendix 1 there are risks identified which could impact on the financial position of the Trust. |

| | |
|---|---|
| **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. |

**5. RISKS**

| | |
|---|---|
| **ARE THERE RELATED RISK(S) FOR THIS MATTER** | No |

# TRUST BOARD

## People and OD Policies and Processes

| | |
|---|---|
| **DATE OF MEETING** | 30 January 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** | Amanda Jenkins, Acting Assistant Director of Workforce |
| **PRESENTED BY** | Amanda Jenkins, Acting Assistant Director of Workforce |
| **APPROVED BY** | Sarah Morley, Executive Director of Organisational Development & Workforce |
| **EXECUTIVE SUMMARY** | This paper provides an overview of updates made to Workforce and OD Policies, bringing them up to date with current employment legislation and best practice. |
| **RECOMMENDATION / ACTIONS** | Trust Board are asked to accept the polices and changes for approval or adoption in the Trust. |

| **GOVERNANCE ROUTE** | |
|---|---|
| **List the Name(s) of Committee / Group who have previously received and considered this report:** | **Date** |
| People and OD Policy Review Group | 17/12/2024 |

**SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS**

The People and OD Policy Review Group has been set up as a systematic way to review the accuracies of POD polices and ensure they are complaint with recent legislation and changes in employment law. The group also considered the importance of only having written control documents that are relevant, intentional, and impactful for staff. Detailed feedback on each policy is included in the body of the paper.

EMB – Endorsed for approval.
QSP – Endorsed for approval, pending completion of the EQIA date being added to the cover paper.

| APPENDICES | |
|---|---|
| 1 | Reviewed – Employing Ex Offenders and People with a Criminal Record Policy |
| 2 | New – Medical and Dental T&C Annual Leave Policy |
| 3 | NHS Wales Job Evaluation Policy and Procedure |
| 4 | NHS Wales Pregnancy Loss Support Policy |
| 5 | NHS Wales Procedure for Recovery of Overpayments |

## 1. SITUATION

This paper provides an overview of updates made to Workforce and OD Policies, bringing them up to date with current employment legislation and best practice.

## 2. BACKGROUND

The new systematic review process is in place within the Trust and the following have been reviewed by the People and OD Policy Group on 17th December 2024, for legislative and best practice compliance.

## 3. ASSESSMENT

3.1 The following are the changes or additions to current policies to bring them up to date with current legislation and best practice that Trust Board are asked to approve:

3.1.1 Employing Ex Offenders and People with a Criminal Record Policy

- Comprehensive review made to bring the policy up to date with legislation and best practice in collaboration with Safeguarding advisors for the Trust.
- Policy Group accepted the amendments with no significant feedback to be considered.

3.1.2 Annual Leave Policy for Medical and Dental

- New policy developed at the request of Medical and Dental Staff and TU colleagues at the BMA.

- The policy has been developed to align with the Agenda for Change Policy but incorporate the key differences in Terms and Conditions of Service for Medical and Dental Staff within the Trust.
- The BMA have requested the organisation also included the statement that staff should not have leave related to a significant life event (i.e. a wedding) declined. This however has not been included for fairness and consistency with other Terms and Conditions across all staff group.
- Policy Group considered if developing a separate policy for terms and conditions that contractually exist was relevant and intentional but also accepted this has been developed on request of staff and BMA.

3.2 The following are new or amended All Wales Polices to be endorsed by EMB for adoption by the Trust:

3.2.1 NHS Wales Job Evaluation Policy and Procedure

- Newly Developed National Policy

3.2.2 NHS Wales Pregnancy Loss Support Policy

- Newly Developed National Policy

3.2.3 NHS Wales Procedure for Recovery of Overpayments

- Newly Developed National Policy.

3.3 It is proposed the following policies and procedures are archived as they are no longer required or have been superseded buy alternative documents:

3.3.1 Policy to Ensure Consistency of National Terms and Conditions

- This policy was developed with the specific intention to ensure consistency of Job Evaluation process when organisations in NHS Wales merge
- This policy will no longer be required if the NHS Wales Job Evaluation Policy and Procedure is adopted within the Trust

3.3.2 Velindre NHS Trust's Recovery of Overpayments Policy

- This policy is a local policy to be replaced by the NHS Wales Recovery of Overpayments Policy if adopted within the Trust.

## 4. SUMMARY OF MATTERS FOR CONSIDERATION

Trust Board are asked to accept these changes and approve the Trust Policies and to adopt the NHS Wales Polices and Procedures.

## 5. IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:<br>YES - Select Relevant Goals below | |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety and experience ☒<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒<br>• A beacon for research, development and innovation in our stated areas of priority ☒<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒<br>• A sustainable organisation that plays its part in creating a better future for people across the globe ☒ | |
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)**<br>*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 ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>Patient Centred ☒ |

| | |
|---|---|
| | Having well designed and values driven People Policies will support the Trust to ensure fairness and inclusion by outlining the responsibilities of both employer and employee. Having well-articulated and clear directions for staff will can impact motivation, organisation reputation and the ability to attract and retain talent, creating mutual benefits for employees and organisations as well as providing statutory protections where these are essential for the Trust. |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:**<br>*For more information:*<br>*https://www.gov.wales/socio-economic-duty-overview* | Yes |
| | NA – assessments completed on each policy |

| | |
|---|---|
| **TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT** | A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities |
| | A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation |
| | A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health |
| | A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| **EQUALITY IMPACT ASSESSMENT**<br>*For more information:*<br>*https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx* | Yes - please outline what, if any, actions were taken as a result |
| | Each policy has undergone an EQIA in line with the statutory requirements of assessing policy |

| | |
|---|---|
| | impact on Protected Characteristics. None of the polices outlined in this paper required further action. |
| **ADDITIONAL LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Not having well designed people polices could result in further challenge through employment tribunals. |

## 6. RISKS

| | |
|---|---|
| **ARE THERE RELATED RISK(S) FOR THIS MATTER** | Yes - please complete sections below |
| **WHAT IS THE RISK?** | TAF 01 - There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.<br>TAF 03 - There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.<br>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.<br>TAF 06 - There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives. |
| **WHAT IS THE CURRENT RISK SCORE** | Various as outlined on the Trust Assurance Framework |
| **HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?** | Having well designed and values driven People Policies will support the Trust to ensure fairness and inclusion by outlining the responsibilities of both employer and employee. Having well-articulated and clear directions for staff will can |

| | |
|---|---|
| | impact motivation, organisation reputation and the ability to attract and retain talent, creating mutual benefits for employees and organisations as well as providing statutory protections where these are essential for the Trust. |
| **BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?** | NA – Specific risks aligned to the strategic Trust risks and reviews as part of the Trust Assurance Framework |
| **ARE THERE ANY BARRIERS TO IMPLEMENTATION?** | Yes - please detail below |
| | Ensuing the right people are able to review and comment on the policy development. This will hopefully be mitigated by a new systematic review process that will commence in September 2024. |
| **All risks must be evidenced and consistent with those recorded in Datix** | |

**Ref: WF19**

# POLICY FOR EMPLOYING EX-OFFENDERS AND PEOPLE WITH A CRIMINAL RECORD

| | |
|---|---|
| **Executive Sponsor & Function** | Director of Organisational Development and Workforce |
| **Document Author:** | Assistant Director of Workforce |
| **Approved by:** | Trust Board |
| **Approval Date:** | TBC |
| **Date of Equality Impact Assessment:** | 12th August 2024 |
| **Equality Impact Assessment Outcome:** | No Impact - Approved |
| **Version:** | Version 4 |

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## 1. POLICY STATEMENT

Velindre University NHS Trust provides equality of opportunity for all job applicants with the required qualifications, experience skills, knowledge and personal qualities as outlined in the job description and person specification for the post. Therefore, the Trust welcomes applications from a diverse range of applicants, including ex-offenders and those with a spent or unspent criminal record.

In accordance with the Rehabilitation of Offenders Act 1974, an applicant's criminal convictions will only be taken into account during the recruitment process, where it is relevant to the post applied for. As the Trust has an exemption order under the above Act, any cautions, reprimands or final warnings, which are not criminal convictions, will also be considered as part of this process.

Having a conviction will not necessarily prevent applicants from being appointed to posts within the Trust. This will depend on the nature of the post that the applicant has applied for and the circumstances and background to their offence(s).

## 2. SCOPE OF POLICY

This policy applies to all applicants who apply for a post within the Trust. As the Trust has an exemption order, which overrules the employment rights of ex-offenders, as outlined in the Rehabilitation of Offenders Act 1974 i.e. they do not have the right to conceal information in respect of spent convictions when applying for jobs within the National Health Service (NHS). All applicants are therefore required to disclose on their application form, any information regarding spent or unspent criminal convictions, cautions, bind overs, reprimands or final warnings.

The Trust uses the Disclosure and Barring Service (DBS), as part of its recruitment process to help it to assess the suitability of applicants appointed to posts, which will require them to work with vulnerable groups, including children in the course of their normal duties, or those to be employed in a financial role.

Please visit the Government website for further information on this service:

https://www.gov.uk/disclosure-barring-service-check/overview

Velindre University NHS Trust is an equal opportunities employer, which is committed to the fair treatment of all job applicants, regardless of their;

- Age
- Convictions Background (criminal or otherwise)
- Ethnic Origin
- Gender Identity
- Gender
- Physical or Mental Disability
- Race
- Religion / Belief
- Responsibilities for Dependants
- Sexual Orientation

The Trust is committed to not discriminating unfairly against any applicant, where they disclose an unspent or spent criminal conviction, a caution, bind over, reprimand or final warning.

All candidates shortlisted for interview will be selected on the basis of their qualifications, experience, skills, knowledge and personal qualities as specified in the post's job description and person specification. The declaration of a conviction etc. will not necessarily prevent applicants from being shortlisted for interview or appointed to a post within the Trust. Conviction information will only be considered, to determine the candidate's suitability in respect of the post applied for.

## 3. RESPONSIBILITIES

### 3.1 Recruiting Manager

The recruiting manager has a responsibility to ensure that they are up to date with the recruitment and selection guidance and processes.

**If the recruiting manager wishes to consider an applicant who has disclosed a conviction, caution, bind over, reprimand or final warning they must undertake a risk assessment, to assess the relevance of the conviction etc. against the post the individual is applying for. This risk assessment must be considered and signed off by the relevant Head of Service / Director before an offer of employment is made. In such circumstances advice should be sought from the People and OD Department.**

### 3.2 People and OD Department

The People and OD Department is required to:

- Provide accurate and up to date advice on the legislation and principles that govern the recruitment and selection process for ex-offenders and individuals with a criminal record.
- Ensure that managers have adequate information, guidance and support to fulfil their role in the fair recruitment and selection of staff.

## 4. REHABILITATION OF OFFENDERS ACT 1974

The Rehabilitation of Offenders Act was introduced to help restore the reputation of individuals who had been convicted of an offence but have since reformed and not committed any further offences. The Act specifies the period of time that an offender is required to disclose previous convictions etc., including when applying for a job. The Act was extended to cover police cautions in 2008. (A caution is considered to be spent as soon as it is given).

Amendments to the Rehabilitation of Offenders Act 1974 were also made by the Legal Aid, Sentencing and Punishment of Offenders Act 2012 in England and Wales and came into effect during March 2014. This Act changed the way some rehabilitation

periods are set, so that they are fairer and better to reflect the seriousness of the sentences imposed.

Details of specific sentences / periods are set out within ***Appendix 1*** of this policy.

### 4.1 EXCEPTIONS ORDER 1975

There is an Exceptions Order within the Act, which sets out when the non-disclosure of an offence does not apply. The Order covers posts that involve particular risks, such as those working with vulnerable children or adults within the healthcare sector and financial services. Where applicants are applying for a post that will require them to work with vulnerable patients or deal with financial matters they are required to disclose all their previous convictions, whether they are 'spent' or 'unspent'. A list of Excepted Professions, Offices, Employment and Work is set out in ***Appendix 2***.

The majority of Trust posts are exempt from the Act, as this legislation sets out that:

"Where a post is concerned with the provision of health services and it is of such of a kind that requires the post holder to have access to persons in receipt of healthcare services, in the course of their normal duties"

*Extract based on wording taken from the Exceptions Order (1975)*

In such instances the applicant is required to disclose 'spent' as well as 'unspent' convictions on their application form.

Should applicants require any additional information regarding how this act applies to their application, they should contact their local Probation Officer, Citizen Advice Bureau, solicitor, or consult the Home Office's rehabilitation document: https://assets.publishing.service.gov.uk/media/653f7e52d10f3500139a6b20/30102023__Guidance_on_the_Rehabilitation_of_Offenders_Act_1974_and_The_Exceptions_Order_1975.pdf

## 5. DISCLOSURE

To ensure that all job applicants are familiar with the Trust's policy in relation to disclosure of convictions etc. all job advertisements will clearly state if a Basic, Standard, Enhanced or Enhanced with barred lists DBS Check is a requirement for the post. The NHS Wales application form will also contain a statement that will inform applicants that they are required to disclose any unspent or spent criminal convictions, cautions, bind overs, reprimands or final warnings, as part of the recruitment process.

## 6. USE OF DISCLOSURE INFORMATION

The Trust provides recruitment interview training for all of its managers, which covers the Rehabilitation of Offenders Act 1974 and the DBS Code of Practice, in relation to employing ex-offenders. Managers are also provided with relevant information regarding this aspect of the recruitment process in the Trust's policy and procedure for

dealing with disclosure of a criminal background for those employed to work with patients and children. This training and information ensures that all interview panel members are able to identify and assess the relevance of convictions, cautions, reprimands and final warnings and explore the circumstances and background sensitively of such convictions etc. with candidates who are shortlisted for interview.

Where an applicant discloses information regarding convictions etc. on their application form, the Trust will ensure that this information is treated confidentially and only divulged to those who need to access it for recruitment processes i.e. interview panel members and People and OD Department.

The lead Interview panel member will conduct a DBS risk assessment (***Appendix 4***) with any candidates made a conditional offer to explore the circumstances and background to their conviction etc. and their rehabilitation, to assess their suitability for employment in the post.

## 7. WITHDRAWING AN OFFER OF EMPLOYMENT

It is against the law to refuse someone a job because they have got a spent conviction or caution, unless it is because the DBS check shows that they are unsuitable for the post they have applied for (see Exemptions ***Appendix 2***).

Where an applicant has a conviction, caution, bind over, reprimand or final warning and they fail to disclose this information on their application form, it could result in the withdrawal of an offer of employment

The Trust reserves the right to withdraw an offer of employment following a Disclosure and Barring Service (DBS) check (Standard or Enhanced), where it reveals a conviction etc. which renders the appointee unsuitable to work directly or indirectly with vulnerable patients / children or a finance related post.

In such circumstances, the lead interview panel member will contact the appointee to discuss the information divulged in the DBS Check and explain why the offer of employment is being withdrawn.

In accordance with the Rehabilitation of Offenders Act (1974) Exception Order, all applicants are required to disclose information in respect of unspent and spent convictions, cautions, reprimands and final warnings on their application form. Where applicants fail to disclose this information and it is later found that they have a conviction, etc. it could result in disciplinary action, including dismissal.

## 8. EQUALITY IMPACT ASSESSMENT STATEMENT

The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment (EQIA) and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership) race, disability, sexual orientation, Welsh language, religion or belief, gender, transgender, age or other protected characteristics.

The assessment found that there was no impact to the equality groups mentioned and this policy will have a positive impact on all of the ‘protected characteristic’ groups where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

## 9. GETTING HELP

Further information and support is available from your divisional People and OD Department.

**APPENDIX 1**

**REHABILITATION PERIOD PER SENTENCE**

| Sentence or disposal | Rehabilitation period if aged 18 or over when convicted or disposal administered | Rehabilitation period if aged under 18 when convicted or disposal administered |
|---|---|---|
| • Sentence of imprisonment for life<br><br>• Sentence of imprisonment, youth custody, detention in a young offender institution or corrective training of over four years for a schedule 18 offence<br><br>• Sentence of preventive detention<br><br>• Sentence of detention at His Majesty's pleasure<br><br>• Sentence of custody for life | These sentences are excluded from rehabilitation and so will always be disclosed | These sentences are excluded from rehabilitation and so will always be disclosed |
| • Public protection sentences* (imprisonment for public protection, detention for public protection, extended sentences of imprisonment or detention for public protection and extended determinate sentences for | | |

| Sentence or disposal | Rehabilitation period if aged 18 or over when convicted or disposal administered | Rehabilitation period if aged under 18 when convicted or disposal administered |
|---|---|---|
| dangerous offenders)<br><br>*A public protection sentence (the provisions for which are set out in Part 12 of the Criminal Justice Act 2003 and Part 8 of the Armed Forces Act 2006 means a sentence of imprisonment or detention, as detailed above, imposed for specified sexual and violent offences. | | |
| A custodial sentence of more than 4 years (not for a schedule 18 offence) | The end of the period of 7 years beginning with the day on which the sentence (including any licence period) is completed | The end of the period of 42 months beginning with the day on which the sentence (including any licence period) is completed |
| A custodial sentence* of more than 1 year and up to, or consisting of, 4 years | The end of the period of 4 years beginning with the day on which the sentence (including | The end of the period of 2 years beginning with the day on which the sentence (including |

| Sentence or disposal | Rehabilitation period if aged 18 or over when convicted or disposal administered | Rehabilitation period if aged under 18 when convicted or disposal administered |
|---|---|---|
| | any licence period) is completed | any licence period) is completed |
| A custodial sentence of 1 year or less | The end of the period of 12 months beginning with the day on which the sentence (including any licence period) is completed | The end of the period of 6 months beginning with the day on which the sentence (including any licence period) is completed |
| Removal from His Majesty's service | The end of the period of 12 months beginning with the date of the conviction in respect of which the sentence is imposed | The end of the period of 6 months beginning with the date of the conviction in respect of which the sentence is imposed |
| A sentence of service detention | The end of the period of 12 months beginning with the day on which the sentence is completed | The end of the period of 6 months beginning with the day on which the sentence is completed |

| Sentence or disposal | Rehabilitation period if aged 18 or over when convicted or disposal administered | Rehabilitation period if aged under 18 when convicted or disposal administered |
|---|---|---|
| A severe reprimand or reprimand under the Armed Forces Act 2006 | The end of the period of 12 months beginning with the date of the conviction in respect of which the sentence is imposed | The end of the period of 6 months beginning with the date of the conviction in respect of which the sentence is imposed |
| Driving endorsements | 5 years from the date of conviction | 2 years 6 months from the date of conviction |
| Driving disqualification | When the period of the disqualification has passed | When the period of the disqualification has passed |
| Simple caution, youth caution** | Spent immediately | Spent immediately |
| Conditional caution, youth conditional | 3 months or when caution ceases to have effect if earlier | 3 months or when caution ceases to have effect if earlier |

| Sentence or disposal | Rehabilitation period if aged 18 or over when convicted or disposal administered | Rehabilitation period if aged under 18 when convicted or disposal administered | |
|---|---|---|---|
| caution, diversionary caution** | | | |
| A fine | The end of the period of 12 months beginning with the date of the conviction in respect of which the sentence is imposed | The end of the period of 6 months beginning with the date of the conviction in respect of which the sentence is imposed | |
| A compensation order | The date on which the payment is made in full | The date on which the payment is made in full | |
| Absolute discharge | Spent immediately | Spent immediately | |
| Relevant orders*** (orders that impose a disqualification, disability, prohibition or other penalty) | The end date given by the order or, if no date given, 2 years from the date of conviction - unless the order states 'unlimited', 'indefinitely' or 'until | The end date given by the order or, if no date given, 2 years from the date of conviction - unless the order states 'unlimited', 'indefinitely' or 'until | The end date given by the order or, if no date given, 2 years from the date of conviction - unless the order |

| Sentence or disposal | Rehabilitation period if aged 18 or over when convicted or disposal administered | Rehabilitation period if aged under 18 when convicted or disposal administered | |
|---|---|---|---|
| | further order' as in these cases it will remain unspent | further order' as in these cases it will remain unspent | states 'unlimited', 'indefinitely' or 'until further order' as in these cases it will remain unspent |

*Suspended custodial sentences are treated the same as custodial sentences for this purpose. It will be the length of the sentence imposed by the court, not the period it is suspended for that dictates when it will become spent.

**Diversionary cautions and community cautions were introduced under the PCSC Act 2022 and are due to come into force in 2024.

***Relevant orders include:

1. community and youth rehabilitation orders,
2. conditional discharge orders,
3. hospital orders,
4. bind overs,
5. referral orders,
6. care orders, and
7. earlier statutory orders and
8. any order imposing a disqualification, disability, prohibition, penalty, requirement or restriction, or is otherwise intended to regulate the behaviour of the person convicted.

Source: https://www.gov.uk/guidance/rehabilitation-periods (Updated 28/10/2023)

**N.B.** Sentences exceeding 4 years are never spent. In such cases it is the sentence imposed by the court which is relevant and not the length of time actually served in prison / young offenders institution. A sentence counts in the same way, whether an individual is actually sent to prison or the sentence is suspended.

Where an individual received two or more prison sentences in the course of the same court case, the rehabilitation period depends on whether the sentences are ordered to take effect **concurrently** *(at the same time)* or **consecutively** *(one after the other)*.

For example, if two, six month sentences are to be served concurrently, the convictions are treated separately, giving each conviction a rehabilitation period of seven years (aged 18 years and over).

If the sentences are to be served consecutively, they are treated as a single term of 12 months, with a rehabilitation period of 10 year (aged 18 years and over).

*Source: The Liberty Guide to Human Rights – Spent Convictions and the Rehabilitation of Offenders (2002)*

**APPENDIX 2**

**EXCEPTED PROFESSIONS, OFFICES, EMPLOYMENTS AND WORK**
**Listed below are the relevant excepted NHS professions set out in the Act:**

- Medical practitioner;
- Chartered accountant, certified accountant;
- Dentist, dental hygienist, dental auxiliary;
- Nurse, midwife;
- Ophthalmic optician, dispensing optician;
- Pharmaceutical chemist;
- Any profession to which the Professions Supplementary to Medicine Act 1960 applies and which is undertaken following registration under that Act;
- Registered osteopath;
- Registered chiropractor; or
- Chartered psychologist.

**Listed below are the relevant NHS excepted offices, employment and work set out in the Act:**

Any employment or other work which is concerned with the provision of care services to vulnerable adults and which is of such a kind as to enable the holder of that employment or the person engaged in that work to have access to vulnerable adults in receipt of such services in the course of his normal duties.

Any employment or other work which is concerned with the provision of health services and which is of such a kind as to enable the holder of that employment or the person engaged in that work to have access to persons in receipt of such services in the course of his normal duties.

**APPENDIX 3**
**VELINDRE NHS TRUST**
**Guidance on Posts Requiring Disclosure and Barring Service Checks**

| **POST** | **Enhanced Check** *(With Barred List -Regulated Activity)* | **Enhanced Check** *(Without Barred List)* | **Standard Check** | **No DBS Check Required** |
|---|---|---|---|---|
| Administrative Staff (Ward/clinical area based – including co-ordinating clinics) | | | **YES** | |
| Administrative Staff (Not based on a ward/clinical area) | | | | **NONE** |
| Allied Health Professionals (Other allied health professional staff who practice healthcare) | **YES** | | | |
| Biomedical Scientists (With patient contact) | **YES** | | | |
| Biomedical Scientists (No patient contact) | | | | **NONE** |
| Clinic Collection Assistants | **YES** | | | |
| Clinic Support Assistants | **YES** | | | |
| Clinical Scientists (With patient contact) | **YES** | | | |
| Clinical Scientist (No patient contact) | | | | **NONE** |
| Catering Staff (Required to work on ward/clinical area(s)) | | | **YES** | |

| POST | **Enhanced Check *(With Barred List Regulated Activity)*** | **Enhanced Check** *(Without Barred List)* | **Standard Check** | **No DBS Check Required** |
|---|---|---|---|---|
| Catering Staff (Not Required to work on ward/clinical area(s)) | | | | **NONE** |
| Counsellors | **YES** | | | |
| Dieticians | **YES** | | | |
| Drivers (Not required to transport patients) | | | | **NONE** |
| Drivers (Required to transport patients) | **YES** | | | |
| Estates and Maintenance Staff (Required to work on / have access to ward/clinical area(s)) | | | **YES** | |
| Estates and Maintenance Staff (Not required to work on / have access to ward/clinical area(s)) | | | | **NONE** |
| Finance Staff (Chartered / Certified accountants) | | **YES** | | |
| Finance Staff (undertaking administrative related finance work) | | | | **NONE** |
| Healthcare Science Practitioners (with patient contact) *Formerly known as MTOs* | **YES** | | | |

| POST | Enhanced Check ***(With Barred List Regulated Activity)*** | Enhanced Check *(Without Barred List)* | Standard Check | **No DBS Check Required** |
|---|---|---|---|---|
| Healthcare Science Practitioners (No patient contact)<br>*Formerly known as MTOs* | | | | **NONE** |
| Healthcare Support Workers | **YES** | | | |
| Healthcare Support Workers (WBS Laboratories no patient contact) | | | | **NONE** |
| Housekeeping Staff (Required to work on ward/clinical area(s)) | | | **YES** | |
| Housekeeping Staff (Not required to work on ward/clinical area(s)) | | | | **NONE** |
| Management Staff (Required to work or access ward/ clinical area(s))/patient contact. | | | **YES** | |
| Management Staff (Not required to work or access ward / clinical area(s)). | | | | **NONE** |
| Medical Secretaries | | | **YES** | |
| Medical Record Staff (Required to visit wards/clinical areas/patient contact) | | | **YES** | |
| Medical Record Staff (Not required to visit wards/clinical areas) | | | | **NONE** |

| **POST** | **Enhanced Check** *(With Barred List Regulated Activity)* | **Enhanced Check** *(Without Barred List)* | **Standard Check** | **No DBS Check Required** |
|---|---|---|---|---|
| Medical Staff | **YES** | | | |
| Nurses (Qualified | **YES** | | | |
| Nurses (Unqualified) | **YES** | | | |
| Occupational Therapists | **YES** | | | |
| Pharmacists | **YES** | | | |
| Pharmacy Technical Officers (With direct patient contact) | **YES** | | | |
| *Assistant* Pharmacy Technical Officer (With direct patient contact) | **YES** | | | |
| Phlebotomists | **YES** | | | |
| Psychologists | **YES** | | | |
| Porters (Who are involved in transferring patients) | | | **YES** | |
| Porters (Not involved in transferring patients) | | | | **NONE** |
| Physiotherapists | **YES** | | | |
| Radiographers | **YES** | | | |
| Scientists (With patient contact) | **YES** | | | |
| Security Staff | | **YES** | | |
| Speech and Language Therapists | **YES** | | | |

| POST | Enhanced Check *(With Barred List Regulated Activity)* | Enhanced Check *(Without Barred List)* | Standard Check | No DBS Check Required |
|---|---|---|---|---|
| Volunteers (Not required to work on ward / clinical area(s)) | | | | **NONE** |
| Volunteers (Required to provide personal care to patients) | **YES** | | | |
| Volunteers (Required to assist with shopping for patients) | **YES** | | | |
| Volunteers (Required to transfer patients) | | | **YES** | |

**STANDARD CHECKS**

A standard check contains details of both spent (old) and unspent (current) convictions, including cautions, reprimands and final warnings held in England and Wales on the Police National Computer (PNC). Most of the relevant convictions in Scotland and Northern Ireland may also be included.

**Eligibility for Standard Checks**

Employers may carry out standard level DBS Checks to assess a person's suitability for work listed in the Exceptions Order i.e. where the type of work enables the person to have *'access to persons in receipt of such services in the course of [their] normal duties*'. The term 'access' only relates to where individuals have direct, physical contact with patients as part of their day to day activities; it does not include positions where there is no contact with patients. **Please note** that positions that purely involve having access to records are not covered under the terms of the Exceptions Order and therefore employers cannot obtain a standard or enhanced DBS Check for these positions

**ENHANCED CHECKS**

An enhanced check contains the same information as a standard check but also includes any non-conviction information held by local police, where they consider it to be relevant to the post. This information is referred to as 'approved information' on the enhanced check certificate.

There are two levels of enhanced check – an enhanced disclosure check for regulated activity i.e. *with* barred list information (Regulated Activity) and an enhanced disclosure *without* barred list information.

**Eligibility for Enhanced Checks *For Regulated Activity*** (is work that involves close and unsupervised contact with vulnerable groups including children, and which cannot be undertaken by a person who is on the Disclosure and Barring Services Barred List)

Individuals seeking work in a regulated activity position must be checked against the DBS lists of those barred from working in regulated activity. This check is accessed through the process of applying for an Enhanced DBS Check for regulated activity.

**Eligibility for an Enhanced DBS Check**
Following recent changes to the eligibility criteria, there are some positions which are no longer eligible for an enhanced disclosure *with* a barred list check. Employers may continue to obtain an enhanced DBS check i.e. *without* a barred list check for those positions that were previously eligible under the Safeguarding Vulnerable Groups Act (SVGA) before 10 September 2012 but no longer fall within the new definition of regulated activity.

**APPENDIX 4**

**DBS RISK ASSESSMENT FORM**

## DBS RISK ASSESSMENT

This risk assessment should be completed by the recruiting manager, with support from the People and OD team. The candidate should be given an opportunity to fully explain any convictions that they have prior to commencement in post.

### PART A – EMPLOYEE / APPLICANT DETAILS

| Applicant Details and Appointed Post Information | | | |
|---|---|---|---|
| Name | Click or tap here to enter text. | | |
| Job title on appointment | Click or tap here to enter text. | | |
| Contracted Hours | Full-time ☐<br>Part-time ☐ | If part-time please state the number of contracted hours per week | 00.00 Hrs Per Week |
| Division / Organisation | Click or tap here to enter text. | Department | Click or tap here to enter text. |
| Expected Start Date | Click or tap to enter a date. | | |
| Level of DBS required for post | Choose an item. | | |

| Pre-screening Commencement in Post<br>Please see note 1 below | | |
|---|---|---|
| **To be completed for commencement in post that requires a DBS check, prior to a certificate being returned** | | |
| Did the applicant declare any criminal convictions on their application form? | Yes ☐ | No ☐ |
| If Yes, please provide details of the offence: | | |
| Click or tap here to enter text. | | |
| Have you obtained satisfactory employer references? | Yes ☐ | No ☐ |
| Does the individual have a DBS from a previous employer that is less than 3 years old? | Yes ☐ | No ☐ |
| Will the role require regular unsupervised contact with children or vulnerable adults? | Yes ☐ | No ☐ |

| | | |
|---|---|---|
| Are you able to reduce unsupervised contact with patients or donors until the DBS certificate has been returned? | Yes ☐ | No ☐ |
| Please provide details of how you can reduce this contact: | | |
| Click or tap here to enter text. | | |
| **Convictions noted on DBS certificate**<br>**Please see note 2 below** | | |
| **To be completed prior to commencement in post when a conviction has been noted on the DBS certificate** | | |
| Did the applicant declare any criminal convictions on their application form? | Yes ☐ | No ☐ |
| Do the details on the DBS certificate represent what the candidate declared on their application form? | Yes ☐ | No ☐ |
| Please provide detail of the conviction (see note 2) | | |
| Click or tap here to enter text. | | |
| Are the convictions relevant to the work the candidate will be undertaking? | Yes ☐ | No ☐ |
| Have employer references been obtained for the candidate that explore their suitability to undertake the role? | Yes ☐ | No ☐ |
| Please provide summary of references and periods covered | | |
| Click or tap here to enter text. | | |
| Has the candidate worked in a similar role to the one they will be undertaking, since committing the offence? | Yes ☐ | No ☐ |
| Does the role require regular unsupervised contact with children or vulnerable adults? | Yes ☐ | No ☐ |
| If yes, does the returned disclosure inform that the candidate is barred from working with children or vulnerable adults? | Yes ☐ | No ☐ |
| | | |
| | | |

**PART B – APPOINTING OFFICER DECISION**

| | | | |
|---|---|---|---|
| Please outline your decision to move forward. | Click or tap here to enter text. | | |
| ***I confirm the decision has been made to the best of my knowledge as the recruiting manager given the information presented to me at the time of the risk assessment.*** | | | |
| Name | Click or tap here to enter text. | | |
| Position Title | Click or tap here to enter text. | | |
| Signed | | Date | Click or tap to enter a date. |

| **People and OD Support Officer** | | | |
|---|---|---|---|
| Name | Click or tap here to enter text. | | |
| Position Title | Click or tap here to enter text. | | |
| Signed | | Date | Click or tap to enter a date. |

**A record of this risk assessment should be retained on the employee's file**

In cases where the candidate commences in post prior to a DBS certificate ensure this risk assessment is regularly reviewed until the DBS certificate is returned.

Ymddiriedolaeth GIG Felindre Velindre NHS Trust

## Ref: XX

# Annual Leave and Bank Holiday Policy and Procedure (Medical Terms and Conditions)

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| | |
|---|---|
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| **Document Author:** | Head of People & OD and Medical, People and OD Business Partner |
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## 1. INTRODUCTION

Annual leave is an important wellbeing entitlement, which is encouraged to be taken by all employees to assist them to achieve a healthy balance between their work and home life. The Trust recognises that the effective management of annual leave by individual employees and line managers is essential to the health, safety and well-being of our employees and the ability of the Trust to continue to deliver high quality services which meet the requirement of its service users.

There is a requirement to provide a statutory minimum amount of annual leave each year. However, National Health Service (NHS) employers want to reward and retain high quality, hard working staff and therefore, offer an enhanced annual leave entitlement. Whilst it is important to book annual leave at regular intervals for adequate rest breaks, it is also recognised that annual leave requests may be declined due to operational requirements. In these cases, managers will be mindful of providing as much notice as possible and will seek to be as flexible as possible with the employee.

## 2. AIMS AND OBJECTIVES

The aim of this document is to provide guidance on how to manage annual leave and bank holiday entitlements, including when transferring or leaving the organisation, and the provisions relating to the carrying over of annual leave due to absence from work.

## 3. SCOPE

This document provides a consistent, fair and equitable approach to the management of annual leave and bank holiday entitlements for all Medical Workforce employed within Velindre University NHS Trust.

It does not vary any contractual terms which apply but provides clarity and consistency in the way these terms are applied in Velindre University NHS Trust.

## 4. ROLES AND RESPONSIBILITIES

### 4.1. Individual Employee Responsibilities

Individual Employees are responsible for:

- Ensuring that their annual leave is planned and where possible taken at regular intervals throughout the leave year, subject to approval and the needs of the service.
- Ensuring that where staff work shifts, weekends and bank holidays, they request their annual leave (which includes their bank holiday entitlement) generally proportionate to these working arrangements. To minimise any disproportionate effect on any job planned activities, annual leave periods should reflect a proportion of Direct Clinical Care (DCC), Supporting Professional Activities (SPA) or other commitments as agreed between the employee and management.
- All leave must be requested via the appropriate Trust Leave System (i.e. Intrepid, Codi or ESR Systems) typically providing a minimum of 6 weeks' notice, prior to taking such approved leave. Subject however to suitable arrangements having been made, doctors may take up to two days of their annual leave without seeking formal permission provided that they give notification beforehand to the Medical Directorate Manager. It is possible for shorter notice periods for leave

requests to be approved by Medical Directorate Manager, pending suitable alternative arrangements being made to cover service needs.

- Annual Leave Systems should be completed (and authorised by management) within 72 hours of the employee's return to work for short notice periods of leave.
- Ensuring that the Bank Holiday process below is followed.
    - Bank Holidays are included in all employee's annual leave entitlement balances, therefore any bank holidays not worked (that falls on employees normal working day needs to be booked off as leave in the same way as annual leave.
    - Staff should, where possible, book these days in Annual leave systems as early as reasonably possible, but in any event no later than the actual bank holiday date(s).
    - If an employee as part of their normal working pattern, works, or as part of their shift pattern may be required to work on any part of a bank holiday, between the hours of midnight and 9 am on a statutory or public holiday, they are not required to book this day(s) off on annual leave systems. Where an employee is required to work or be on-call on a bank holiday they are entitled to take the equivalent of their bank holiday day off, at another time. By not booking their Bank Holiday entitlement off on annual leave system (Intrepid) in advance this ensures that the corresponding number of hours are available within the employee's annual leave allowance to be taken at another time.
    - It is an employee's responsibility to ensure Annual leave and Bank Holiday leave is being booked on annual leave systems and that they maintain accurate records and it is their managers responsibility to be accountable for ensuring this compliance. If an audit shows that records are repeatedly not up to date, both the employee and their line manager may be asked to explain the reason.

Please Note: *The Bank Holiday entitlement may vary each year depending on when Easter falls and therefore will be calculated accordingly.* 2 sets of Easter bank holiday dates may fall in the same annual leave year, resulting in one year having more bank holidays and the next one having fewer.

### 4.2. Managers Responsibilities

Managers are responsible for:

- Working with their employees to ensure that they appropriately manage their annual leave throughout the leave year and ensuring that they apportion their leave so they can have regular rest breaks across the year.
- Calculating the annual leave entitlement for those staff employed on part-time contracts; reaching a number of years' service during the annual leave year to increase entitlement; those who have requested to change their contracted sessions during the annual leave year. In these circumstances, the manager is responsible for recalculating and uploaded to annual leave system (Intrepid), checking the accuracy of the leave calculation.
- Checking that where a bank holiday(s) fall on an employee's normal working day and they are not required to work it, that the leave has been requested and approved. Should an employee not book a bank holiday(s), the manager will bring this matter to their attention immediately and request that they submit retrospective and if appropriate prospective bank holiday leave requests. Where



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this becomes a regular pattern and a cause for concern, the manager should seek advice from the People and OD Department.

- Approving annual leave requests in a timely manner when an employee submits it through the annual leave system (Intrepid). Until leave is approved on the annual leave system (Intrepid) it will not be deducted from the employee's annual and bank holiday leave total, resulting in an inaccurate entitlement.
- Ensuring that employees take the minimum statutory leave per year, in accordance with the Working Time Regulations (advice on this can be sought from People and OD Department).
- Encouraging staff to use their full contractual entitlement to support and promote their health and wellbeing.
- Ensuring service delivery is maintained by arranging appropriate cover for staff on annual leave. This may mean that managers have to decline annual leave requests where it would have an extreme negative impact on the service, or not agreeing to colleagues in the same team, taking their leave at the same time.
- Ensuring that where staff work shifts, weekends and bank holidays, they request and take their annual leave (which includes their bank holiday entitlement) generally proportionate to these working arrangements.
- To minimise any disproportionate effect on any job planned activities, annual leave periods should reflect a proportion of DCC, SPA or other commitments as agreed between the employee and management. If this occurs, managers will speak to staff to discuss reasons and agree an outcome that takes account of business and personal needs.

## 5. BOOKING LEAVE AND COMPLIANCE

### 5.1 Annual Leave Year

The annual leave year for medical staff are set out in the respective Terms and Conditions of Service. If you have any queries, please consult People and OD Department. The annual leave year will run from the employee's anniversary of the date of appointment.

### 5.2 Annual Leave Entitlements

Annual Leave entitlements for medical workforce are set out in Appendix 1.

Part Time (PT) employees will be entitled to a pro-rata share of the whole-time equivalent annual leave and bank holiday entitlement (as defined in Appendix 1)

For practical purposes the management of annual leave for all employees is to book and take their annual leave in Weeks or Days; or where necessary hours. Their leave application will be based on the actual time worked in the week/ day in line with doctors normal working patterns.

Please Note: The calculation of annual leave and bank holiday entitlements is pro rata for part time staff to the exact figure and will not be rounded up or down. With the exception of the first year of employment, when leave is rounded to the nearest half. If the amount of leave that has accrued in a particular case includes a fraction of a day other than a half day, that fraction must be treated as a half day if it is less than a half day, and as a whole day if it is more than a half day

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**5.3 Bank Holiday**
There are normally 8 bank holiday days per year: Good Friday, Easter Monday, May Day, Spring Bank Holiday, August Bank Holiday, Christmas Day, Boxing Day and New Year's Day. Where additional public/statutory holidays days are sanctioned these will be added to bank holiday entitlements.

Please Note: The Bank Holiday entitlement may vary each year depending on when they fall and therefore will be calculated accordingly.

To ensure consistency and equal allocation of bank holidays for all employees the Trust also converts this element of leave into days/ hours (pro – rata for part time workers) which are then added to an employee's overall annual leave entitlement. This will result in a deduction of days/ hours, equivalent to those that would have been worked, from the employee's aggregated entitlement on each bank holiday that falls on a scheduled working day, on which they are not required to work.

Staff who are not rostered to work on a bank holiday but agree to do so on a voluntary basis, will be entitled to be paid Additional Duty Hours (ADH). They are not however, entitled to an additional day off in lieu, as this day is already added into their annual leave / bank holiday entitlement and can therefore be taken off on an alternative date as set out in paragraph 4.1 above.

If a bank holiday falls on a day that is uncontracted (not a scheduled working day) this day is not taken out of an individual's entitlement.

**5.4 Calculation of Annual Leave**
Annual Leave entitlements for medical workforce are set out in Appendix 2.

**5.5 Entitlement on Joining the Trust**
Medical workforce will receive full entitlement on commencement of employment with the Trust as, set out in the respective Terms and Conditions of Service. The annual leave year will run from the employee's anniversary of the date of appointment.

Medical workforce will receive Bank holidays entitlement on commencement of employment with the Trust, pro rata, as they fall.

**5.6 Booking Annual Leave and Bank Holiday Leave**
Staff should book annual leave or bank holiday leave, according to the number of weeks, days (hours if necessary) they would have been due to work during the contracted shift or working day on which they wish to take leave.

Different calculation methods may be employed: each method should ensure that leave for both full time and part time staff is fair and equitable. Any calculation must be based on an individual's specific work commitment. See appendix 2 for examples.
Calculations will be based on a notional day of 2 sessions (3.75 hours per session) for Consultants and (4-hour sessions) for SAS and 8-hour day for doctors in training.

The simple examples in appendix 2 should cover most scenarios, however more detailed calculations could be done from any member of the Medical People and OD Department with a more complex work scenarios.

### 5.7 Entitlement on Termination from the Trust

Employees who leave the Trust will be entitled to the pro-rata of their annual leave entitlement for each completed day worked in the current leave year, plus any bank holidays entitlement based on bank holidays that have occurred prior to leaving.

Please note - Managers must remember to deduct any annual leave and bank holidays already taken. If, due to the needs of the service, the balance of annual leave cannot be taken or where the amount of leave taken exceeds the entitlement on leaving, adjustments to the individual's final salary will be made.

### 5.8 Transferring to another post within the same Trust (Velindre University NHS Trust)

Both positive and negative annual leave balances will be carried with the individual when they transfer to another post within the Trust. Prearranged leave would need to be discussed with the manager on point of transfer. This would not be unreasonably refused, although it will be determined based on service need.

### 5.9 Outstanding Leave on Termination from the Trust

The manager will work with the employee to ensure that all outstanding annual leave is taken before their termination date, where possible.

Where an employee has been absence from the workplace for an extended period of time i.e. long term sickness or maternity/adoption/shared parental leave and would have accrued annual leave entitlement, that they have been unable to take, the Trust will make a payment for any outstanding leave owed to the employee as set out in the respective policies. Advice from the People and OD Department needs to be sought in all cases of this nature.

### 5.10 Carry Over of Annual Leave

#### 5.10.1 Normal circumstances

Employees are responsible for managing their annual leave throughout the leave year, ensuring that they take regular annual leave for rest breaks across the whole year.

Subject to the urgent needs of the Service up to a maximum of 5 days (pro rata) can be carried forward on application and approval by the line manager to be taken in the following leave year. Any one-off exceptions to this, will be agreed by the Executive Management Team and communicated as appropriate.

#### 5.10.2. Long Term Sickness Absence

Where staff return from long term sickness absence, they should be expected to take any outstanding leave within the current leave year. This should be managed carefully, taking account of the needs of the service and the practicalities of the employee being able to use up all of their entitlement in that leave year.

Employees on long term sick leave will be given the opportunity to take annual leave during their sick leave period. Please refer to Trust Managing Attendance at Work Policy.

Where the employee has not taken their annual leave entitlement during the period of sickness absence, and the sickness absence spans two or more leave years, they will accrue annual leave for the period of their sick leave. A discussion will take place with the line manager to mutually agree how to plan and take all of their accrued, but untaken annual leave as soon as reasonably possible after their return to work. However, there are provisions that where this is



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not possible to take an employee can carry over into subsequent leave years (however it must generally be used within 18 months from the end of the leave year in which they accrued it). If more advice is required, please refer to People and OD Department. This carryover of annual leave is based on the statutory entitlement of 20 days if working full time, and pro rata for part time staff.

The leave entitlement for the previous year/years will be the statutory element (20 days) of their leave not their full contractual annual leave and bank holidays.

Where an employee returns to work in a new leave year, after a period of long term sickness absence, they are entitled to carry over the statutory element of their leave, in line with Trust Managing Attendance at Work Policy. Managers need to remember to deduct any annual leave and/or bank holidays that they took before or during their period of sickness absence.

Any annual leave accrued, at the time of the return to work, may also be taken to extend an agreed phased return to work i.e. whereby a phased return to work is extended beyond the expected maximum of 6 weeks period (in line with the Trust Managing Attendance at Work Policy).

**5.11 Sickness Occurring during Annual Leave**

When an employee falls sick during annual leave they will be required to report that episode of sickness in line with normal notification procedures and produce a fit note covering the period from the first day of sickness (in line with Section 7 of the Trust Managing Attendance at Work Policy).

In order to allow annual leave to be reinstated a medical fit note needs to be received within 3 working days of the beginning of the illness (unless abroad). In such cases the employee will be deemed to have been on sickness absence rather than annual leave from the date of the certificate.

Only in exceptional cases will a foreign medical certificate of more than one month be accepted for payment purposes. A United Kingdom fit note should be obtained on return to the country.

**5.12 Maternity/ Adoption and Parental Leave**

**5.12.1. Annual Leave**

Annual leave will continue to accrue during all forms of paid and unpaid parental leave, as set out in the NHS Terms and Conditions of Service. Managers are encouraged to discuss with employees prior to their leave and reach agreement where possible when they will take said leave. Employees are encouraged to take any outstanding annual leave due to them before the commencement of Occupational Maternity Leave / adoption or parental leave, or towards the end of the leave period, if the leave period falls within the current annual leave year and there is sufficient time to take this leave. It should be noted that the provisions relating to the carry forward of annual leave will apply equally to staff on all forms of parental leave.

Employees returning to work on reduced hours are encouraged to take any accrued annual leave either prior to the commencement of all forms of parental leave or prior to their return.

Employees not intending to return to work following all forms of parental leave should take any outstanding annual leave prior to commencement of that leave. The date of termination of service will then be calculated as the last working day plus any outstanding annual leave days, plus the full parental leave period.



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As statutory paternity leave is shorter in length, the above provisions do not apply, with exception that leave will continue to accrue during periods of paternity leave.

**5.12.2. Accrual of Bank Holidays**
In accordance with the Maternity and Parental Leave Regulations 2008, employees are entitled to accrue bank holidays (pro rata) that fall during their parental leave. Please refer to the Maternity, Adoption, Paternity and Parental Leave Policy for further information.

**5.13 Annual Leave Entitlement on Changing Contracted Sessions/ Hours**
Where employees change their contracted sessions/ hours, this will result in a re-calculation of their annual leave entitlement based on completed days on the new and the old contracted sessions/ hours to give the full year entitlement. Depending on the change, the annual leave entitlement may go up or go down. This will be a manual calculation and then this will be recorded on Trust Annual leave Systems (Intrepid), managers should however check the accuracy of this calculation. Please note this does not apply for Ad Hoc ADH/ locum shifts.

If a reduction in contracted sessions/ hours results in leave being overtaken, (where this does not reduce below statutory entitlement) a discussion should be had with the line manager regarding unpaid leave or an agreement to work back the time.

**5.14 Annual Leave Entitlement for Term-time Working**
An employee who wishes to work term time will have their annual leave and bank holiday entitlement annualised, and the entitlement included in their salary payments, over the period of the year.

Please liaise with the Medical People and OD Department and/or Trust's Payroll Department, should you wish to see your calculations.

**5.15 Annual Leave Entitlement for Annualised Hours Working**
An employee who wishes to work annualised hours are asked to liaise with Medical People and OD Department to calculate entitlement.

## 6. BANK HOLIDAYS FALLING ON SATURDAY OR SUNDAY
When any of the Christmas /New Year bank holidays falls on a Saturday or Sunday arrangements will be made to ensure that the right of staff to receive the official bank/ public holidays are preserved. The Trust will communicate this, as relevant, on the years that it applies.

## 7. SICKNESS OCCURRING DURING A BANK HOLIDAY
Employees will not be entitled to an additional day where an employee's sickness absence falls on a Bank Holiday (which was not a rostered work day and booked as leave),

Please refer to the Managing Attendance at Work Policy for further information Statutory Entitlements during long term sickness absence.

## 8. ANNUAL LEAVE WHEN UNDER SUSPENSION

Medical Workforce, please refer to the Upholding Professional Standards in Wales Section 2.25.

## 9. PURCHASE OF ANNUAL LEAVE

The Trust operates an Annual Leave Purchase Scheme, which provides staff with the opportunity to apply to purchase additional annual leave, with the associated cost being deducted from their salary on a monthly basis, if approved. The purchase of additional annual leave is subject to certain conditions and is at the line manager's discretion. Please refer to the Trust's Purchase of Annual Leave Scheme Procedure.

## 10. EQUALITY IMPACT ASSESSMENT STATEMENT

The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees, reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment (EqIA) and received feedback on this document and the way it operates. The EqIA has been undertaken to identify and address any possible or actual negative impact that this document may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership) race, disability, sexual orientation, Welsh language, religion or belief, gender, transgender, age or other protected characteristics.

The assessment found that there was no impact to the equality groups mentioned and this policy will have a positive impact on all of the 'protected characteristic' groups. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

## 11. GETTING HELP

Further information and support is available from your Medical People and OD Department.

NWSSP staff should refer any queries to nwssp.hrcontactpoint@wales.nhs.uk.

## 12. RELATED POLICIES

Recovery of Overpayments Policy;
Purchase of Annual Leave Scheme;
Managing Attendance at Work Policy;
Maternity, Adoption, Paternity and Parental Leave Policy;
NHS Wales Medical and Dental Handbook.
Special leave policy

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## APPENDICES

## APPENDIX 1 - ANNUAL LEAVE ENTITLEMENT – MEDICAL WORKFORCE

### Table 2: Annual Leave Entitlement (Complete Year) for Medical Workforce Exclusive of Bank Holidays.

(Please note this is full time equivalent, for part time staff this would be pro rata)

| Annual Leave Entitlement by Grade | Annual leave entitlement | Date of Leave Year | Notes |
|---|---|---|---|
| Consultant (pre-2003 contract) | 6 weeks | Anniversary of start date | |
| Consultant (2003 contract) | 5 weeks (+ 4 days in Wales) | Anniversary of start date | |
| Specialist (2021 contract) | 6 weeks (+ 4 days in Wales) | Anniversary of start date | |
| Specialty doctor (2008 contract) | 5 weeks for first 2 years, 6 weeks in subsequent years (all +4 days in Wales). | Anniversary of start date | A newly appointed specialty doctors will be entitled to 6 weeks leave immediately if previous post carried 6 weeks entitlement |
| Specialty doctor (2021 contract) | 5 weeks for first 2 years, 6 weeks in subsequent years (all +4 days in Wales). | Anniversary of start date | A newly appointed specialty doctors will be entitled to 6 weeks leave immediately if previous post carried 6 weeks entitlement |
| Junior Doctors: Foundation year 1, Foundation year 2 and StRs, StR(FT)s and SpRs on the minimum, 1st or 2nd points of the payscale | 5 weeks (+3 days in Wales) | Anniversary of start date | |
| Junior doctors: StRs, StR(FT)s and SpRs on the 3rd or higher points of the payscale | 6 weeks (+3 days in Wales) | Anniversary of start date | |
| Junior Clinical Fellows | 5 weeks (+3 days in Wales) | Anniversary of start date | Locally agreed terms see contract (mirrors the trainee contract) |
| Senior Clinical Fellows | 6 weeks (+3 days in Wales) | Anniversary of start date | Locally agreed terms See contract (mirrors the trainee contract) |

Dependent on individuals Terms & Conditions, medical workforce are entitled to additional days leave (which include the 2 previous statutory days which were awarded in lieu of pay increase):

- Consultants and SAS Doctors 3 days
- All Other Grades 2 days

In addition to the above addition - Annual Leave entitlement increased by an additional day per annum following Pay Circular AFC, M&D & ESP (W) 01/2021 issued in December 2021

- Consultants and SAS Doctors additional 1 day
- All other Grades additional 1 day

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## APPENDIX 2 – ANNUAL LEAVE CALCULATION EXAMPLES – MEDICAL WORKFORCE

### Example 1 – Full Time (FT) worked over Part Week.

Facts

- Consultant works 10 sessions a week over Tuesday-Friday

Adjust the total number of days of annual leave to reflect the length of the working week. If a consultant works 10 sessions a week over Tuesday-Friday with no on-call or weekend working, then their annual leave allowance could be calculated follows:

4 days x 6 weeks = 24 days per year (plus 3.2 days to account for the additional 4 days entitlement adjusted to the 4 day week (4 working days x 0.8 of a week = 3.2 days).

Total 24 +3.2 = 27.2 days

The consultant would then need to use four days of annual leave to be absent from the hospital for one week.

### Example 2 – Part Time (PT) calculation

(For the purposes of the example the sessions are recorded as half days as this is the unit used on the Trusts Annual Leave System (Intrepid)

Facts

- Part-time consultant works 6 half days over 4 days;

Monday and Tuesday's – 2 half days per day;
Wednesday and Thursday's – 1 half day per day.

Annual leave allowance is 6 half days (0.5) x 6 weeks = 36 half days year plus pro rata of the additional 4 days entitlement to account for the pro rata'd working week and half days (4 days x 0.6 of the week = 2.4 days = 4.8 half days)

Totals is 36 plus 4.8 half days. For ease of understanding, this would equate to a total of 40.8 half days or 20.4 days.

For recording purposes leave on Trusts leave System (Intrepid), the employee would book either 1 day on a Monday or Tuesday and half day on a Wednesday or Thursday depending on the working day the annual leave falls.

Medical Workforce should book leave in, weeks, days or (hours if necessary), according to the number of days they would have been due to work during the contracted shift or working day on which they wish to take leave. However, this example uses half day blocks as intrepid does not record booked leave in session units, in the electronic system. Where the leave equates to less than a 0.5-day period the corresponding hours can be derived and taken as hours.

**Example 3 – Change of Sessions Part Way Through the Year.**

Facts

- Consultant changes their 10 session to 9.25 sessions.
- Annual leave year starts on 6th July – 5th July.
- The change occurred on the 1st April.

Pro rata annual leave entitlement for 6th July – 31st March at 10 sessions formula is (Yearly entitlement ÷ total No days in the year) x No of days worked up until date of change)

Therefore 5 days x 6 weeks plus 4 extra days = 34 days full time entitlement for a year, to pro rata this to the 'part year entitlement' you use the formula (Yearly entitlement ÷ total days in the year) x No of days worked up until date of change) 34 days ÷ 365 days x 270 days = 25.15 days

Pro rata entitlement for second part of the year 1st April – 5th July at 9.25 sessions is (no. of P/t sessions 9.25 ÷ full time sessions 10 x full time entitlement 34 = 31.45 days per year) for part year entitlement, remaining days worked of the year 95 days (31.45 ÷*365 x 95 = 8.18 days)*

Total entitlement for the year after the change of sessions is 25.15 +8.18 days = 33.33 days.

Plus Bank Holiday Entitlement

Calculation Of Bank Holiday Entitlement (Part Year)
Formula: No. of Bank Holiday Days Entitlement in Pro Rata Period x Part time weekly contracted sessions ÷ Full time Weekly Contracted Sessions (10)

5 bank holidays fell between 6th July – 31st March
(Aug, Christmas, Boxing Day, New Year's Day, Good Friday – 5 days)
5 x 10 sessions / 10 sessions = 5 days
3 bank holidays fell between 1st April – 5th July (Easter Sunday, Whitsun, May Day -3)
3 x 9.25 /10 = 2.77 days

Total Bank Holiday entitlement 5 +2.77 = 7.77 days per year

**Example 4 – Termination of Contract**

Facts

- Consultant who works 37.5 hours per week leaves the Trust on 27th July
- Works 22 ½ hours per week (6 sessions).
- Annual leave year starts on 1st April

Formula is (A x B) - C

A - period of leave to which worker is legally entitled to in a full holiday year *(yearly entitlement).*
B is the proportion of the year that has expired before termination *(number of days worked divided by 365 would give you the proportion of the year)*
C is the period of leave already taken by the worker between start and finish date in the leave year.

Annual Leave

A. 22.5/37.5 x34 gives yearly entitlement = 20.4 days
B. 118 days proportion / 365 = 0.323 (30 April,31 May,30 June,27 July =118)
   (AxB) 20.4 x0.323 = 6.59 days
C. Manager to check with medical staffing for leave already taken.

Bank Holidays

Calculation Of Bank Holiday Entitlement (Part Year)
Formula: No. of Bank Holiday Days Entitlement in Pro Rata Period x Part time weekly contracted sessions ÷ Full time Weekly Contracted Sessions (10)

4 bank holidays fell between 1st April – 27th July
(April x 2 Good Friday, Easter Monday, and May x 2 May Day, Spring Bank Holiday = 4 days)

4 x 6 sessions / 10 sessions = 2.4 days

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## APPENDIX 3 – GLOSSARY OF TERMS

| | |
|---|---|
| NHS | National Health Service |
| DCC | Direct Clinical Care |
| SPA | Supporting Professional Activities |
| ESR | Electronic Service Record |
| OD | Organisational Development |
| ADH | Additional Duty Hours |
| SAS | Specialist and Specialty Doctors |
| EqIA | Equality Impact Assessment |
| NWSSP | NHS Wales Shared Services partnership |
| StR | Specialty Trainee Registrar |
| SpR | Specialty Registrar |
| FT | Full time |
| PT | Part time |

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# Job Evaluation
# Policy and Procedure

Fforwm Partneriaeth Cymru
Welsh Partnership Forum

GIG Cymru yn Gweithio mewn Partneriaeth
NHS Wales Working in Partnership

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# Section 1

# Policy scope, principles and benefits

## 1.Introduction

This policy has been developed in line with the nationally agreed NHS Job Evaluation Scheme

Introduced in 2004, the scheme is used to determine the pay bands for all staff on AfC contracts and relies on consistent application within organisations and across the service. The scheme is based on fairness and equality in line with equal pay legislation and is a continuing requirement as organisations develop new services and roles and incorporate the job evaluation process into procedures, particularly, but not exclusively, organisational change and service improvement.

The Job Evaluation Handbook contains guidance on interpreting and applying the AfC JE scheme and National Job Profiles, which have been developed nationally and approved by the executive on behalf of Staff Council.

This policy and procedure will set out the requirements for fulfilling the scheme across Wales to ensure a consistent approach across organisations.

## 2.Policy statement

NHS Wales is committed to the fair and consistent application of the Agenda for Change (AfC) NHS job evaluation scheme (JE) both at national and local organisation level.

This is in line with the commitment of employers, trades union representatives and Welsh Government to work in partnership to maintain a fair and consistent NHS pay system which supports NHS Service modernisation and delivery and meets the reasonable career aspirations of staff.

## 3.Scope

This policy applies to all staff employed under Agenda for Change terms and conditions of service

## 4.Principles

The aim of this policy is to ensure that all NHS Wales organisations are consistent in their application of the national job evaluation scheme. In addition, the policy sets out the process for approval and application of NHS Wales Job Descriptions where they are available and the review of these job descriptions on a three yearly cycle.

# Section 2

## 5. Governance Arrangements

All employers in NHS Wales are required to ensure they have effective systems and arrangements in place to discharge their AfC responsibilities. They are accountable for ensuring compliance with AfC policy and the NHS Wales Job Evaluation Scheme Handbook.

Specific actions include –

- Working in partnership at a local level with an appointed Management and Staff Side Job Evaluation Lead (see annex 1). Organisations should provide facilities time to staff side leads to enable them to participate in JE lead work. This does not include sitting on panels which should be treated in the same way as management JE panel members.
- Provide suitably funded job evaluation support who can provide guidance and administration of the job evaluation processes.
- Have trained job evaluation trainers to provide training in the various job evaluation packages (see annex 2).
- Have an appropriate number of both management and staff side trained JE practitioners in matching, analysis, evaluation and consistency checking.
    - Management practitioners can be anyone who is not representing a union.
    - Staff practitioners do not need to be, accredited trade union representatives, but they should be employed by their local organisation and be nominated by and accountable to their local trade union branch and/or staff side. When sitting on panels staff side practitioners should not use facilities time but be released from their substantive role in the same way a management practitioner is.
- Ensure appropriate records and information is kept on CAJE (Computer Aided Job Evaluation System) to be able to provide
    - Local and NHS Wales monitoring and consistency checking of activity.
    - Robust notes on decisions and audit trails that would stand up in legal proceedings.

# 6. Job Descriptions

## 6.1. NHS Wales Approved National Job Descriptions

NHS Wales Job Descriptions are intended to ensure consistency in role descriptions for key roles across NHS Wales organisations. The aim of this is to facilitate movement and progression, together with ensuring equal pay for equal value within and across organisations. As these form part of National terms and Conditions, where an NHS Wales approved job description is in place, organisations must use this Job Description for relevant roles. These Job Descriptions will be subject to review on a minimum 3-year cycle to ensure they are up to date. These are available through the Wales Job Evaluation web pages https://www.nhsconfed.org/wales/nhs-wales-employers/job-evaluation and will be added to as NHS Wales job descriptions are developed.

## 6.2. Job Descriptions

An NHS Wales Job Description Template has been developed to -

- address attraction and recruitment challenges arising from overly lengthy job descriptions that didn't really identify what the job was about
- Aid in sharing approved job descriptions across Wales
- Increase the creation of NHS Wales Job descriptions

Where an NHS Wales approved Job Description is not available, the Job Description template must be used for all new job descriptions and/or when a job description is used for recruitment purposes. All AfC staff must have an up to date and agreed job description that describes the role, and the tasks required of them to carry out their job. It should not be about the individual person in the role. It is the means by which our employees understand what has to be achieved and can be used to determine criteria by which their performance

will be assessed. There is guidance on writing job descriptions in the Introduction to Job Evaluation and Writing Job Descriptions guide.

### 6.3. Organisation Job Descriptions

Where NHS Wales Approved Job Descriptions are not suitable for particular roles, organisations may have their own library of generic job descriptions which can be used. Again, these should be on the NHS Wales Job Description Template and should be subject to a three-year review to ensure they are still fit for purpose.

### 6.4. Individual Job Descriptions

It is important to remember that where there is no suitable NHS Wales or organisation job description then job descriptions for individual roles should be developed, remembering that this is for the role and not the person in the role.

### 6.5. Reviewing Job Descriptions to ensure they are up to date

All staff must have the duties that they undertake reviewed against their job description on an annual basis as a minimum to ensure they reflect the role to be carried out. Organisations must develop their own local process to undertake this, ensuring it is part of the PADR process and where a job description is more than 3 years old it must be reviewed in full.

Organisations must ensure that members of staff are undertaking the role detailed in their job description. Where this is not the case then organisations must –

- Allocate an appropriately banded job description for the role being undertaken which may involve a re-banding of pay
- Review the wider role in the department which may involve ensuring that the member of staff works to their current job description

It is also important to review the job description when roles are redesigned, changed as a consequence of service redesign, or a vacancy occurs. Organisations must check whether there is an appropriate NHS Wales approved or local job description to fit the role before developing a new job description.

Depending on the level of change to role the following options would be available –

- Identify if there is an NHS Wales Job Description that better matches the role required and the duties being undertaken
- Agree no changes to the job description - no further action
- Agree changes to the job description. The job evaluation team must be consulted to assess the job description in partnership. The outcome will be -
    - Advice that the changes have no effect on the current pay band.
    - Advice that a re-evaluation of pay band is required.

Organisations should have clear processes on how changes to roles will be identified and verified. Any changes must go through the job evaluation process to ensure robust and auditable outcomes

Where job descriptions cannot be agreed there must be an attempt to reach agreement using an early resolution approach. If an agreement cannot be reached and there is no resolution, then employees can choose to use the Wales Respect and Resolution policy.

### 6.6. Re-evaluation of Changed Jobs (Re-evaluation of Pay Band)

Where it is agreed that the demands of the post have changed significantly, a re-evaluation of the post needs to be carried out which should assess the whole job.

The result could be being allocated a NHS Wales Job Description or when none exists by submitting a new agreed job description which details the skills and responsibilities applicable to the post.

If the banding outcome changes as a result of re-evaluation, that change should be backdated to when the postholder and manager agree that the job had changed. This could vary depending on how long the member of staff has been carrying out the duties or the time it has taken to develop and match the new job description. This date should be agreed before the re-evaluation takes place.

Disputes about back-dating should be resolved through local procedures.

## 7. Job Evaluation Process

In order to assign an appropriate pay band to a job description it must go through the job evaluation process. The full process for both job matching, job evaluation and consistency checking is available in the NHS Job Evaluation Scheme Handbook. Procedures should be consistent across Wales for ease of monitoring (see annex 3).

## 8. New and Updated National Job Profiles

From time-to-time new national job profiles are developed or current ones updated via requests from employers and trade unions. Employers will want to prepare for this in advance by ensuring that job descriptions are up to date, and staff are undertaking the duties against the job description. Organisations will need to ensure they have sufficient job evaluation capacity to handle an increase in activity when this occurs.

## 9. Further Advice

The full process for both job matching, job evaluation and consistency checking is available in the NHS Job Evaluation Scheme Handbook.

Further advice can be sought from your local Job Evaluation Leads the NHS Wales Job Evaluation Lead and if required this can be escalated up to the UK Job Evaluation Group (JEG).

## Annex 1

## Outline for Organisation Job Evaluation Scheme Leads

The benefit to the organisation of appointing JE Leads is to ensure the organisation is applying the Job Evaluation Scheme in line with that nationally agreed, which will ensure roles are appropriately banded and the graded scheme is consistently applied.

The role of the Job Evaluation Leads (JE Leads) is to support the organisation to maintain specialist detailed knowledge of the NHS Job Evaluation Scheme and processes. They will be experienced JE practitioners, with one representing management and one representing, and appointed by, a recognised trade unions/staff side in the organisation.

Partnership working is an essential requisite of the JE Scheme, and it is essential that the organisation has a partnership pair of job evaluation leads, together they share the responsibility and ownership of the JE processes and how they operate within the organisation, supports the transparency and integrity of the process.

**Working in Partnership the JE Leads have a joint responsibility to**

- Ensure that nationally agreed good practice guidelines contained in the NHS Job Evaluation Handbook and supplementary guidance sent out by the NHS Staff Council are integrated into the organisation's job evaluation policies and practices.
- Keep up to date on NHS Job Evaluation developments and share recommended practice locally, keeping Job Evaluation practices up to date and relevant to the organisation.
- Work with management and staff side to ensure that Job Evaluation Policies and Procedures are monitored and reviewed in partnership.
- Provide advice and guidance to employees, managers, and accredited staff representatives about good practice in job evaluation process, on all aspects of the scheme and the interpretation of the organisations JE policies. For example, the evaluation of new and changed jobs.
- To ensure that there are adequate numbers of trained job matchers and evaluators to meet the demands of the organisation including keeping an up-to-date register of trained matchers and evaluators.
- Alert the organisation to any failures in process or operation of the JE process which may expose the organisation to equal pay challenges.
- Keep an overview on the management and storage of documentation involved in job evaluation so that a clear audit trail is maintained in the recording of panel decisions and JE processes.
- Have an awareness of the national Job Evaluation Group (JEG) and provide a link to the national group in terms of seeking their technical advice and guidance where required.

**Technical competence**

- Trained in all aspects of the NHS Job Evaluation Scheme including Job Matching, Job Evaluation and Job Analyst and Consistency checking
- Be the technical experts and advise the organisation on the application of the Scheme

- Understanding of equal pay legislation
- Ability to implement and ongoing maintenance of the JES within organisation
- Working knowledge of CAJE or other similar electronic system for storage and audit of outcomes.
- Keep their own technical knowledge up to date by undertaking refresher training as required and accessing NHS Employers websites for up-dates on profiles etc.

**Behavioural competence**

- A commitment to working in partnership and ensuring this is embedded within the organisation's JE Scheme processes
- A commitment and ability to challenge poor practice in order to ensure the credibility and governance of the scheme is maintained.
- Resilience
- Ability to influence others
- Ability to mediate and build consensus when opinions differ
- Ability to work as part of a Team, build local capacity for panels and ensure succession planning
- Ability to maintain confidentiality and to convey the importance of this to those involved in the scheme.

**Skills**

- High level attention to detail
- Ability to analyse a large amount of information and draw conclusions from the data.

**Support for JE Leads**

It is important that JE Leads are given the necessary support and resources to enable them to undertake their roles effectively. This may include, but is not limited to, access to computer systems, administration support, finance to support the individual practitioners training and panel members training.

## Annex 2

## Job Evaluation Training

Organisations need to ensure that staff are trained in the matching, analysis, evaluation and consistency checking processes of the NHS JE Scheme for continuity

Every job evaluation practitioner is required be up to date on current practices, before they take part in local panels/processes.

It is essential that organisations keep a register of names of practitioners and trainers.

JEG has developed a number of courses that cover the full scope of the NHS Job Evaluation Scheme. All courses should be completed in order, as the second, third and fourth courses require attendees to have a level of experience in NHS job evaluation. This training is endorsed by the NHS Staff Council.

In Wales, we have our own trained trainers delivering the JEG courses at a local and national level. There are no costs to organisation other than the release of time for the trainers and the provision of training materials. Each organisation should have its own JE trainers in partnership who will provide training in their own organisation and also assist in training across Wales where needed. By using shared trainers across Wales, it enables training to be provided free of charge.

The following JEG accredited courses are available and can be delivered face-to-face and virtually.

**Stage 1 - Job Matching Course (2 days)**

A course for new and inexperienced members of staff in job evaluation.

Job matching is the main method of undertaking job evaluation (JE) within the NHS.

All practitioners that sit on matching panels should be trained to ensure they understand the scheme and the methodology it uses. As all JE work should be completed in partnership, we try to run this course with equal numbers of management and staff-side representation.

**Stage 2 - Consistency Checking Course (1 day)**

This is a course for those who have already completed the job matching course, with a good understanding of job evaluation and a desire to undertake consistency checking in their organisation.

All job evaluation outcomes must go through consistency checking. This work is often undertaken by the two job evaluation leads, or alternatively, an experienced partnership pair who are up to date in JE practices.

**Stage 3: Job analysis and Job evaluation (2 days)**

This course is course designed for experienced job matchers who will have some understanding of how to assign values across the 16 factors.

On the rare occasion that a role is so specialised and unique that it cannot be matched to a national job profile, it must be fully evaluated. This requires analysis and evaluation by trained practitioners of the job analysis questionnaire that is agreed by the post holder and/or line manager. Most roles match to profiles, so an organisation would not need to train all practitioners in analysis and evaluation, but a select few, experienced practitioners.

**Stage 4: Refresher training (1 day)**

This is a condensed course to be completed by job evaluation practitioners who may need a refresher to remain up to date with job evaluation practices.

**WALES JOB EVALUATION UNIT COURSES**

**CAJE Administrators Course (1/2 Day)**

This course is for those who are responsible for the administration of the Computer Aided Job Evaluation (CAJE) system. All new administrators must attend this course to ensure consistency and good practice across Wales. Having a standard approach to using the system enables organisations to undertake local consistency checks and have a good auditable trail for all job evaluation outcomes.

**Train the Trainer (1 day)**

This course is for experienced JE practitioners to provide JE training in their own organisation and across Wales.

Delegates must have completed the full 2-day job matching training and be experienced in panel work. To deliver the job analysis job evaluation training they must have also completed this course themselves.

Delegates can be either management or staff side job matching practitioners and should be confident in delivering training to an audience and have an engaging interactive aptitude to support all learning types

## Annex 3

## Job Evaluation Process

In order to assign an appropriate pay band to a job description it must go through the job evaluation process.

This should be carried out using the Computer Aided Job Evaluation (CAJE) web-based system. Members of the job evaluation team must be trained to use the system to ensure consistency across Wales and have their own login details. Job descriptions should be numbered with the agreed Wales code which enables organisations and Wales monitoring to easily identify roles. All new job descriptions and re-evaluation of pay bands should be entered onto CAJE as a new job with a new job match reference code e.g. 2024/0012

The following has been taken form the NHS Job Evaluation Scheme where you can find the full processes.

### Job Matching

Job matching is an analytical way of evaluating as many different jobs as possible to nationally evaluated profiles in the most efficient and consistent manner possible. Job matching avoids the need for many local evaluations

- Job matching is carried out by a panel of between three and five representatives comprising both management and staff side, who must have been trained as job matchers in the NHS Job Evaluation Scheme. The majority of roles are expected to match to a national profile.
- Once matched it must be checked for both quality and consistency by two trained JE practitioners in partnership.
- The outcome, including a copy of the matched job report, should be sent to the relevant manager following the local processes and procedures in place. Where there is a job holder in the role the outcome must also be notified to the member(s) of staff, including a copy of the matched job report, details of the proposed pay banding and what to do in case of disagreement.

### Job Evaluation

Local evaluation is much more detailed and thorough than job matching, so it is important to be sure that a local evaluation is necessary before starting the process.

A job will need to be evaluated, where an attempt has been made to match them to one or more national profiles, but this has not proved possible, for example unusual and/or very specialist clinical and non-clinical NHS roles or jobs going through role re-design.

- As part of the full job evaluation process the member of staff (where there is one) and manager compete a job analysis questionnaire (JAQ) which is analysed by two representatives comprising both management and staff side, who must have been trained as job analysts in the NHS Job Evaluation Scheme.

- Once the JAQ has been agreed the job evaluation is carried out by a panel of between three and five representatives comprising both management and staff side, who must have been trained as job evaluators in the NHS Job Evaluation.
- Once evaluated it must be checked for both quality and consistency by two trained JE practitioners in partnership.
- The outcome, including a copy of the evaluation job report, should be sent to the relevant manager following the local processes and procedures in place. Where there is a job holder in the role the outcome must also be notified to the member of staff, including a copy of the evaluation job report, details of the proposed pay banding and what to do in case of disagreement.

**Review Process**

In the event that groups of staff or individuals are dissatisfied with the result of matching or evaluating they may request a review which must be submitted within three months of notification of the original panel's decision.

All reviews must be entered onto CAJE using the original job match reference code and adding an 'R' to the end of the job match reference to indicate it is a review e.g. 2024/0012R

- In order to trigger a review, the jobholder(s) must provide details in writing of where they disagree with the match or evaluation and evidence to support their case. It is good practice for organisations to have a review evidence form listing the factors for the jobholder(s) to complete. Jobholders only need to provide information on the factors where they disagree.
- The review must be carried out in partnership by a panel of between three and five representatives comprising both management and staff side, the majority of whom should be different from the original panel.
- A review panel will –
  - Confirm the same match / evaluation outcome.
  - Confirm a match to a different profile or make a different evaluation. The band can go up or down.
  - Possibility of referring the job for full evaluation (JAQ).

Once the full job evaluation process has been completed the job holder has no right of appeal beyond the review panel if their complaint is about the banding outcome. However, in the event that the jobholder can demonstrate that the process was misapplied they may use the All-Wales Respect and Resolution policy. Where this is upheld, a possible remedy may be to use a new panel or escalate to the Wales Job Evaluation Lead who can arrange for a new panel outside of the organisation.

**NHS Wales Approved/ Shared Job Descriptions**

NHS Wales Approved Job Descriptions do not need to and should not be taken through organisational job evaluation processes.

However, there are occasions where organisations may want to use a job description that hasn't been through their own job evaluation process. For example: There is a job description available that has been through the evaluation process in another NHS Wales organisation and has been agreed for sharing at All-Wales level.

Jobs that have been approved for wider sharing must be uploaded to your own CAJE account and advice has been produced by the NHS Job Evaluation Group (JEG) to support employers when using a job description that has been developed and banded by another organisation. In all these situations the employer must ensure that:

- They are satisfied and can prove that the job matches to a national profile or evaluates at the stated band **AND**
- The outcome is consistent with other jobs within that employer **AND**
- They have an audit trail demonstrating that the pay band can be justified.

Wales has an agreed process for sharing of job descriptions which have been banded by other NHS organisations in Wales (see annex 4). It is important to remember that when adding a Wales or Shared job description to your CAJE account you use the same job match reference to allow for the monitoring of use.

**Updating Job Descriptions**

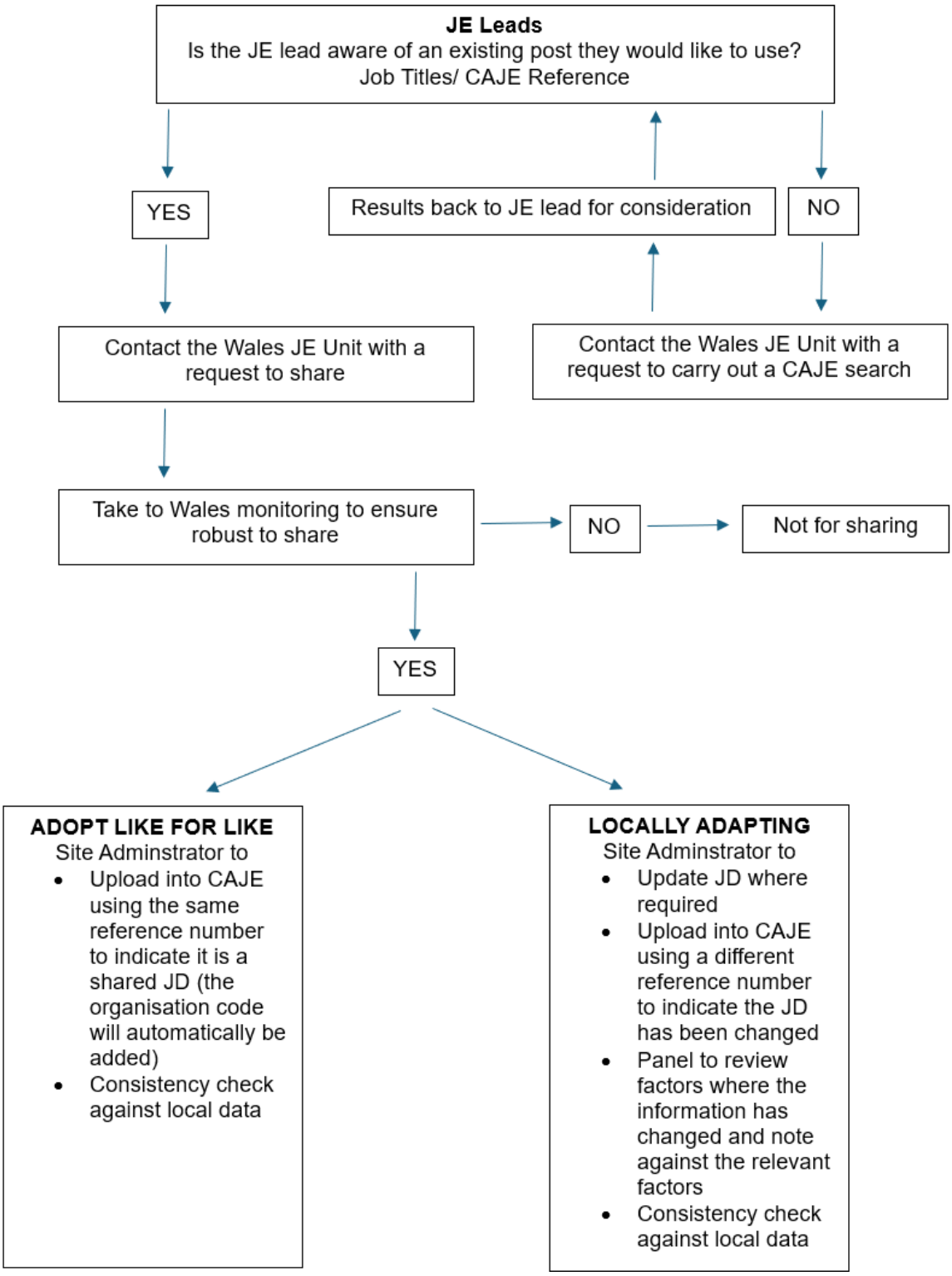
A substantial amount of job evaluation work involves updating/amending job descriptions that have already been matched/evaluated or using a pre-banded job description to develop a new one i.e. basing the job description on one that already has a band outcome.

These must be assessed by the job evaluation team in partnership to see if the changes impact upon the pay band.

The process for dealing with these types of updated/amended jobs can be found in Annex 5.

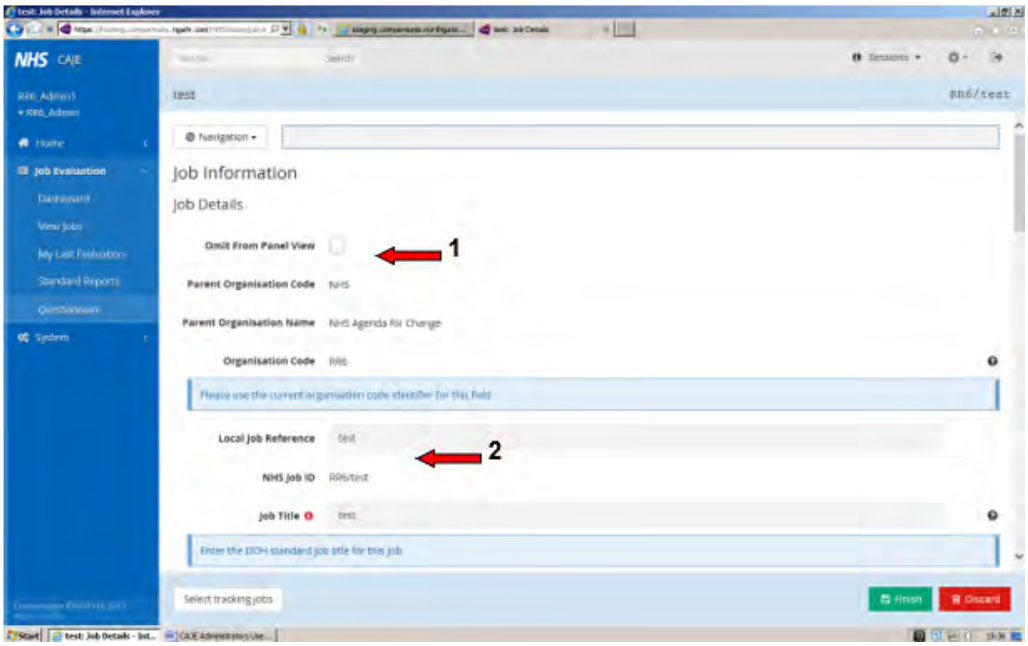
## Annex 4

## Wales Process for Sharing of Job Descriptions



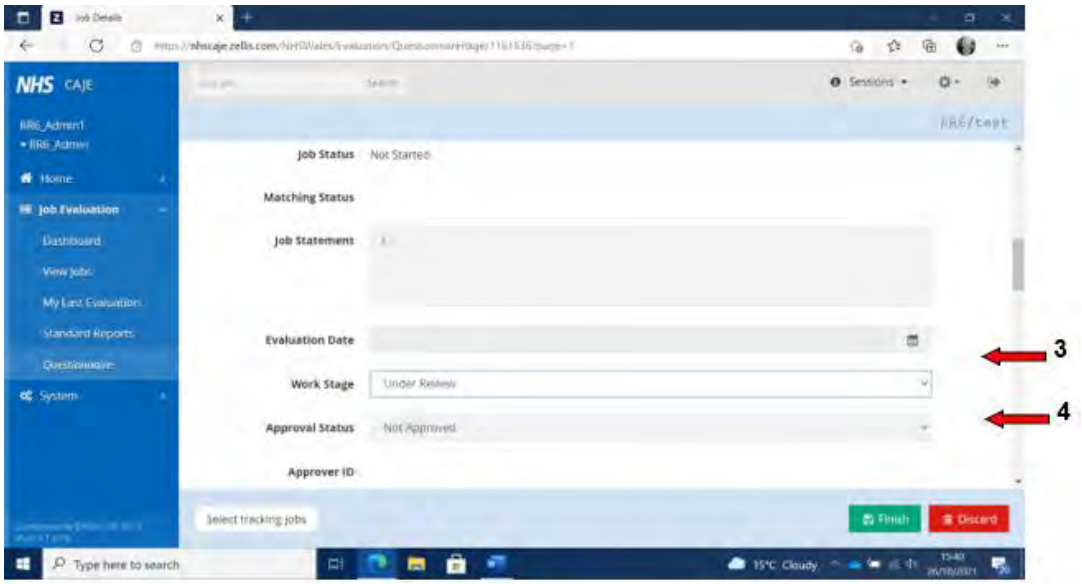
**Adopting the JD Like for Like**

In CAJE add a New Evaluation and complete the Job Details page as you would usually when adding a job but remembering the following:



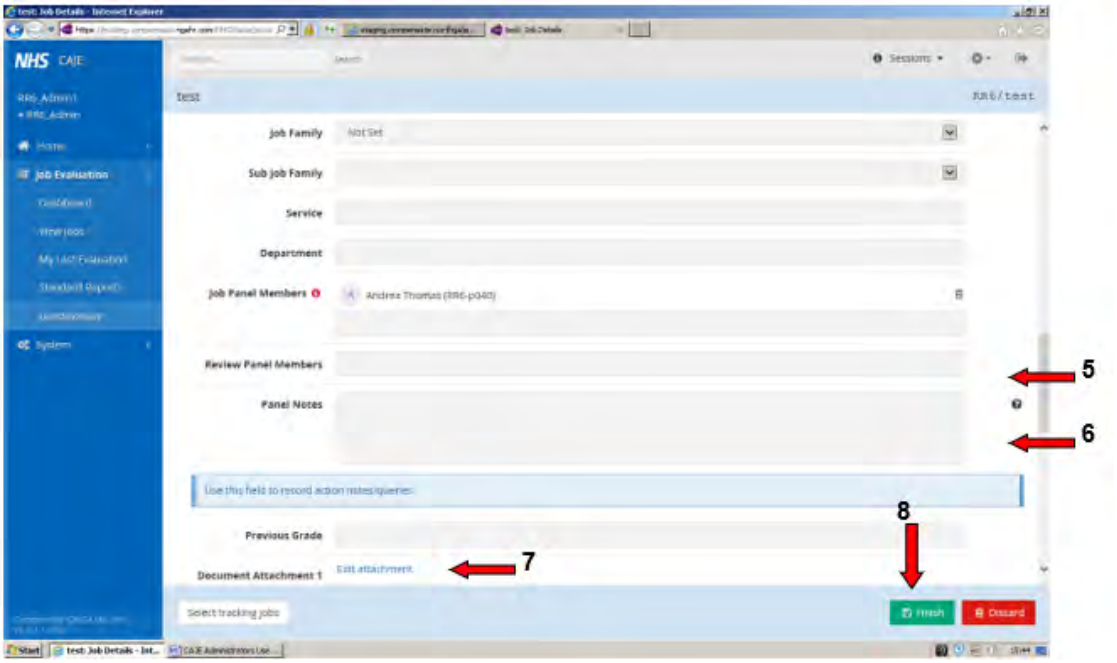

1 Click in the 'Omit from Panel View' box.

2 Add in the same CAJE reference - Please use the same reference code when adding to CAJE. This helps identify it as a shared JD. (Your Org Code will automatically be added by CAJE)




3 The evaluation date should be the date job description was approved for sharing

4 Change both ‘Work Stage’ and ‘Approval Status’ to ‘Approved’



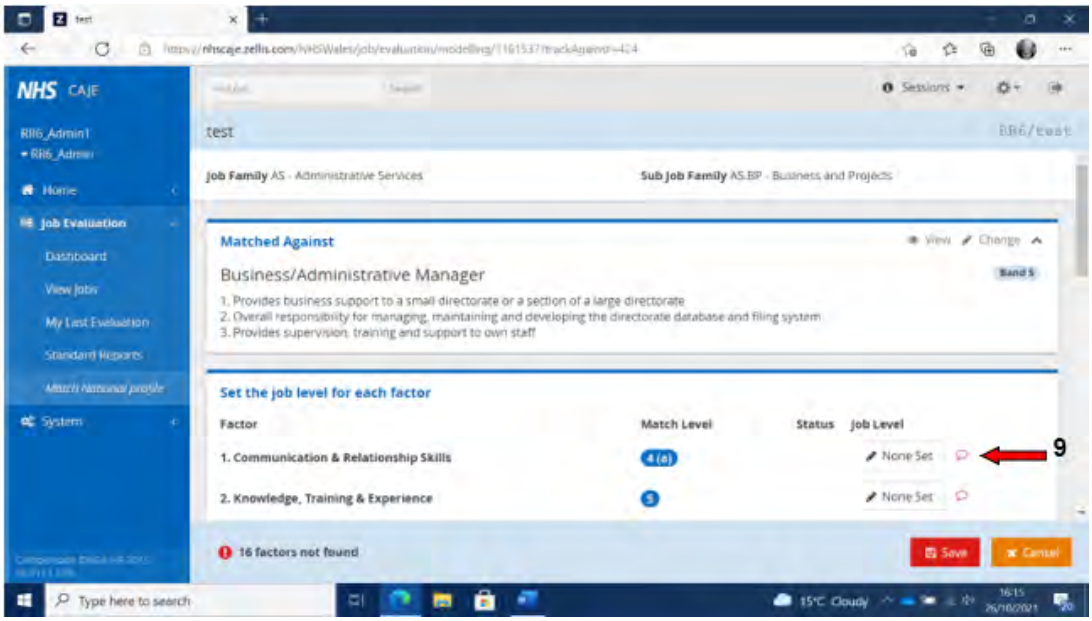

5 Job Panel Members should be the person entering the job onto the system

6 Add a panel note for audit trail e.g., ‘Matched by ABMUHB code RVC/2017/0093 and approved at Wales Monitoring for wider sharing’ or ‘Wales job description CYM/Wales/2024/0003’

7 Upload your JD

8 Finish and proceed to Profile Matching

9 Chose the same profile that was originally used and copy ALL the information and scores from the Job Match report into CAJE as if you were carrying out a job match and save. This is ready for partnership consistency checking against organisation data before release




**Locally Adapting the JD**

Follow the steps above, however as this will be looked at by a panel you will need to –

1 Give the JD your own CAJE reference code because you are changing the JD

2 Enter the panel members details

3 Make a note in the panel notes that the JD has been adapted e.g., 'Matched by ABMUHB code RVC/2017/0093 and adapted for local use'

4 The panel should review the information that has been changed or updated, all other scores should remain the same

5 Once completed and save you should follow through your usual local consistency checking and approval steps.

## Annex 5

## Wales Process for Updated/Amended Job Descriptions

In order to know how many jobs of this type are being processed and to ensure an audit trail the following process should be followed using CAJE.

This process should only be followed where updates and amendments are not significant enough to change the band. This assessment should be carried out in partnership by the job evaluation team.

All jobs that have been updated or amended should use the same job match reference code and add an 'A' to the end of the job match reference to indicate it is an amended job description e.g. 2024/0012A and a number relating to the number of times this original JD has been used.

Only original job descriptions should be used when updating but these can be used several times to create different jobs. Therefore, you may have

- 2024/0012A1
- 2024/0012A2
- 2024/0012A3.

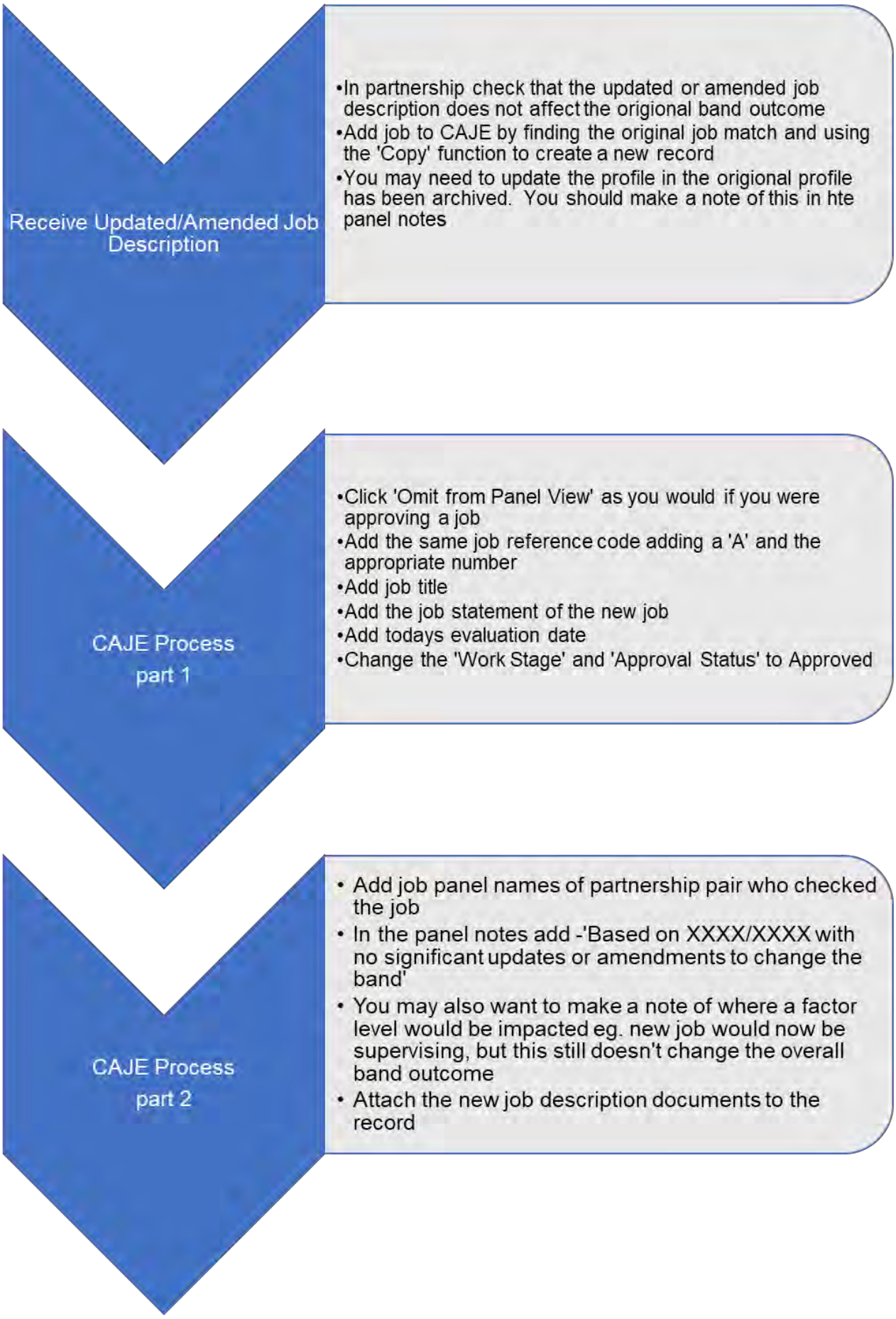
They may or may not have the same job title. For example, Radiology Secretary 2024/0012 may become –

- Radiology Secretary 2024/0012A1
- Rheumatology Secretary 2024/0012A2
- Clinical Secretary Radiology Secretary 2024/0012A3

As an audit trail it is clear to see that job description 2024/0012 has been updated or amended but the changes were not significant enough for it to need matching.

You should not use Rheumatology Secretary 2024/0012A2 as a basis for updating or amending as this is not an original JD. You should refer the manager to Radiology Secretary 2024/0012.

The approval date on the job description should be the date it was checked.


Receive Updated/Amended Job Description
•In partnership check that the updated or amended job description does not affect the origional band outcome
•Add job to CAJE by finding the original job match and using the 'Copy' function to create a new record
•You may need to update the profile in the origional profile has been archived. You should make a note of this in hte panel notes
CAJE Process part 1
•Click 'Omit from Panel View' as you would if you were approving a job
•Add the same job reference code adding a 'A' and the appropriate number
•Add job title
•Add the job statement of the new job
•Add todays evaluation date
•Change the 'Work Stage' and 'Approval Status' to Approved
CAJE Process part 2
• Add job panel names of partnership pair who checked the job
• In the panel notes add -'Based on XXXX/XXXX with no significant updates or amendments to change the band'
• You may also want to make a note of where a factor level would be impacted eg. new job would now be supervising, but this still doesn't change the overall band outcome
• Attach the new job description documents to the record

**NHS Wales**

**Pregnancy Loss Support Policy**

Fforwm Partneriaeth Cymru
Welsh Partnership Forum

GIG Cymru yn Gweithio mewn Partneriaeth
NHS Wales Working in Partnership

Version: FINAL July 2024

**NHS Wales**

**Pregnancy Loss Support Policy**

## 1.0 Background

1.1 The aim of this policy is to provide the support employees need during this difficult time in their life, and to help managers and colleagues know how to support people affected, with kindness, understanding and without judgement.

1.2 It supports pregnant employees and employed partners through pregnancy loss and encourages them to feel confident to talk to their manager, colleagues and friends at work about what has happened. It challenges attitudes that pregnancy loss is a taboo subject, and that people have to suffer in silence.

1.3 If an employee is reading this document, it is likely they are either going through or supporting somebody through this very difficult period so please do reach out to your local workforce department or a manager to talk with in order to ensure that you receive appropriate support.

## 2.0 Scope

2.1 The scope of policy is defined in Appendix 1 and includes, but is not limited to: miscarriage, anembryonic pregnancy, ectopic pregnancy, molar pregnancy, embryo transfer loss and termination of pregnancy.

2.2 This policy applies to employees only. It does not apply to agency workers, consultants, self-employed contractors, volunteers or interns. If you are not an employee but have experienced pregnancy loss, we encourage you to speak with your normal point of contact in our organisation [our Pregnancy and Baby Loss Champion] or a member of the HR Department. They will be able to discuss with you what support is available.

2.3 This policy applies to all employees that suffer a pregnancy loss, at any time before 24 weeks, regardless of whether it has happened directly to them, their partner, surrogate or the adoptive parents in an approved adoption placement. It also applies regardless of the employee's gender, type of contract of employment, length of service, role or base.

2.4 When an expectant employee suffers a pregnancy loss after 24 weeks, they will still be entitled to statutory maternity leave and SMP if their baby is born early; is stillborn after the start of their 24th week of pregnancy or dies after being born. This is in addition to the provisions contained within Section 23: Child Bereavement Leave of the NHS Terms and Conditions of Service Handbook (the provisions equivalent to those contained in section 23 will apply to medical and dental staff); as well as the provisions within local organisational policies.

2.5 If an employee is affected by pregnancy loss but is not the carrier of the pregnancy, the partner of the employee carrying the pregnancy or the intended parent in a surrogacy or adoption arrangement, they should speak with their line manager or the HR Department about how they can be supported.

2.6 The NHS Organisation recognises the distress, both physical and emotional, that may result from pregnancy loss and the impact this may have on individual employees regardless of when or how the loss occurs. This policy has been prepared to provide paid time off and support in relation to pregnancy loss. However, it is appreciated that no situations will be identical, and that pregnancy loss can result in grief unlike other types of grief. Employees are therefore encouraged to discuss with their line manager or a member of the HR Department what support they may need.

2.7 [An employee may prefer to speak with our Pregnancy and Baby Loss Champion in the first instance, while keeping in mind that their line manager or the HR Department may need to be involved in subsequent discussions.]

Note: - An employer may wish to appoint a Pregnancy and Baby Loss Champion. This individual would be trained in pregnancy and baby loss and perhaps have some experience of this type of loss themselves. Appointment of a Pregnancy and Baby Loss Champion would enable employees experiencing pregnancy loss to speak with someone outside of their reporting line and HR who would be well-equipped to listen to their questions or concerns. If an employer appoints a Pregnancy and Baby Loss Champion, appropriate references should be included in this policy.

## 3.0 Experiencing Pregnancy Loss at Work

3.1 If a pregnancy loss starts while at work, employees are encouraged to speak with their line manager or a trusted colleague. They can then arrange for your preferred contact to be notified and find a suitable place for you to remain while any medical care is organised, or arrangements are made for you to travel home.

3.2 It is recognised how traumatic the experience may be, both physically and emotionally. Consequently, the NHS Organisation wants to ensure that no employee feels that they have to go through the experience on their own or continue with their work. The employee's line manager or colleague should agree with you on how your absence will be communicated to others, if needed.

3.3 The preferred contacts of an employee experiencing pregnancy loss will be allowed to leave work at short notice to provide support.

## 4.0 Pregnancy Loss Paid Leave

4.1 Those affected by a pregnancy loss, regardless of the reason (See Appendix 1 for further information), before week 24 are entitled to a maximum of ten working days' full pay (pro-rata for part-time staff). Depending on the employee's wishes and needs, the leave may be taken as consecutive or ad hoc days/hours. It is appreciated that some employees may not want to take leave straight away, or at all. If an employee

does want to take leave under this policy, they are asked to take it within 26 weeks of the pregnancy loss.

4.2 If the NHS Organisation employs the employee affected by pregnancy loss and their partner, they will both be entitled to apply for pregnancy loss leave in their own right.

4.3 If an employee suffers more than one pregnancy loss in a calendar year, they will be entitled to receive the maximum amount of paid leave, per loss.

4.4 In order to apply for leave following a pregnancy loss, the employee should contact their line manager in the first instance who will advise them on any local arrangements. An employee may self-certify any leave taken in accordance with this policy. They will not be required to provide a Fit Note or letter from a healthcare professional. The employee and their manager can complete the application process retrospectively, following the return to work, as long as they have discussed and verbally agreed the leave.

4.5 It is recognised that it will not always be possible to request pregnancy loss leave in advance. However, an employee is encouraged to speak with their line manager or a member of the HR Department as soon as possible if they are considering taking pregnancy loss leave in accordance with this policy.

**5.0 Additional Leave**

5.1 Emotional and physical recovery from a pregnancy loss does not have a time limit. Grieving could go on longer than the initial bereavement event.

5.2 The employee may therefore require a further period of absence from work, following the period of paid leave. The additional absence by the employee could be facilitated by the Managing Attendance at Work Policy and / or the Flexible Working Policy or by taking unpaid leave. Leave taken under this policy will not count for monitoring purposes under the Managing Attendance at Work policy. Where appropriate, and with the consent of the employee, consideration will also be given to an occupational referral or temporary redeployment.

5.3 The NHS Organisation recognises that flexibility is often important to employees that are suffering a pregnancy loss. Managers should therefore, where possible, aim to facilitate flexible working requests for these employees, wherever possible. Further guidance around Flexible Working can be found in the All-Wales Flexible Working Policy.

5.4 We recognise that returning to work after pregnancy loss may be challenging and the preferred support will vary from employee to employee. With this in mind, we encourage employees to speak with their line manager about how they can support a return to work. If an employee has any suggestions for steps that can be taken as to support you during this time, they should discuss these with their line manager.

## 6.0 Paid Time Off for Medical Appointments

6.1 Employees will be entitled to receive additional paid time off to attend pregnancy loss related appointments, or to accompany their partner, should they not fall within the agreed period of paid pregnancy loss leave (10 working paid days, pro-rata part-time staff). This will include but is not limited to medical examinations, scans and tests, and mental health-related appointments.

6.2 Managers should recognise that it would not always be possible for employees to arrange these appointments around the demands of their work, due to the nature of pregnancy loss. Therefore, they should support employees in managing the impact of time away from work, in these circumstances.

## 7.0 General Support

7.1 The NHS Organisation aims to facilitate an open and understanding working environment. Employees are therefore encouraged to inform their manager that they are suffering a pregnancy loss at an early stage. This will help to ensure that they are provided with the necessary support, in a timely manner.

7.2 Where an employee does not initially feel comfortable discussing the issue with their direct line manager, they may find it helpful to have a confidential conversation with, e.g.

- A trusted manager or colleague;
- The Staff Psychological Wellbeing Service;
- A member of the Occupational Health Team;
- A Health Board Maternity Bereavement Officer;
- The Chaplaincy Service;
- An external bereavement support charity or organisations (See Appendix 2);
- Member of Workforce & OD Team; or
- A Trade Union representative

## 8.0 Responsibilities

8.1 Everyone is expected to be sensitive to the impact of pregnancy loss and to consider their colleagues with kindness and understanding.

8.2 It is the manager's responsibility to support the employee with kindness, compassion and flexibility. Each person is different, and individuals may also need temporary work adjustments, or other levels of support.

8.3 Employees who have experienced pregnancy loss are actively encouraged to reach out and talk to someone they trust at the earliest opportunity, if they feel they need additional support or signposting.

## 9.0 Talking about a loss

9.1 It is entirely the employee's decision whether or how much to talk about their loss. The organisation will endeavour to provide an open and welcoming environment in which an employee can do so.

9.2 Equally, it is appreciated that there may be circumstances in which an employee may want to limit the number of individuals who know about their pregnancy loss, to the extent this is possible in the circumstances. If an employee chooses to discuss their pregnancy loss with their line manager, they are encouraged to speak with them about how they would like any related absences from work to be communicated to colleagues.

9.3 Any information you provide to us about your health will be processed in accordance with our Data Protection Policy. We recognise that this data is sensitive and will handle it in a confidential manner.

**Appendix 1**

Pregnancy loss includes but is not limited to:

- **Miscarriage**: the spontaneous loss of pregnancy until 24 weeks of gestation. NHS Information on Miscarriage

- **Termination**: a medical or surgical procedure to end a pregnancy. NHS Information on Termination

- **Ectopic Pregnancy**: when a fertilised egg implants and grows outside of the uterus. NHS Information on Ectopic Pregnancy

- **Anembryonic Pregnancy**: when the cells of a baby stop developing early on, and the tiny embryo is reabsorbed. However, the pregnancy sac, where the baby should develop, continues to grow.
  Miscarriage Association Information on Anembryonic Pregnancy

- **Molar Pregnancy**: a rare form of pregnancy in which a non-viable fertilised egg implants in the uterus and will fail to reach full term. NHS Information on Molar-Pregnancy

- **Embryo transfer loss** – when the embryo does not transfer during fertility treatment and results in no pregnancy. Learn more about embryo transfer loss www.liverpoolwomensnhs.uk

**Appendix 2**

## External Bereavement Support Charities and Organisations

Many charities in the UK that provide help, support and information to those are suffering from a pregnancy loss. The following are some of the largest and where applicable, local charities:

- **ARC**

Is a charity that offers non-directive information and support to parents before, during and after antenatal screening; when they are told their baby has an anomaly; when they are making difficult decisions about continuing with or ending a pregnancy, and when they are coping with complex and painful issues after making a decision, including bereavement.

**Telephone:** 0207 713 7486. Helplines are answered by trained staff Monday to Friday, 10.00 to 17:30pm.

- **Cruse Bereavement Care**

Trained bereavement volunteers, who offer emotional support to anyone affected by bereavement, staff the Cruse Bereavement Care free phone national helpline.

**Telephone:** 0808 808 1677
**Email:** helpline@cruse.org.uk
Helplines are open Monday-Friday 09.30 to 17.00 (excluding bank holidays), with extended hours on Tuesday, Wednesday and Thursday evenings, when they are open until 20:00.

- **London Friend LGBT Bereavement Helpline**

Support for gay, lesbian, bisexual and transgender people expecting or experiencing bereavement.

**Telephone:** 0207 7837 3337 Tues 19:30 to 21:30
**Webpage**: www.londonfriend.org.uk

- **Miscarriage Association**

Provides advice and support to those who had experienced miscarriage, molar pregnancy or ectopic pregnancy.

**Telephone:** 01924 200799
**Website:** www.miscarriageassociation.org.uk

- **NHS Bereavement Helpline**

Qualified nurse that can provide guidance and support to individuals who are suffering a pregnancy loss runs the NHS Bereavement Helpline.

**Telephone:** 0800 2600 400 – Helpline is open every day 08:00 to 20:00.

- **Petals - The Baby Loss Charity**

Petals provide a free, counselling service to support women, men and couples through the devastation of baby loss. Their counselling programme meets the needs of those who have suffered pregnancy complications, pregnancy loss or the death of a baby. Their counsellors

are experts in this field and have years of experience between them of counselling people after all types of baby loss.

Telephone: 0300 688 0068
**Email:** counselling@petalscharity.org
**Website:** Petalscharity.org

♥ **Stillbirth and Neonatal Death Society (SANDS)**

Welcomes calls from anyone affected by a stillbirth of a baby.

**Telephone**: 020 7436 5881
**Email:** helpline@uk-sands.org
**Website:** www.sands.org.uk

♥ **The Ectopic Pregnancy Trust**

A registered national charity established to meet the needs of people who have experienced ectopic pregnancy and the health care professionals who care for them.

**Telephone:** 020 7733 2653
**Website**: www.ectopic.org.uk

♥ **Tommys**

Tommys believe that every baby lost is one too many. Tommys exists to support, care for and champion people, no matter where they may be on their pregnancy journey. They provide expert, midwife-led advice for parents before, during and after pregnancy, working together towards safer, healthier pregnancies. Click her for Tommys Baby Loss Support Information

If you would like to speak to one of the Tommys midwives about your pregnancy, or need support and advice following a pregnancy loss, you can contact the team directly.

**Telephone**: **0800 014 7800** (Monday to Friday, 09:00 to 17:00).
**Email:** midwife@tommys.org
**Website:** www.tommys.org

♥ **The Samaritans**

24-hour helpline support every day of the year for anyone in distress, including those who are bereaved.

**Telephone:** 08457 90 90 90
**Website:** www.samaritans.org

♥ **Canopi (nhs.wales)**

# PROCEDURE FOR THE RECOVERY OF OVERPAYMENTS – Salary & Expenses

Procedure Status: FINAL APPROVED
Procedure Issued: September 2024
Implementation Date: October 2024
Review Date: October 2027

# Procedure for the Recovery of Overpayments

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## 1. Introduction

This Procedure has been written to bring a unified approach in how an overpayment should be handled across NHS Wales. This All-Wales procedure will replace any existing local processes to ensure consistency by NHS Wales Shared Services Partnership Payroll Services and NHS Wales Organisations upon the identification of an overpayment.

An overpayment is defined as any monies incorrectly paid to a current or former employee or worker through the payroll system.

## 2. Procedure Statement

Everyone involved in the application of the procedure will be treated with respect and dignity throughout the process.

It is recognised that overpayments are not usually the fault of the employee or worker, and this procedure seeks to support those who have been overpaid to have the overpayment recovered in a fair and reasonable manner.

Overpayments primarily arise from a "mistake of fact" (where a payment was inconsistent with the facts e.g. due to clerical, computer input or procedural error). NHS Wales Organisations have a legal right to recover any overpayments which have arisen from a mistake of fact.

NHS Wales Organisations must pursue the recovery of all overpayments regardless of fault. NHS overpayments come out of public funds and therefore NHS Wales Organisations have an obligation to recover them although this must be done in a fair and reasonable way.

Consideration will be given to individual needs and financial circumstances.

## 3. Aims

This procedure aims to standardise the recovery of overpayments to ensure consistency across NHS Wales.

It also aims to ensure all overpayments are recovered efficiently and as quickly as possible without imposing hardship and to ensure that employees, ex-employees, workers and ex-workers are treated fairly and consistently without any needless stress or worry.

## 4. Equality

NHS Wales aims to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. It is recognised that equality impacts on all aspects of day-to-day operations and all policies and procedures have an Equality Integrated Impact Assessment (EqIIA) undertaken and Welsh Language Impact Assessment undertaken.

We will ensure that we deliver this procedure in line with the requirements of the Welsh Language Standards, specifically:

- Making our service available in Welsh that is equal to the English language service that we provide by:
  - Providing Welsh language correspondence to staff through the medium of Welsh without staff having to request this.
  - Provide any communication about this procedure through the medium of Welsh without staff having to request communications from us through the medium of Welsh.
  - Provide a telephone service through the medium of Welsh that is equivalent and equal to the English language service that we provide.
  - Make available all documents and forms in relation to this procedure and its delivery available through the medium of Welsh without hesitation or delay.
  - Ensure that information about this procedure is available on our intranet pages and webpages are available to NHS Staff.
  - Any social media posts relating to this procedure will be made available through the medium of Welsh at the same time as English medium posts are available.

## 5. Objectives

The objectives of this procedure are to ensure:

- An equitable process for the recovery of overpayments while allowing the personal financial circumstances of those who have been overpaid to be considered.
- The recovery of the overpayment should be affordable and sustainable.
- The responsibilities of those who may be involved in the process are made clear - Appendix A.
- The potential reasons for overpayments are explained - Appendix B.
- The reduction in the frequency of overpayments through using information found in this procedure to educate and improve.

## 6. Scope

This procedure will apply to employees, ex-employees, workers and ex-workers of NHS Wales Organisations and covers both manual and electronic systems utilised across NHS Wales.

Where NHS Organisations have rolled out Manager Self-Service (MSS) in the Electronic Staff Record (ESR), the Line Manager should utilise MSS to update employees' assignments. If MSS is not fully rolled out, information should be communicated to Payroll Services using the forms/Staff Movement Advice (SMA) available under Useful Documents through the Organisations page on the link below.

This link also details Payroll Services contact information: Payroll Services (sharepoint.com)

## 7. Overpayment Recovery Process

**Automatic Recovery**

There may be circumstances where an overpayment could be automatically recovered from future salary payments.

This will only happen if the following applies:

- The overpayment was a result of late notification of changes i.e. a change of hours, termination of employment, sickness, pension or other absence **and**
- The change or termination of employment should have been actioned less than one month before notification was received by Payroll Services **and**
- The deduction will not amount to more than a 30% reduction in gross monthly pay.

If all these criteria are met, the overpaid salary will automatically be recovered over a maximum 3-month period. Gross monthly pay overpayments of 0-10% will be recovered over 1 month, 10-20% over 2 months and 20-30% over 3 months.

If an automatic deduction is to happen, Payroll Services will inform the individual before pay day by sending an **Adjustment to Salary Letter** (Appendix C). The letter will detail the intended recovery values per month. This is intended to provide an affordable and sustainable recovery option. Tools to help you work out what is affordable can be found at Appendix D.

If the proposed overpayment recovery timescale is not affordable, NWSSP Payroll Services can be contacted via the contact information provided on the letter. If recovery cannot be agreed over the 3-month period, the overpayment will be referred to the All Wales Overpayments Team to progress the standard recovery procedure outlined below.

If the individual terminates their employment before the overpayment is repaid in full, payroll will contact the individual with a view to recovering the outstanding amount from the final salary.

**Standard Recovery**

Where an overpayment is a larger sum of money and/or has occurred over a longer time period, so the criteria for automatic recovery are not met, the standard recovery process will be as follows.

This is also set out in a flow chart at Appendix E.

1. Payroll Services will send **Overpayment Letter 1** (Appendix F) to the individual who has been overpaid as soon as they are made aware of a potential overpayment.
   The letter will provide notice that a potential overpayment has occurred, detail the reason for the suspected overpayment and the period it relates to (if known). It will reference the follow up letter (**Overpayment Letter 2** – Appendix G) that will be sent with the detailed overpayment calculation once confirmed.
2. Payroll Services will send an email with an attached letter to the individuals Line Manager informing them of the potential overpayment (Appendix H). This may include an MS Forms link to provide details or reasons for why and how the overpayment may have occurred and a video link explaining how to reduce overpayments in future.

3. Once the overpayment has been calculated, Payroll Services will issue **Overpayment Letter 2** to the individual and their Line Manager detailing the overpayment calculation (Appendix G). The Finance Department from their Organisation will be copied into this letter.

### *(a) Where the individual remains in post within the Organisation:*

**Overpayment Letter 2** will show the calculation of the overpayment and the full value. The letter will explain that the overpayment will need to be recovered in full and the ways this can be done.

We aim to recover any overpayments over the same time frame as the overpayment occurred e.g. if you were overpaid for 3 months, this should be recovered over 3 months. There is also the option to repay the overpayment as a lump sum or to discuss the arrangement of a more affordable monthly recovery option.

Any requests to recover the overpayment in excess of 12 months will need to be agreed by the Director of Finance and/or Director of Workforce/People for that Organisation or their nominated deputies. Any requests will be reviewed with consideration of how and when the overpayment occurred and the individual's financial circumstances.

There can also be the consideration of alternative options such as undertaking additional hours to pay back the sums owed.

Overpayment recoveries should be made via salary unless you choose to repay in full separately or agree to set up a standing order.

Overpayment Letter 2 will mention that an invoice will be sent shortly, and this will include information on who you can contact to agree the recovery of the overpayment.

The Finance Department for your Organisation will receive a copy of this letter so that the invoice can be sent. They will note that you are a current employee or worker who may have recoveries made via salary deductions.

A copy of the salary deduction request proforma is included in Appendix I to be completed if requested.

Tools to help you work out what is affordable can be found at Appendix D.

### *(b) Where the individual is no longer working for the Organisation:*

Overpayment Letter 2 will show the calculation of the overpayment and the full value. The letter will explain that the overpayment will need to be recovered in full and the ways this can be done.

The letter will mention that an invoice will be sent shortly, and this will include information on who you can contact to agree the recovery of the overpayment.

The Finance Department for your Organisation will receive a copy of this letter so that the invoice can be sent. As the individual is no longer an employee or worker for the Organisation, recovery via salary is not possible so payments can be made by Standing Order, Bank Transfer, Cheque or Debit/Credit Card (where Organisations have this facility).

We aim to recover any overpayments over the same time frame as the overpayment occurred e.g. if you were overpaid for 3 months, this should be recovered over 3 months. There is also the

option to repay the overpayment as a lump sum or to discuss the arrangement of a more affordable monthly recovery option.

Longer recovery periods **may** be possible but will need to be agreed by the Director of Finance and/or Director of Workforce/People for that Organisation or their nominated deputies.

Tools to help you work out what is affordable can be found at Appendix D.

The Finance Department reserves the right to progress debt collection procedures through a debt collection agency once local Organisation procedures and attempts to collect the outstanding debt have been exhausted.

**Counter Fraud**

There may be occasions where an overpayment needs to be assessed by Counter Fraud Services.

An initial high-level assessment by Counter Fraud Services will be requested only if **all three** of the criteria below are met which indicate there may be evidence to suggest fraud may have occurred:

1. The individual has not notified the Organisation/Line Manager/Payroll Services of the overpayment; **and**
2. The overpayment has occurred for more than 3 months; **and**
3. The overpayment value is estimated at more than £5,000

If all three criteria are met, Payroll Services will send a notification to the relevant Local Counter Fraud team using the review form in Appendix J.

Local Counter Fraud teams will make an initial assessment and advise within 5 working days if an investigation is required, or if the overpayment recovery can continue with the usual recovery procedure. If no response is received from the Local Counter Fraud team within 5 working days, Payroll Services will request final confirmation to continue with recovery of the overpayment in line with this procedure and as shown in Appendix E.

Any overpayments under initial assessment by Local Counter Fraud teams are included under the Counter Fraud section of the overpayments dashboard. Senior Workforce/People and Finance colleagues within Organisations have access to this dashboard to monitor assessments being undertaken.

If Counter Fraud Services identify that further investigation is required, the overpayment recovery will be placed on hold by Payroll Services until further advice is received from the Local Counter Fraud team.

Prior to further investigations commencing, the Local Counter Fraud team will follow local Organisation procedure for informing the Director of Workforce/People and/or Director of Finance of the details of the case to be investigated. This may include obtaining any agreement to further investigation if required locally by Organisations. In the event of any local disagreement on the correct course of action, the Local Counter Fraud team will seek advice from the national NHS Counter Fraud Service Wales.

**To ensure any potential criminal investigations are not compromised, it is important that no contact is made with the individual who has been overpaid until the Local Counter Fraud team has confirmed they do not need to investigate the matter further.**

## 8. Dispute Resolution

Where an individual refuses to consent to the recovery of the overpayment and where discussions have been exhausted, the overpayment should be referred to the Director of Workforce/People and/or Director of Finance or their nominated deputies for the Organisation with the aim of reaching an agreement for the recovery of the overpayment, taking into account the individual's personal circumstances.

A meeting should be arranged between the individual who has been overpaid and the Director of Workforce/People and/or Director of Finance or their deputies. The individual has the right to be accompanied by either a Trade Union representative or a workplace colleague.

Members of the Finance team or Payroll Services along with the Line Manager or Budget Holder may also be requested to attend this meeting where it would be helpful. The proposed outcome of the meeting may require approval by the Director of Finance or other authorised budget holder if they are not present at the meeting.

Where an individual feels they have been treated unfairly, they are encouraged to use the Respect and Resolution policy. No further action should be taken on recovery during any dispute resolution process including a complaint under the Respect and Resolution process.

If you have left NHS Wales employment and have been unable to reach an agreement, you may be able to get support through:
Acas | Making working life better for everyone in Britain or
Work - Home (citizensadvice.org.uk)
Or your Trade Union if you are still a member (if you pay through your salary, you can switch to Direct Debit to maintain membership).

It is important to remember that there is a legal right for NHS Organisations to recover any overpayment. NHS Organisations reserve the right to engage a debt collection agency should it be required.

## 9. Training and Awareness

NHS Organisations should make employees or workers and managers aware of this procedure on commencement. A copy of the procedure should be available on the NHS Organisation's Intranet Site and referenced in any induction and/or new manager training.

Overpayments can be minimised if everyone does their part. Managers can ask for guidance on how to ensure prompt and accurate updates of employment information including new starters, changes, terminations, and employee or worker absence should they require.

Delayed submission of payroll documentation or Manager Self-Service updates can cause significant inconvenience and anxiety for staff and unnecessary additional administration for

NWSSP Payroll Services. It can also lead to complexities for those affected in respect of tax and universal credit issues.

The roles and responsibilities of all parties detailed in this procedure are outlined in Appendix A.

## 10. Information Governance

Any personal data utilised within the application of this procedure will be processed in accordance with the relevant UK General Data Protection (UK GDPR) and records management strategic frameworks and policies.

## APPENDIX A

Key responsibilities in respect of the overpayments process can be summarised as:

**NHS Wales Shared Services Partnership Payroll Services will: -**

- Pay staff correctly and on time in accordance with employee/worker data held on ESR at the point of payrolls being run.
- Make an itemised payslip available to the employee/worker. This will be an electronic payslip where MyESR (Employee Self Service) is in use.
- Inform relevant staff regarding cut-off dates for submission of Electronic Paperwork for example starters, changes, terminations, and variable pay data Payroll Services (sharepoint.com).
- Correct identified errors.
- Undertake an assessment of overpayments against the criteria to establish if a review by Local Counter Fraud Services is required
- Rectify any identified overpayment in line with this procedure for the recovery of overpayments of salary. This will include writing to the employees/ex-employees/workers/ex-workers, providing them with a detailed explanation of the overpayment.
- Inform the Line Manager that an overpayment has occurred and issue a MS Forms link for them to complete an overpayment report, which will request detail on why the overpayment has occurred and what remedial action has been taken to prevent future reoccurrence.
- Maintain a register of overpayments to share monthly/bi-monthly with nominated representatives from each Organisation. NWSSP will inform the NHS Organisation of overpayments, the reasons for them and if there is a recurrence of the manager not complying with processes and procedures relating to employee/worker data.
- Review the register of overpayments with NHS Organisations in the regular Payroll Customer Relationship Manager meetings
- Liaise with local trade union representatives where appropriate.
- Deduct monies from the employees'/workers salary in line with the agreed recovery period where appropriate.
- Upon termination, deduct any outstanding overpayments, overtaken annual leave, including salary sacrifice arrangements from the final salary where possible.
- Deal with overpayment matters with compassion and understanding, noting that in the vast majority of cases the employee/worker is not at fault
- For a limited time after termination of employment, ensure ex-employees/ex-workers have access to their payslips, P60s and P45s via a Leavers Dashboard.

- Liaise with HMRC and/or NHS Pensions if an overpayment is likely to affect tax or pension.

- Implement this procedure through the medium of Welsh in line with the Welsh Language Standards.

**Employee/Ex-employee/Worker/Ex-worker Responsibility:-**

Employees/Ex-employees/Workers/Ex-workers must:

- Verify basic pay, contracted hours and other regular payments included in their payslip to ensure they are in line with their contract.

- Where applicable, and possible, verify variable hours are correct on e-roster systems before rosters are finalised.

- Raise any payslip queries with their Line Manager in the first instance. This may be in respect of incorrect contracted salary, hours, regular payments, incorrect receipt of variable hours or receipt of any unexpected monies.

- Seek clarification from Payroll Services if their Line Manager cannot resolve any queries on their payslip.

- Immediately inform Payroll Services if an overpayment is identified so that recovery can begin. Any employee, ex-employee, worker or ex-worker that knowingly or willingly fails to advise Payroll Services of an overpayment may be subject to referral to the Local Counter Fraud team and if necessary the Police.

- Agree terms of recovery and ensure full recovery of any overpayments.

- Be aware of payroll cut-off dates to know when to reasonably expect payment of travel, subsistence claims, shifts on e-roster systems or variable pay elements.

- Submit expense claims and additional hours worked claims for payment within 3 months. Please note that any claims older than 3 months will not be processed for payment unless circumstances prevented the submission of the claim in time.

- Ensure the NHS Organisation is aware of any change of address and contact details to be updated via MyESR (Employee Self Service).

- Access support and advice from trade union representatives where applicable.

**Line Managers:**

Line Managers must notify Payroll Services of any pay impacting changes as soon as they become aware of them and their responsibilities include:

- To complete the employee change notifications and submit to Payroll Services prior to employees/workers commencing new position/hours/base.

- To complete the employee termination process at the point of the employees/workers resignation.

- For employees/workers accessing NHS Pension - in line with NHS Organisations Retirement Policy a termination form must be completed a minimum of 4 months prior to termination.

- To resolve any initial queries received from employees/workers regarding variable hours paid in month or receipt of unexpected payments, advising them they must report any suspected overpayments to Payroll Services without delay.

- To open and close employee/worker sickness absence on their ESR record at the point of notification.

- To notify Payroll Services of any unpaid leave.

- To submit authorised notification of Maternity/Paternity/Adoption/Career Break. Application forms for payment under these policies must be completed and submitted to Payroll Services prior to the date the employee/worker commences the period of leave.

- To verify an employee's/worker's contract details via Manager Self Service and monthly budgets and advise Payroll Services immediately where an employee's/worker's contractual details are incorrect.

- To ensure the employee/worker rotas (where applicable) are correct in accordance with E-roster systems. Discrepancies should immediately be brought to the attention to Organisational E-Systems Teams.

- To ensure payroll workbooks (where applicable) are completed accurately in accordance with the employees/workers working pattern.

- Support individuals who have received an overpayment.

**The Workforce/People Department will: -**

- Act as a link between NWSSP Payroll Services, the Line Manager, the Finance team and the employee/worker where required.

- Ensure that managers are aware of their requirements to submit payroll data including employee/worker change notifications, termination notifications and e-rostering data in line with published payroll submission deadlines.

- Ensure that managers are aware of the potential for overpayments and their requirement to see that such instances are kept to a minimum.

- Ensure that managers are aware of the Recovery of Overpayments Procedure through the inclusion on induction and Manager training programmes.

- Review overpayment data on a regular basis to identify key themes and any areas where overpayments are a regular occurrence bringing it to the attention of the respective Managers to escalate.

- In conjunction with Senior Finance staff, review and jointly agree any hardship applications with regard to extended recovery periods.

- Ensure individuals who are subject to the overpayment process are treated fairly and compassionately.

**Finance/Accounts Receivable Teams will: -**

- Be responsible for issuing invoices to individuals to recover overpayments.

- Agree recovery terms in line with this procedure.

- Progress debt collection procedures where recovery of overpayments is not forthcoming.

**Local Counter Fraud Teams will: -**

- Undertake an initial assessment of any overpayments referred to them by NWSSP Payroll Services that meet the three referral criteria

- Respond to any referrals within 5 working days and confirm to Payroll Services whether normal recovery proceedings can commence or if further investigation is required.

## APPENDIX B

**Reasons for Overpayments**

It is important that all information relating to appointments, changes and terminations are completed promptly and accurately by the Line Manager. Notifications/Staff Movement Advice (SMA) must be submitted to NWSSP Payroll Services or updated on ESR via Manager Self-Serve (MSS) immediately after they have been agreed.

Please note that:

- Employees or workers will continue to be paid according to the details held in ESR until Payroll Services are instructed to do otherwise (i.e. via change form or termination form)
- For changes to be reflected in the next monthly salary, any changes must be notified to Payroll Services by the last day of the current month (i.e. changes to be reflected in the April salary must be notified to Payroll Services by 31st March).
- monthly salary payments cover the period to the end of the month and not only up to the pay date.
- If an employee or worker self-declares an overpayment of salary, with their agreement in writing, Payroll Services will look to suspend the relevant overpaid element of their pay to prevent any further overpayments occurring while the issue is investigated and relevant documentation is requested.

**Prevention of an overpayment occurring is paramount.**

**NHS Wales Organisations must ensure that managers are adhering to policies and procedures that minimise the potential for overpayments.**

The most frequent reasons for overpayments are: -

- Late Termination Notification – A termination form, Staff Movement Advice or update via Manager Self-Serve must be actioned as soon as it is known that an employee or worker is leaving their post, i.e. at the point of resignation, end of contract or on dismissal. Consideration must be given to whether the employee or worker has taken the correct amount of annual leave. If they have taken more leave than they have accrued, they can either work additional hours to repay the time, or they can repay the money. If they are owed annual leave, they may be able take the leave off the notice period or can be paid instead if required.
  It is important that the termination form is submitted to NWSSP Payroll Services as swiftly as possible in case a deduction needs to be made from the final salary payment.
- Late and inaccurate update of employee or worker contractual hours – as soon as the new hours are agreed, the information should be passed on via Manager Self-Serve or an employee change form. This should be prior to the date that the employee or worker begins working the new hours.
- Late and inaccurate update of an employee or worker absence (sickness, maternity, unpaid leave etc) – absences should be reported via ESR Manager Self-Serve or submission of forms to payroll as soon as possible and monitored for the duration.

Managers must ensure that the absence is closed as soon as the individual reports as fit for work.
Payroll Services will (on behalf of NHS Organisations) pay 'average sick pay' based on open sickness absence periods. If the absence is not closed, this may lead to inaccuracies.

- Late or inaccurate reporting of enhancements, overtime, on call, start date, salary, banding etc – the manager or supervisor should submit information, changes or variable pay promptly and with enough time for it to be processed by Payroll Services.
- System errors - while these errors do not happen often, once a system error is discovered, action should be taken as soon as possible in order to minimise incorrect payments. These can include ESR, E-roster and E-Expenses.

Where NHS Organisations have rolled out Manager Self-Service (MSS) in the Electronic Staff Record (ESR), the Line Manager should utilise MSS to update employees' assignments. If MSS is not fully rolled out, information should be communicated to Payroll Services using the forms/Staff Movement Advice (SMA) available under Useful Documents through the Organisations page on the link below.

This link also details Payroll Services contact information: Payroll Services (sharepoint.com)

NWSSP Payroll Services will endeavour to keep errors to a minimum, however human error can occur due to inaccurate calculation or misinterpretation of information.

# APPENDIX C – ADJUSTMENT TO SALARY LETTER

**NWSSP All Wales Overpayment Team**
**NWSSP Payroll Services**
**4th Floor**
**Companies House**
**Crown Way**
**Cardiff**
**CF14 3UB**

**Private and Confidential**

Name
Address 1
Address 2
Address 3
Post Code

**Our Ref:** JEC/Assignment number
**Tel:** 02921 500100

**Email:** NWSSP.AllWalesoverpayments@wales.nhs.uk

**Date:**

**RE: Overpayment of Salary**

Dear

We are writing to let you know that we have discovered an overpayment of your salary and/or expenses.

The amount overpaid is **£XXX** and occurred due to the late submission of information to NWSSP Payroll Services relating to a change to your pay that should have been made within the last month.

The All-Wales Procedure for the Recovery of Overpayments classes such an overpayment as an 'Adjustment to Salary' and allows the automatic recovery of overpayments of up to 30% of salary, with 0-10% recoverable in one month, 10-20% over two months and 20-30% over three months. Your overpayment was **X%** of your salary so will be recovered over **X** months.

If you would like further details of the overpayment or feel the planned automatic recovery is not affordable, please contact us on 02921 500100 quoting the reference number above. The team is happy to help and support both employees and managers.

If you would like more information on how the recovery of overpayments are handled, please read the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services sharepoint site link Payroll Services (sharepoint.com)

Yours sincerely,

**Insert OP Team Leader Name**
All Wales Overpayment Team
NWSSP Employment Services

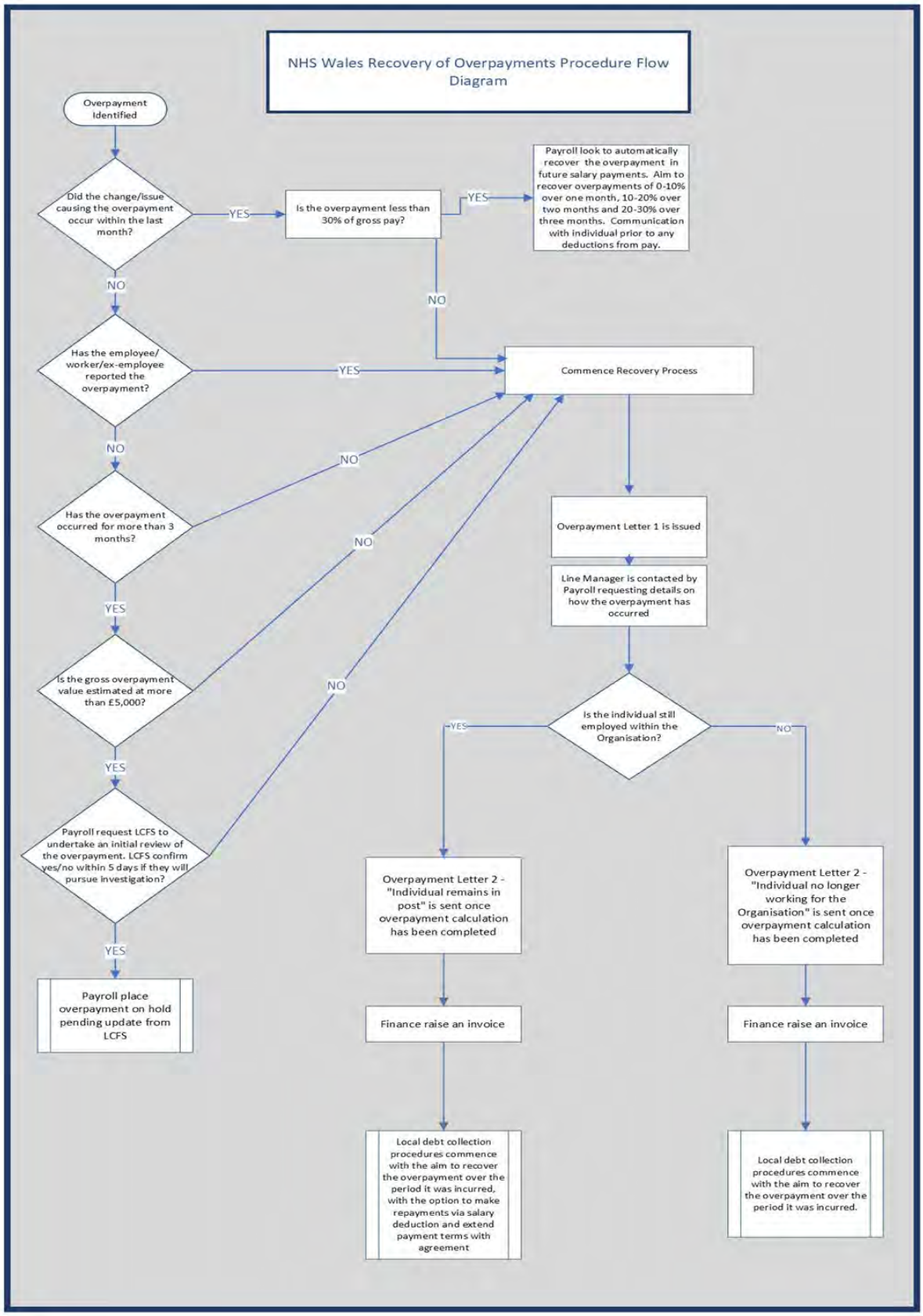
## APPENDIX D – INCOME & EXPENDITURE TEMPLATE

Income%20and%20
Expenditure%20Sum

[Tools and calculators | MoneyHelper]

If you find yourself in financial hardship, there may be help or debt advice available from your Trade Union.
You can also check if you may be eligible for any benefits here:
[Tackling Financial Insecurity Together | Turn2us]
Debt advice from reputable sources [Get free debt advice - GOV.UK (www.gov.uk)]

## APPENDIX E – OVERPAYMENTS PROCESS DIAGRAM



# APPENDIX F – OVERPAYMENT LETTER 1

**NWSSP All Wales Overpayment Team**
**NWSSP Payroll Services**
**4th Floor**
**Companies House**
**Crown Way**
**Cardiff**
**CF14 3UB**

**Private and Confidential**

Name
Address 1
Address 2
Address 3
Post Code

**Our Ref:** JEC/Assignment number
**Tel:** 029 21 500055

**Email:** NWSSP.AllWalesoverpayments@wales.nhs.uk

**Date:**

**RE: Notification of Potential Overpayment of Salary**

Dear

We are writing to let you know that we have discovered a potential error that may have resulted in an overpayment of your salary and/or expenses.

The potential error was a result of ******Insert reason here******.

The payroll team are currently looking into this and will be in touch soon to confirm the overpayment, show a detailed calculation of the amount and give details of how this can be recovered.

We have also contacted your manager to advise them of the potential overpayment so they may provide any additional information which could help clarify the overpayment calculation.

You do not need to do anything at this time, but should you want to contact the **Overpayments team you can reach them on 02921 500055 quoting the reference number above [JEC/Assignment].** The team is happy to help and support both employees and managers.

Please be aware, until the calculations are complete NWSSP Payroll Services will not be able to provide you with any overpayment figures, therefore, please allow time for these to be completed before contacting us.

If you would like more information on how the recovery of overpayments are handled, please read the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services sharepoint site link Payroll Services (sharepoint.com). You can access support and advice from Trade Union representatives where applicable.

Yours sincerely,

**Insert OP Team Leader Name**
All Wales Overpayment Team
NWSSP Employment Services

**NWSSP Payroll Services**
**4th Floor**
**Companies House**
**Crown Way**
**Cardiff**
**CF14 3UB**

**Private and Confidential**

# APPENDIX G - OVERPAYMENT LETTER 2

**Individual remains in post**

**Our Ref:** JEC/Assignment
**Department:** NWSSP Payroll Services for All Wales Overpayments
**Tel:** 029 21 500055

**Email:** NWSSP.AllWalesoverpayments@wales.nhs.uk

**Date:**

**RE: Overpayment of Salary**

Dear

Following on from our previous letter dated ** [insert date] ** we can now give more details of your overpayment. Please accept our sincere apologies for this overpayment and any upset or inconvenience it may cause you.

The overpayment is calculated as follows: -

| | |
|---|---|
| **Period of Overpayment:** | |
| **Reason for Overpayment:** | |

| | | |
|---|---|---|
| **Gross Overpayment:** | | **£** |
| Less | | |
| | Pension: | £ |
| | PAYE: | £ |
| | National Insurance Contributions: | £ |
| | Student Loan: | £ |
| **Net Overpayment Due:** | | **£** |

An invoice will be sent to you directly from your previous organisation's Finance Department so they can begin to recover this overpayment.

Contact details of the Finance Department will be shown on the invoice should you have any queries on how to make payment. As you are no longer employed by your previous Organisation the options to repay will be either by bank transfer, standing order, cheque or debit/credit card if the facility is available within the Organisation.

You can arrange an affordable monthly recovery option or choose to repay the amount in full in one payment. Ideally, the recovery of the overpayment should occur over the same time period in which the overpayment occurred. Should you wish to discuss a different recovery time frame please contact the Finance Department.

If you have any queries in relation to the calculation of the overpayment please do not hesitate to contact the NWSSP All Wales Overpayments Team by emailing NWSSP.AllWalesOverpayments@wales.nhs.uk, or contact them on **02921 500055 quoting the reference number above [JEC/assignment number]**. The team are happy to help and support both employees and managers.

We do understand that overpayments are regrettable and may cause anxiety, so we aim to answer all queries swiftly to minimise any upset or distress.

**NWSSP Payroll Services**
**4th Floor**
**Companies House**
**Crown Way**
**Cardiff**
**CF14 3UB**

## Individual no longer working for the Organisation

**Private and Confidential**

**Our Ref:** JEC/Assignment
**Department:** NWSSP Payroll Services for All Wales Overpayments
**Tel:** 029 21 500055

**Email:** NWSSP.AllWalesoverpayments@wales.nhs.uk

**Date:**

**RE: Overpayment of Salary**

Dear

Following on from our previous letter dated ** [insert date] ** we can now give more details of your overpayment.

Please accept our sincere apologies for this overpayment and any upset or inconvenience it may cause you.

The overpayment is calculated as follows: -

| | |
|---|---|
| **Period of Overpayment:** | |
| **Reason for Overpayment:** | |

| | |
|---|---|
| **Gross Overpayment:** | **£** |
| Less | |
| Pension: | £ |
| PAYE: | £ |
| National Insurance Contributions: | £ |
| Student Loan: | £ |
| **Net Overpayment Due:** | **£** |

An invoice will be sent to you directly from your organisation's Finance Department so they can begin to recover this overpayment. Contact details for the Finance Department will be shown on the invoice should you have any queries. As you are still employed by your Organisation recovery of the overpayment is possible through monthly salary deductions.

You can arrange an affordable monthly recovery option or choose to repay the amount in full in one payment. Ideally, the recovery of the overpayment should occur over the same time period in which the overpayment occurred. Should you wish to discuss a different recovery time frame please contact the Finance Department.

If you have any queries in relation to the calculation of the overpayment please do not hesitate to contact the NWSSP All Wales Overpayments Team by emailing NWSSP.AllWalesOverpayments@wales.nhs.uk, or contact them on **02921 500055 quoting the reference number above [JEC/assignment number]**. The team are happy to help and support both employees and managers.

We do understand that overpayments are regrettable and may cause anxiety, so we aim to answer all queries swiftly to minimise any upset or distress.

Recovery of overpayments will be made in line with the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services sharepoint site: Payroll Services (sharepoint.com). The Procedure also includes a budgeting tool to help you work out what you can afford to pay at Appendix H. You can also access support and advice from Trade Union representatives where applicable.

Yours sincerely

**Insert OP Team Leader Name**
All Wales Overpayment Team
NWSSP Employment Services

**NWSSP Payroll Services**
**4th Floor**
**Companies House**
**Crown Way**
**Cardiff**
**CF14 3UB**

Recovery of overpayments will be made in line with the All-Wales Procedure for the Recovery of Overpayments, a copy of which can be provided if requested.

The Procedure also includes a budgeting tool to help you work out what you can afford to pay at Appendix H. You can also access support and advice from Trade Union representatives where applicable.

Yours sincerely

**Insert OP Team Leader Name**
All Wales Overpayment Team
NWSSP Employment Services

**NWSSP Payroll Services for All Wales Overpayments**
**4th Floor**
**Companies House**
**Crown Way**
**Cardiff**
**CF14 3UB**

# APPENDIX H – LINE MANAGER LETTER

**Private and Confidential**

**Our Ref:** JEC/Assignment Number
**Department:** NWSSP Payroll Services for All Wales Overpayments
**Tel:** 029 21 500055

**Email:** NWSSP.AllWalesOverpayments@wales.nhs.uk

**Date:**

**RE: Overpayment of Salary**

Dear Manager

We are writing to let you know that a potential overpayment of salary has occurred for a member of staff that you line manage.

Details of the potential overpayment of salary are noted below:

| |
|---|
| **Employee Name:** |
| **Assignment Number:** |
| **Period of Overpayment:** |
| **Reason for Overpayment:** |

**Next Steps…**

Once the overpayment has been verified and processed in ESR, both you and the employee will receive a further letter which will confirm the overpayment and show a detailed calculation of the amount. It may take up to 14 days from the date of this letter.

The employee will then be issued with an invoice from your Organisation's Finance Team with instructions on how recovery of the overpayment can be made.

As the manager of the individual who has been overpaid, please could you discuss the overpayment with them and ensure they understand the need to repay the overpaid funds and that all overpayments are recoverable regardless of fault.

The employee will need to be made aware that if they do not repay the overpayment, the Organisation has the right to engage a debt collection agency or take legal action in order to recover the debt.

Please be supportive of your employee and draw their attention to the tools at Appendix D of the Procedure mentioned below if they need help to work out what is affordable.

For full details of how the overpayment will be treated, please refer to the All-Wales Procedure for the Recovery of Overpayments which can be found on the NWSSP Payroll Services SharePoint site: Payroll Services (sharepoint.com)

You will also be sent an Overpayment notification form to complete electronically. The information gathered will support your Organisation to monitor overpayments, understand how they occurred and what measures have been put in place to avoid future overpayments.

If there are any questions about the overpayment, please contact the **Overpayments Team on 02921 500055 quoting the reference number above [JEC/assignment].** The team are there to help and support employees and managers.

Yours sincerely

**Insert OP Team Leader Name**
All Wales Overpayment Team
NWSSP Employment Services

## APPENDIX I – SALARY OVERPAYMENT DEDUCTION

**Deduction direct from Salary Payment – Authorisation Form**

| | |
|---|---|
| **Name:** | |
| **Assignment Number:** | |
| **Health Board/Trust/SHA:** | |
| **Department:** | |

I authorise NHS Wales Shared Services Partnership Payroll Services to deduct the sum of £ _____ direct from my Salary each month.

I understand that this will be deducted as a Net payment and that this deduction will continue until the overpayment £ _____ has been repaid in full.

I give my full consent for this deduction.

If my employment comes to an end, I agree that I will contact the Finance department to discuss options to either recover the outstanding balance of the overpayment from my final pay or agree how payment of the outstanding balance will be made.

Signed _____

Print Name _____ Date: _____

**Once completed, please email to [Organisations to insert their accounts receivable teams email].**
**Finance Teams to note recovery of the overpayment is being made in instalments via salary deduction and then forward this deduction authorisation form to NWSSP.AllWalesOverpayments@wales.nhs.uk for Payroll services to action**

## APPENDIX J – COUNTER FRAUD INITIAL ASSESSMENT - INFORMATION REQUIRED

| | | |
|---|---|---|
| **Individuals Name** | | |
| **Pay Group / Pay Number** | | |
| **NHS Organisation** | | |
| **Job Title** | | |
| **Pay Grade /Hours**<br><br>**Full/Time Part time** | Grade | Hours |
| **Workplace / Location** | | |
| **Value of Overpayment**<br>Please attach O/P Breakdown | **Gross** | **Net** |
| **Period of Overpayment** | **Date From** | **Date to** |
| **Reason for overpayment** | | |
| **Dept / Manager contact name and details** | | |
| **Payroll Services Contact details** | | |
| **Salary Overpayment contact details** | | |
| **Please confirm what checks have been made to verify whether the individual has contacted Payroll Services** | | **Checks made by:**<br><br>**Date:** |
| **FURTHER DETAILS OF INDIVIDUAL:** | | |
| **Address** | | |
| **Date of Birth** | | |
| **NI Number** | | |
| **Bank A/C details** | | |
| **Form Completed by:** | **Date:** | |
| **Please add any further details which may assist the Local Counter Fraud Team with their review:**<br><br>**Please do not contact individuals without consulting your Local Counter Fraud Service team.**<br><br>**Please report any further contact to or from the individual to the Local Counter Fraud team immediately.** | | |

| VELINDRE UNIVERSITY NHS TRUST BOARD | |
|---|---|
| **AUDIT COMMITTEE HIGHLIGHT REPORT** | |
| **DATE OF MEETING** | 28 November 2024 |
| **PUBLIC OR PRIVATE REPORT** | Public |
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |
| **PREPARED BY** | Alison Hedges, Business Support Officer |
| **PRESENTED BY** | Gareth Jones, Chair |
| **EXECUTIVE SPONSOR APPROVED** | Non Gwilym, Interim Director of Corporate Governance |
| **REPORT PURPOSE** | FOR NOTING |

## 1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 17 September 2024. Key highlights from the meeting are reported in Section 2.

The Board is requested to **NOTE** the contents of the report and actions being taken.

## 2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meetings of the Audit Committee held on the 17 September 2024:

| | |
|---|---|
| **ALERT / ESCALATE** | There were no items to escalate to Trust Board. |
| **ADVISE** | **AUDIT WALES UPDATE:**<br>Audit Committee was advised that the backlog of audit work from 2023 which has resulted in delays and lateness of reports for the Structured Assessment 2023 Deep Dive – Financial Efficiencies and Local project work – Examination of the setting of well-being objectives was due to capacity issues within Audit Wales. In that context, Health Boards were the initial focus of Audit Wales resource in relation to the Financial Efficiencies audit given their financial deficits. |

| | |
|---|---|
| | It was suggested there may be some issues raised from the Wellbeing Objectives Report that would tie in well with the work of the Quality Safety and Performance Committee.<br><br>The Audit Committee **RECEIVED** the report and **NOTED** the content.<br><br>**AUDIT WALES - FINANCIAL ACCOUNTS ADDENDUM REPORT**<br>Audit Committee was advised that a paper was being prepared to look at the evidence base in relation to the consolidation of Velindre Charity into the Trust accounts. It was stated by Audit Wales that the Velindre Charity accounts do not need to be consolidated into the Trust accounts as Welsh Government is the ultimate parent and they consolidate the Trust into its accounts~~,~~; however, pre-2018/2019 the Welsh Government did not consolidate the Trust's accounts into Welsh Government accounts.<br><br>**2024/25 INTERNAL AUDIT PROGRESS UPDATE**<br>Audit Committee was advised that Audit Report contents had been rationalised with the aim of providing a more succinct summary of the work undertaken to reach the recommendations to assist management in understanding the information from the audit and provide its management responses.<br><br>Audit Committee was advised that it had been agreed that the Professional Advisor Review be changed to an Advisory Report in order to provide the Trust with some specific support and examples of how its processes and systems can be changed.<br><br>Audit Committee was advised that compliance with an audit of statutory Nurse Staffing Levels may potentially replace the Medical Job Planning Audit which has been deferred to next year, but this is subject to discussions with the relevant team.<br><br>The Audit Committee:<br>• **NOTED** the 2024/25 internal audit progress update.<br>• **APPROVED** the deferral of the Medical Job Planning audit from 2024/25 to Q1 of 2025/26.<br>• **NOTED** the Audit Service Improvement Plan. |
| **ASSURE** | **TRUST RISK REGISTER**<br>Audit Committee received the Trust Risk Register Report and was informed that there had been one key change since the Quality Safety and Performance Committee discussions; the inherent score on risk 3338, was misreported and the inherent and current risk scores are 20.<br><br>Audit Committee was notified that that some of the key steps in reviewing and improving the Trust's risk management processes would be included in the Governance Assurance & Risk (GAR) Programme Phase 2 plan and that the implementation of improvements would run concurrently with that exercise. |

| | |
|---|---|
| | The Committee raised concerns about the scoring of the SACT risk of 20. Audit Committee also raised concerns about the quality of the input into DATIX which is being addressed by re-defining the training requirements to ensure a consistent approach.<br><br>**TRUST ASSURANCE FRAMEWORK**<br>Audit Committee felt that the content of the Integrated Medium-Term Plan should be further summarised into higher level objectives to support the strategic goals.<br><br>Audit Committee **NOTED** the current status and on-going development of the Trust Assurance Framework subject to the above comments and actions.<br><br>**GOVERNANCE ASSURANCE & RISK PROGRAMME OF WORK**<br>The Audit Committee **DISCUSSED** the update on the GAR programme and proposed approach for Phase two.<br><br>**REVIEW OF AUDIT ACTION TRACKER – OVERDUE AND COMPLETED RECOMMENDATIONS / ACTIONS FROM INTERNAL & EXTERNAL AUDIT**<br>Audit Committee:<br>• **NOTED** the contents of the report and the assurance it provides regarding the activities undertaken to address the audit recommendations and associated risks.<br>• **APPROVED** the 29 Internal Audit Report actions identified as complete and agreed these could be formally closed.<br>• **APPROVED** the extension dates identified on the 9 Internal Audit Report Actions that were past the target completion date.<br>• **NOTED** the actions that are on target for completion by the agreed date. |
| **INFORM** | **INTERNAL AUDIT REPORTS**<br>The Audit Committee received one internal audit report~~s~~, which reported a reasonable level of assurance:<br>• Medicine Management Internal Audit Report<br><br>**OTHER BUSINESS:**<br>The Committee also received written reports under the following agenda items:<br>• Counter Fraud Progress Report Quarter 2 24/25<br>• Private Patient Service Plan<br>• Private Patient Service Debt Position<br>• Losses and Special Payments Report<br>• Receipt of Finance Technical Updates<br>• Standing Orders / Standing Financial Instructions<br>• Procurement Compliance Report<br>• Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria |
| **APPENDICES** | **NONE** |

**3. RECOMMENDATION**

The Trust Board is asked to **NOTE** the contents of this report.

| VELINDRE UNIVERSITY NHS TRUST BOARD | |
|---|---|
| **AUDIT COMMITTEE HIGHLIGHT REPORT** | |
| **DATE OF MEETING** | 30th January 2025 |
| **PUBLIC OR PRIVATE REPORT** | Public |
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |
| **PREPARED BY** | Alison Hedges, Business Support Officer |
| **PRESENTED BY** | Gareth Jones, Chair |
| **EXECUTIVE SPONSOR APPROVED** | Non Gwilym, Interim Director of Corporate Governance |
| **REPORT PURPOSE** | FOR NOTING |

## 1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 12 December 2024. Key highlights from the meeting are reported in paragraph 2.

The Board is requested to **NOTE** the contents of the report and actions being taken.

## 2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Audit Committee held on the 12 December 2024:

| | |
|---|---|
| **ALERT / ESCALATE** | There were no items to escalate to Trust Board. |
| **ADVISE** | **AUDIT WALES UPDATE:**<br>Audit Committee were informed of the following by Audit Wales:<br>• Currently in the process of undertaking the Charitable Funds Audit, which is on track for completion in time for January 2025 Charitable Funds Committee, with no issues identified currently.<br>• Forthcoming work for Trust Accounts 24/25 audit - the deadline for Auditor General Certification has been moved forward to 30 June 2025.<br>• Starting to undertake audit work in December 2024.<br>• Undertaking payroll testing in the New Year. |

| | |
|---|---|
| | • Financial Efficiency and Wellbeing Objectives report still awaiting clearance from the Trust. Financial Efficiency Report Positive. Wellbeing Objectives has three recommendations awaiting management response. These reports will be brought to the March 2025 Audit Committee.<br>• 23/24 programmes aiming to complete and bring to Audit Committee in July 2025.<br>• For the 2025 Plan, Audit Wales propose having joint meetings with the Executives to agree and review areas of work programmes.<br>Audit Committee **RECEIVED** The report and **NOTED** the content.<br><br>**2024/25 INTERNAL AUDIT PROGRESS UPDATE**<br>Audit Committee were advised that since publication of the report, there has been further progress with audits, having four final reports and approaching completion on several more. Not anticipating any delay in the plan, as have made good progress and have good engagement from Trust staff. The Capital Plan audit has been delayed slightly.<br><br>Audit Committee were assured that there have been robust discussions around timely management responses. Trust Senior Leadership Teams have access to the Internal Audit Progress Dashboard and Executive Management Board members will be continuously reminded of the importance of meeting deadlines for management responses. An updated process to support Management teams and Executives with the response times to Audit recommendations has been produced and Internal Audit has seen an improvement in general with engagement over the past 5-6 months.<br><br>The Audit Committee **NOTED** the 2024/25 internal audit progress update and KPI report (appendix 1) and the new more concise Internal Audit report style focussed on key recommendations. |
| **ASSURE** | **TRUST RISK REGISTER**<br>Audit Committee were notified that in terms of the risk process, one of the next steps regarding what is reported to Audit Committee is what a de-escalation of the concerns around risk management looks like, so officers are measuring progress against the expectations of where the Trust Board wants to be. How this is achieved is being discussed with the Risk and Assurance Officer currently. It was agreed to try and capture this on the categories of risk in the report so the register can be reviewed with that in mind.<br><br>Audit Committee were informed of the work ongoing to understand what is contained in each part of Datix with the aim of improving consistency in reporting.<br><br>Audit Committee were assured that there is a replacement operational oversights group for SACT Gold and this meeting will occur fortnightly and it will continue to work through the improvement plan. The group members are |

equivalent in seniority to SACT Gold, led by the Chief Operating Officer and supported by other members of the Executive team, with support from the SACT Delivery Group.

Audit Committee were informed that to ensure items are added accurately onto Datix, further training is being rolled out across the Trust.

Audit Committee were given assurance that on the 24 December 2024 there will be a consolidated, updated view on the management view of all the Trust workforce risks and SACT risks and consideration will be given as to how assurance regarding actions to mitigate these risks is evidenced in the future.

Audit Committee:

- **NOTED** the risks in the quality and safety domain with a score of 12 and above and risks in other domains with a score of 15 and above.
- **NOTED** the on-going development of the Trust's risk framework.
- **NOTED** the work underway to improve organisational management of risk reporting.

**TRUST ASSURANCE FRAMEWORK**

Audit Committee were made aware that there have been conversations on the structure around the Trust Risk Register, Governance Assurance & Risk (GAR) and Trust Assurance Framework (TAF) and the need to ensure consistency on how information is being represented and the timelines of that information as well as reminding ourselves of the purpose of bringing the risks to various Committees.

Audit Committee recognised that the GAR work will continue based on progressing improvement in the assurance provided around the controls and actions to close gaps in controls associated with the eight strategic risks. Discussion at the Audit Committee will move to the delivery of the strategic objectives and the risks associated with that delivery based on the work to develop the IMTP and the associated TAF being combined. The importance of the Audit Committee being able to provide the Trust Board with assurance about the delivery of the strategic objectives was highlighted.

Audit Committee were informed that the latest version of the TAF would be presented to Executive Management Board (EMB) on the 24 December, which would then be reported to the Quality Safety & Performance Committee with any EMB updates on the 16 January 2025 for endorsement for approval by Trust Board.

The Audit Committee **NOTED** the current status and on-going development of the Trust Assurance Framework.

**GOVERNANCE ASSURANCE & RISK PROGRAMME OF WORK**

It was confirmed to Audit Committee that the risk policy is being reviewed. This would involve considering issues, templates, timings, and the Task and Finish Group will help support and inform the process of review of the policy, that would then inform the GAR Group prior to the Risk Policy itself going through the required governance process. Have missed deadline for reviewing in accordance with the Policy Management Framework, now have a March 2025 date.

The Audit Committee **NOTED** the update on the Governance, Risk and Assurance programme.

**REVIEW OF AUDIT ACTION TRACKER – OVERDUE AND COMPLETED RECOMMENDATIONS / ACTIONS FROM INTERNAL & EXTERNAL AUDIT**

Audit Committee:

- **NOTED** the contents of the report and the assurance it provides regarding the activities undertaken to address audit actions in response to audit report recommendations and associated risks.
- **APPROVED** the 27 (67%) Internal Audit Report actions and 1 External Audit Report action that have been completed since the September '24 Audit Committee (Green Status). If agreed these actions will be formally Closed (Blue Status).
- **APPROVED** the extension dates identified within the (Red Status) Actions and discussed at the Committee. 10 (25%) Internal Audit Report actions that have passed the agreed implementation date (Red Status) since the September '24 Audit Committee.

**CONSOLIDATION OF THE CHARITABLE FUNDS ACCOUNTS**

At the September 2024 Audit Committee, Audit Wales presented their Audit of Accounts Addendum Report setting out the recommendations arising from their audit and one of the recommendations was that there was no requirement to consolidate the Charity's accounts into the Trust accounts on the basis that the Welsh Government is the ultimate parent of the Trust and they consolidate only the Trust into their accounts. Historically the Charity's accounts have always been consolidated based on previous advice from Audit Wales. Audit Wales have since confirmed that pre 2019, Welsh Government did not consolidate the Trust accounts into the Welsh Government group resource accounts and so Charitable Funds accounts pre 2019 had to be consolidated.

Audit Committee **APPROVED** the recommendation to not consolidate the Charity's accounts into the Trust's accounts.

**DELEGATION OF FINANCIAL LIMITS**

Audit Committee:

- **ENDORSED** for Trust Board **APPROVAL** increasing the delegated financial limit of the Chief Executive Officer (CEO) from £100k to £500k.

| | |
|---|---|
| | • **NOTED** the proposed delegated financial limits to be provided to officers of the Trust, which is below that of the Chief Executive as set out in the Trust SFIs. |
| **INFORM** | **EXTERNAL AUDIT REPORTS**<br>Audit Committee received one external audit report:<br>• The Structured Assessment 2024 Report and Management Response<br><br>**INTERNAL AUDIT REPORTS**<br>The Audit Committee received four internal audit report, which reported a reasonable level of assurance:<br>• WBS Futures Governance Internal Audit Report<br>• Acute Oncology Service Internal Audit Report<br>• Key Financial Controls Internal Audit Report<br>• Estates Assurance: Energy Management Internal Audit Report<br><br>**OTHER BUSINESS:**<br>The Committee also received written reports under the following agenda items:<br>• Counter Fraud Progress Report Quarter 3 24/25<br>• Private Patient Service Plan<br>• Private Patient Service Debt Position<br>• Losses and Special Payments Report<br>• Procurement Compliance Report<br>• Legislative and Compliance Register<br>• Chair's Urgent Action |
| **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 STRATEGIC DEVELOPMENT 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, Vice Chair and Chair of the Strategic Development Committee |
| **EXECUTIVE SPONSOR APPROVED** | Lauren Fear, Director of Transformation - Interim |
| **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 22nd October 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** | **Welsh Blood Services Research, Development and Innovation Strategy**<br><br>The Committee considered the Welsh Blood Services Research, Development and Innovation Strategy and the following key areas were noted:<br>- The strategy has been developed over 12 months with input from multiple stakeholders across Wales.<br>- Effective internal communications will be key to implementation.<br>- The Strategy enables WBS to build on our strengths tying in with Destination 2033 and the WBS Futures programme.<br>- A huge amount of work had been undertaken, including appendices, and the Committee congratulated Dr Sian James on coordinating the Strategy's development.<br>- There was query on the dependency on secondments for implementation and measuring "what good looks like" with a need for a more tangible progress plan. The Committee was assured that the annual plan would review progress and measurables and be monitored by the Research, Development and Innovation Sub-Committee.<br><br>The Committee **ENDORSED** the Welsh Blood Services Research, Development, and Innovation Strategy for submission to the Trust Board for approval, subject to the minor amendments discussed by the Committee.<br><br>**Welsh Blood Service: Fleet Replacement Business Justification Case**<br>The Committee considered the Welsh Blood Service Fleet Replacement Business Justification Case (BJC) and the following points were noted:<br>- The Welsh Government Capital Team were aware and ready to receive the BJC.<br>- Fleet replacement vital for future of patient care – BJC is business critical.<br>- Options and vehicle need are clearly highlighted in the BJC which has been presented to EMB twice with a supported Quality Impact Assessment (QIA).<br>- Efficiencies and future fuel solutions have been considered and will be considered in time as part of the framework.<br><br>The Committee **ENDORSED** the BJC for Trust Board approval<br><br>**Funding Request for Integrated Business Case for Talbot Green Infrastructure Programme**<br>The Committee received and considered the funding request for an Integrated Business Case for the Talbot Green Infrastructure Programme and the following points were noted: |

| | |
|---|---|
| | - update on the progression of the plan for Outline Business Case and Full Business Case including the letter exchange with the Welsh Government Capital Team included in the pack. Confirmation has recently been received that the conditions for progressing with combined cases have been met.<br>- a requirement for further draw down of funding by the end of October to enable uninterrupted contractor provision via Urgent Chair's Action, since the timing for Board approval did not align.<br><br>The Committee **ENDORSED** the Funding Request for Integrated Business Case for Talbot Green Infrastructure Programme for Trust Board approval. |
| **ASSURE** | **ChemoCare Contract Extension**<br>The Committee **NOTED** that the Executive Management Board had approved a contract extension for ChemoCare. The intent of an extended 11 months was to give time to deliver a new All- Wales contract managed through the NHS Wales Shared Services Partnership.<br><br>**Data and Insight Priority Areas**<br>The Committee received an updated on the four key areas, which were the refreshed input into the Performance Management Framework, Quality Metrics, patient tracker list for VCS, and service transformation.<br><br>The Committee will be receiving the revised Priority Plan at its meeting scheduled in February 2025.<br><br>**Trust Assurance Framework**<br>The Committee discussed the Trust Assurance Framework and provided a number of comments in preparation for submission to the Trust Board for consideration.<br><br>**Chair's Urgent Action Report**<br>The Committee **ENDORSED** the Strategic Development Committee Chair's Urgent Action Report. |
| **INFORM** | **Integrated Medium Term Plan 2025 – 2028 Framework**<br><br>The Committee received an update on progress with the development of the IMTP Framework for 2025-2028 and discussed the work that the Executive Management Board (EMB) was undertaking on the templates for reporting the PMF and Major Transformation with the new template for the IMTP developing at pace.<br>The Committee **NOTED** the updated and that the proposed template will be considered by EMB before submission to the Committee for consideration. |

| | |
|---|---|
| | **Major Programme Reporting**<br><br>It was highlighted that the report details the progress since the Q5 recommendation on the need for the Trust to have a view of the totality of the change portfolio in order to determine priorities. The purpose of the report is to bring together the change space into one place.<br><br>Work is ongoing with Executives colleagues on the overview of the Programme in that context and in discussion with the incoming CEO.<br><br>The Committee **NOTED** the following:<br>• Welsh Blood Services Futures Programme Highlight Report<br>• Digital Programme Highlight Report<br>• Value Based Healthcare Programme Update<br>• Research, Development, and Innovation Sub-Committee Highlight Report<br>• Velindre Oncology Academy Highlight Report |
| **APPENDICES** | **NOT APPLICABLE** |

# 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 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 25th September 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**<br>The overall forecast outturn for the Programme as at end of August 2024 is an overspend of £7.684m for the financial year 2024-25 against a budget of £0.666m. No capital funding has been allocated as yet for the projects for the financial year, due to the overspend. |

| | |
|---|---|
| | 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.<br><br>The Sub-Committee **NOTED** the TCS Programme Finance Report.<br><br>**TCS Programme Scrutiny Sub-Committee Terms of Reference**<br>In light of the Pricewaterhouse Coopers (PwC) review, the Sub-Committee Terms of Reference were required to be reviewed and updated. As a result, the following changes have been made:<br>• General formatting.<br>• Job role descriptors updated.<br>• SRO / CEO role disaggregated.<br>• Inclusion of Critical Friends / Observers – Welsh Government, NWSSP – Specialist Estates Services (SES).<br>• Diagrams updated at the end of the document.<br>• Version control added.<br><br>In order to address the PwC recommendations, the updated Sub-Committee Terms of Reference will be submitted to the Trust Board for approval.<br><br>The Sub-Committee **ENDORSED** the TCS Programme Scrutiny Sub-Committee Terms of Reference subject to the following two recommendations being actioned prior to being submitted to Trust Board for approval:<br>• At least two **Independent** Members must be present to ensure the quorum of the Sub-Committee.<br>• The Chair **must be agreed between the Independent Members, in the absence of the TCS Programme Scrutiny Sub-Committee chair**. |
| **ASSURE** | **Programme Director's Report (including all project updates in scope)**<br><br>The Sub-Committee received the report for the period covering 1st August – 31st August 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 |

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| | focus also more directly meets the PwC Governance and Capability Review recommendations.<br><br>The following areas were highlighted for escalation to the Sub-Committee for information:<br>• Risk of delay to the scheduled Satellite Radiotherapy Unit (SRU) opening date in February 2025 due to unresolved issues regarding PSBA (Public Sector Broadband Aggregation), temperature control, CCTV and potential asbestos within the undercroft (see below).<br>• Project 7 Decommissioning should be initiated in the next 6-12 months and early discussions with Welsh Government are needed regarding the future capital requirements to decommission the site.<br><br>It was confirmed the Full Business Case for nVCC and Enabling Works Addendum is to be considered by Infrastructure Investment Board (IIB).<br><br>The Trust is progressing the development of a Major Transformation dashboard and currently there are a total of 59 projects across the Trust, but it was confirmed these all need to be reviewed as some of these projects are classed as either “business as usual” (BAU) or legacy projects. The Major Transformation dashboard will be reported through the Executive Management Board and Strategic Development Committee.<br><br>The Sub-Committee discussed in detail the Delivery Confidence Assessment (DCA) of Amber status for the current definition of the TCS Programme, current progress against plans and related risks and issues and this will be reviewed and monitored closely going forward. Should the projects continue to report a red status, this could potentially mean the DCA will escalate to amber - red. It was confirmed the RAG status for each project is governed by each Project Board.<br><br>The Sub-Committee **NOTED** the TCS Programme Director and Interdependencies Report.<br><br>**new Velindre Cancer Centre (nVCC) Highlight Report**<br>The new Velindre Cancer Centre (nVCC) Project Highlight Report provides high level status report for the following areas:<br>• Overview of progress for the reporting period<br>• Key decisions pending<br>• Project Governance Assurance |

| | |
|---|---|
| | • Top Project Risks and Issues<br>• Progress against Key Milestones in the reporting period, including missed milestones<br>• Update on Project Agreement (PA) obligations for the period and compliance status<br><br>The Management Case and Finance Case as part of the Full Business Case (FBC) have been submitted to Welsh Government, the Health Strategy Board (HSB) and Infrastructure Investment Board (IIB).<br><br>The top risk that is being reported within the nVCC Project Board is the fibre divergence. The Project Board are currently exploring what can be done to improve the resilience.<br><br>Once the FBC has been approved, the resources will be increased to ensure the appropriate resources are supporting the project at the right time including a combination of frameworks and agencies, and employees (permanent and fixed term).<br><br>The Sub-Committee **NOTED** the nVCC Highlight Report. |
| **INFORM** | **Communication and Engagement Report**<br>The Sub-Committee received the Communication and Engagement Update report that provided an outline of the activities and outcomes delivered by the nVCC Communication and Engagement Team.<br><br>The Sub-Committee noted that it had been a busy summer with good engagement across the region and community has taken place.<br><br>The Communication and Engagement Team continue to support Acorn with their Communications and Engagement Programme, which includes regular resident drop-in monthly meetings.<br><br>The Big Conversation Staff Engagement Programme has now been launched within the Trust and feedback will be incorporated within the October update report.<br><br>The Sub-Committee **NOTED** the Communication and Engagement Update Report. |
| **APPENDICES** | None. |

# 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 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 21st November 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.

### 1.4 HIGHLIGHT REPORT

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|---|---|
| **ALERT / ESCALATE** | There were no items identified for alert/escalation to Trust Board. |
| **ADVISE** | **TCS Programme Finance Report**<br>As at 31st October 2024, the year-to-date spend for the TCS Programme is £4.431m Capital and £0.333m Revenue, with a forecast expenditure for the current financial year of £7.201m Capital and £0.666m Revenue. The Revenue budget for the year is £0.666m; there is currently no capital budget. |

The overall forecast outturn for the Programme is an overspend of £7.867m for the financial year 2024-25 against a budget of £0.666m.

The Sub-Committee was informed that the interim CEO had received notification from Welsh Government on 14th November 2024 about the imminent approval of the nVCC FBC.

The Sub-Committee **NOTED** the TCS Programme and Associated Projects Finance Report as of 31st October 2024.

**new Velindre Cancer Centre (nVCC) Highlight Report**
The Sub-Committee received the nVCC Project Highlight Report and noted the following missed milestones for the reporting period up to 31st October 2024:

- Resolution of fibre diversion not achieved as response from BT Openreach was not sufficient to allow informed Trust decision making;
- Delays in recruitment;
- Delay to getting the license extended for the access road to the south of the site.

Other progress highlights included:

1. Approval of the Management and Finance Cases of the nVCC Full Business Case by Welsh Government's was received at the month end.
2. The Equipment Supplier market generally accepted the extension of the Framework terms and conditions for major medical equipment (Category 2c) and there was a positive response to the launch event.
3. The Authority remained compliant with all its EPSL obligations during the month.
4. Procurement processes for construction contractors for both the 278 highways works and the HV Intake rooms are on track.
5. Monitoring of Acorn's construction work has continued by the Trust and the Independent Tester.
6. Discussion with technical advisors and Project Co during the month identified that guidance and regulations on fire safety should not prevent construction of the Lolfa as per agreed design but there may be a requirement for some mitigations.
7. An Interim Planner started on 3rd October, building an integrated plan, and supporting the implementation of the wider PWC Governance and Capabilities Review recommendations.

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| | Recruitment for the full time post commenced, with 55 applications received for shortlisting and interview in November.<br>8. Consultants from Gardiner and Theobald and Currie and Brown started working with the Project from 3rd October to support implementation of the recommendations in the PWC Governance and Capabilities Review.<br><br>The Sub-Committee **NOTED** nVCC Project –Highlight Report. |
| **ASSURE** | **Outreach Update**<br>The Sub-Committee received a presentation that provided an overview of the provision of Outreach Services as a critical enabler to the delivery of chemotherapy and as a key strategy to enable cancer care closer to a patients' home and increased accessibility for patients.<br><br>The outreach Model includes the following components:<br>1. Outpatients.<br>2. SACT.<br>3. Radiotherapy.<br><br>The Sub-Committee noted the following next steps:<br>• Revised forecast assumptions to support further planning work, delivered by the Life Sciences Hub Wales e.g. population demographics update to inform VCS modelling for future cancer services.<br>• Discussion with Health Boards to understand their population requirements.<br>• Establish regional governance structure (internal and regional structures)<br>• Test & revise assumptions of original business case<br>• Agree Principles/assumptions for workforce model: nursing, pharmacy.<br>• Digital enablement across the region<br>• Opportunities for expansion of Care @ home to support further planning work.<br>• Challenges in outpatient repatriation Potential impact of RAAC/pharmacy reconfiguration/digital systems/health board reconfiguration in the region on ability to realise benefits of proposed outreach model.<br><br>The Sub-Committee welcomed and **NOTED** the Outreach Services presentation.<br>**Programme Directors Report (including all project updates in scope)** |

| | |
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| | The Sub-Committee received the report for the period covering 1st October – 31st October 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 following points were noted:<br><br>- Significant update on recruitment interdependencies to be provided on a quarterly basis;<br>- Next level of detail for the joining up of milestones is being progressed;<br>- There are a number of actions that do not have specific dates, and this is because different projects report these in difference ways. The Programme Team are reviewing this detail.<br>- Risk – there is a specific discussion on risks ongoing regarding the use of Datix and alignment of project/programme risks with the Trust policy.<br>- TrAMS update to be presented as part of the report at each meeting.<br><br>The Delivery Confidence Assessment (DCA) for the TCS Programme has been assessed against the DCA criteria and deemed to remain as Amber Red in this reporting period.<br><br>The Sub-Committee **NOTED** the Programme Director and Interdependencies Report and the actions being taken forward as discussed. |
| **INFORM** | **Communication and Engagement Update Report**<br>The Sub-Committee **NOTED** the Communication and Engagement Update Report.<br><br>**Public Accounts and Public Administration Committee**<br>The Sub-Committee **NOTED** that Trust representatives had attended the PAPAC meeting on 21st November 2024 to provide evidence on the procurement process to appoint the nVCC project developer and that a link to the video recording of the meeting which was held in Public was on the Senedd Website. |
| **APPENDICES** | None. |

# TRUST BOARD

## HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

| | |
|---|---|
| **DATE OF MEETING** | 30th January 2025 |
| **PUBLIC OR PRIVATE REPORT** | Public |
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |
| **PREPARED BY** | Sarah Haberfield, Business Support Officer |
| **PRESENTED BY** | Sarah Morley, Executive Director of OD and Workforce |
| **EXECUTIVE SPONSOR APPROVED** | Sarah Morley, Executive Director of OD and Workforce |
| **REPORT PURPOSE** | FOR NOTING |

| **ACRONYMS** | |
|---|---|
| LPF | Local Partnership Forum |
| SLT | Senior Leadership Team |
| VCC | Velindre Cancer Centre |
| WBS | Welsh Blood Service |

## 1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 12th December 2024.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

## 2. HIGHLIGHT REPORT

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|---|---|
| **ALERT / ESCALATE** | Nothing to escalate to Trust Board |
| **ADVISE** | Nothing to advise to Trust Board |
| **ASSURE** | Nothing to assure |
| **INFORM** | The Local Partnership Forum considered the following matters at the meeting:<br><br>**Senior Leadership VCC**<br>• **NOTED** Engagement will be starting WC 16th December 2024 about organisational change with the Senior Leadership Team at Velindre Cancer Service.<br><br>**Non-Payment Elements**<br>• **NOTED** the assurance prior to reporting to Welsh Government on the implementation of the non-pay parts of the 2022 to 2024 collective agreement.<br><br>**Sickness Deep Dive**<br>• **NOTED** the ongoing work around the Managing Attendance at Work Policy.<br>• **NOTED** the recommendations and outcomes from the audit undertaken two years ago; and improved sickness levels.<br><br>**Sexual Harassment Update**<br>• **NOTED** the changes to Worker Protection (Amendment of the Equality Act 2010) Act 2023, and the emphasis of the Trust's commitment to taking reasonable steps to prevent sexual harassment and aligning current practices with the new legislation.<br>• The Board is undertaking a session on WC 16th December 2024 on the expectations of the legislation.<br>**Annual People Strategy Update**<br>• **NOTED** the progress towards delivery on the implementation plan and highlighted key achievements and details some of the planned activity expected for the next IMTP. This included |

supporting staff with flexible working and the reduction in sickness absence.

**Anti Violence Collaboration**

- **DISCUSSED** and **NOTED** the Anti-Violence Collaboration update. Discussion took place regarding assurance that staff are reporting violence and aggression issues throughout the Trust. Welsh Government and South Wales Police highlighted the importance of this behaviour being reported to understand the true picture and themes. In November 2024 drop-in sessions were held for VUNHST staff with Cardiff and Vale Case Manager; another is planned before Christmas to look at individual safety. Violence and aggression issues are reported though the Health and Safety Report that feeds into the Performance Management Framework. Further comms is required to ensure all staff are reporting incidents on DATIX. The next Anti Violence Collaborative meeting will take place in January 2025.

**nVCC Update**

- **NOTED** the importance of Workforce and OD elements being put in place to support the transition period into the nVCC. Sarah Morley and Claire Budgen have a planned meeting with Aneirin Bevan Health Board to learn from their experiences whilst moving into the Grange University Hospital.

**Education Strategy Update**

- **NOTED** the Education Strategy Update that included.
  - The development of a competent, caring, and capable workforce
  - Future and Development of new training pathways
  - Roles and Academic Partnerships
  - High Quality Learning Environment

**People and OD Policies and Procedures**

- **ENDORSED** the amendments of the following policies bringing them up to date with current legislation and best practice.
  - Reviewed – Employing Ex Offenders and People with Criminal Record Policy
  - New – 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

| | |
|---|---|
| | **NHS Staff Survey Results**<br>• **NOTED** that 34% of VUNHS staff had completed the 2024 NHS Wales Staff Survey. |
| **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 PRIVATE REMUNERATION COMMITTEE** | |
| **DATE OF MEETING** | 30 January 2025 |
| **PUBLIC OR PRIVATE REPORT** | Public |
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |
| **PREPARED BY** | Sarah Haberfield, Business Support Officer |
| **PRESENTED BY** | Prof Donna Mead OBE, Velindre University NHS Trust Chair |
| **EXECUTIVE SPONSOR APPROVED** | Sarah Morley, Executive Director of Organisational Development & Workforce |
| **REPORT PURPOSE** | FOR NOTING |

## 1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Private Remuneration Committee on 20 November 2024.

1.2 Key highlights from the meeting are reported in section 2.

## 2. HIGHLIGHT REPORT

| | |
|---|---|
| **ALERT / ESCALATE** | There are no items for escalation to the Trust Board. |
| **ADVISE** | There are not items to advise to the Trust Board. |
| **ASSURE** | There are no items for assurance for the Trust Board. |

| | |
|---|---|
| **INFORM** | The Remuneration and Terms of Service Committee took the following actions:<br>• **NOTED** and **APPROVED** the JESP salary change within NWSSP.<br>• **APPROVED** the application of the new pay band for the previous Chief Executive Officer from 17 April 2024.<br>• **NOTED** the details of the pay awards for staff on Agenda for Change and Executive and Senior Management Pay Scales for 24/25.<br>• **APPROVED** the temporary appointment of the Executive Director of Strategic Transformation, Planning and Digital as the Deputy Chief Executive Officer up to 31 March 2025. |
| **APPENDICES** | N/A. |

3. The Board is requested to **NOTE** the contents of the report and actions being taken.

# TRUST BOARD

## TRUST SEAL REPORT: 28 NOVEMBER 2024 – 29 JANUARY 2025

| | |
|---|---|
| **DATE OF MEETING** | 30 January 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 **(28 November 2024 to 29 January 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 **(28 November 2024 to 29 January 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:<br>NO | |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety and experience ☐<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐<br>• A beacon for research, development and innovation in our stated areas of priority ☐<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐<br>• A sustainable organisation that plays its part in creating a better future for people across the globe ☐ | |
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)**<br>*For more information: STRATEGIC RISK DESCRIPTIONS* | 10 - Governance |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | **Select all relevant domains below** |
| | Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☐<br>Efficient ☒<br>Patient Centred ☐ |
| | |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:**<br>*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**<br>*For more information:*<br>*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 |
|---|---|---|
| **6th December 2024** | Counterpart Lease relating to units 4/5 Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff CF15 7QZ; between (1) Treforest Trustee (Jersey) Ltd and Treforest Nominee (Jersey) Ltd as Trustees of the Treforest Unit Trust (as Landlord) and (2) Velindre (as Tenant). | Stephen Harries, Vice Chair and David Donegan, CEO |

# TRUST BOARD

## HEALTH AND WELLBEING CHAMPION ANNUAL REPORT

| | |
|---|---|
| **DATE OF MEETING** | 30 January 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** | LAIRE BUDGEN, HEAD OF ORGANISATIONAL DEVLEOPMENT |
| **PRESENTED BY** | STEPHEN HARRIES, VCE CHAIR |
| **APPROVED BY** | SARAH MORLEY, EXECUTIVE DIRECTOR OF WORKFORCE AND ORGANISTIONAL DEVELOPMENT |
| **EXECUTIVE SUMMARY** | During 2024, individual positive health and wellbeing practices seen in some areas of the trust have been systemised and made available to all staff through improved communication and access to resources. Evaluation of wellbeing interventions is now being undertaken. SMART objectives for wellbeing actions will be developed for 2025-26. |
| **RECOMMENDATION / ACTIONS** | **Trust Board are asked to NOTE this report.** |

| **GOVERNANCE ROUTE** | |
|---|---|
| **List the Name(s) of Committee / Group who have previously received and considered this report:** | **Date** |
| **N/A** | |
| **UMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS** | |

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

## 1. SITUATION

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

1.2 Health and Wellbeing is a broad concept and it is applied in a wide range of ways within the Trust. At one end of the spectrum, there is a focus on individual health and wellbeing, both physical and psychological. At the other end, we are working to create conditions at an organisational level that will enable individuals, teams and the whole service to develop healthy work practices and to thrive. Employee wellbeing is an essential component of a healthy organisation; it decreases sickness, lowers stress and improves retention of staff whilst also enabling better patient outcomes and good team relations.

1.3 As the Health and Wellbeing Champion, I present a report each year to the Trust Board setting out activity and achievements for the previous year and priorities for the next year.

## 1. ACTIVITY AND ACHIEVEMENTS IN 2024

1.1 I have seen the support for staff health and wellbeing develop over the past 12 months. This is formally reported to me through reports from the Healthy and Engaged Steering Group to the Quality Safety and Performance Committee. During 2024, the Terms of Reference and the Membership of the Healthy and Engaged Steering Group were refreshed to ensure the correct level of representation from Divisions and professions which I see as essential in building a culture where wellbeing is prioritised in everything we do.

1.2 There have been many very positive events during 2024 which have supported health and wellbeing, including:

- Accessing the Working Together Charity fund of £110,000 over two years to employ the Wellbeing Project Coordinator in April 2024 and to furnish Noddfa in October 2024
- Re-commissioning the Employee Assistance Programme and moving over to Vivup as our partner
- Receiving the results from the new national NHS Staff Survey
- Launching the Health and Wellbeing Champions network
- Creation of a Trust Wide Health and Wellbeing resource page (August 2024)
- Trust Wide Monthly Menopause Cafes (October 2024)
- Undertaking health and wellbeing roadshows following the health and wellbeing calendar such as Stress awareness week, Menopause awareness week, World Mental Health Day and World Kindness Day
- The launch of the one-to-one wellbeing signposting service
- Welcoming the new Clinical Psychologist for Staff and Teams in October 2024
- Running the Employee Excellence Awards 2024, which attracted over 200 nominations and culminated in an Awards Event on 8 October 2024
- Compiling evidence-based reports on Sickness (November 2024) and Harassment, Bullying and Discrimination (January 2025) setting out the state of play in 2023-24 and organisational responses to these situations.

1.2 Nevertheless, at the start of 2024 it was clear that the positive wellbeing activities in some areas were not spread comprehensively across the Trust. The appointment of the Wellbeing Project Coordinator has allowed the Trust to improve communication and consistency of opportunities as well as evaluating and implementing further wellbeing activities.

1.3 The Health and Engaged Workplan for 2024-25 includes six objectives for health and wellbeing which have all contributed to improvements for staff. Progress with each is shown below.

**Developing an organisational culture of openness and psychological safety.**

The Trust Values of Caring, Respectful and Accountable have been embedded into recruitment, appraisal and all people processes. A Behavioural Framework has been published which brings the values to life. A programme of work has commenced on Employee Voice to:

- put into practice the Trust's approach to Speaking Up Safely through improved information and resources, producing an induction level video on How to Speak Up and organising the second tranche of Working Together sessions which are taking place in 2025.
- promote staff wellbeing activities, resources and roadshows highlighting the importance of wellbeing to the organisation.

**Building staff survey data into our work**
NHS Wales embarked on a new approach to the national staff survey in 2023, after a break from the former approach two years previously. The results were received in March 2024. The results have been reported at Trust level and a range of activities put in place to improve conditions for all staff. Alongside this, specific items of data are now being utilised for specific reasons, for example:

- The PADR and training results are reported to the People Development and Education Steering Group
- The Harassment, Bullying and Discrimination results have been used in a Deep Dive review linked to the Strategic Equality Plan
- The Medical Staff results have been reviewed by that professional group to formulate improvements to their working lives.

The 2023 results will be a benchmark for measuring change once the 2024 results are released.

**Embedding Values into recruitment, appraisal and development**
The Trust values of Caring, Respectful and Accountable have been embedded in all People and OD processes. A Behavioural Framework has been issued to bring these values to life. A Working Together session chaired by the Interim Chief Executive in July 2024 shared the values formally with staff.

**Introduce an evaluation methodology for health and wellbeing**
In August 2022, the Trust received and Advisory Report recommending that we introduce more robust evaluation of health and wellbeing activities so that we know what works well. With the appointment of the Wellbeing Project Coordinator in April 2024 and the Clinical Psychologist for Staff and Teams in September 2024, this has been put into practice and reports will be taken to the Healthy and Engaged Steering Group each quarter. Together they have produced an evaluation framework.

**Enhance Peer Support for Wellbeing**

The Health and Wellbeing Champions network was launched in 2024 as a proactive peer support tool and there are 35 fully-fledged Champions listed on the intranet for staff to contact with any issue. They are given the encouragement and support to facilitate health and wellbeing activities such as Couch to 5k or guided journalling. The network offers a forum for sharing and providing support to ensure Champions remain safe within this voluntary role. This is in addition to the one-to-one signposting talks or counselling available in the Trust from our own staff. Staff have reported that this has supported them and reduced the likelihood of taking sickness absence.

**Review against the NHS Wales Health and Wellbeing Framework**

The NHS Wales Health and Wellbeing Framework and the HEIW Best Practice Guide, which was published in April 2024, are embedded into our Health and Wellbeing project plan. The frameworks have been used to identify gaps in our provision for staff and thereby lead to relevant actions.

## 2. PRIORTIES FOR 2025

3.1 We will communicate and embed all the options for staff wellbeing that have been developed during 2024. This means working at local level with individuals and teams to ensure everyone is aware of an able to access any of the wide range of support that is available. In practice, this involves developing the Health and Wellbeing Champions network, ensuring that they are supported to provide peer support.

3.2 Specific goals for 2025 will be:

- Develop a response to the Harassment, Bullying and Discrimination review and build in 2024 data to complete the picture. Agree changes with staff to minimise these behaviours at work.
- Develop the Employee Voice process for Speaking Up Safely and Working Together engagement sessions.
- Introduce support for Sexual Safety at Work in partnership with NHS Wales colleagues.
- Develop a Staying Well at Work Package with the aim of preventing sickness absence and improving perceived organisational wellness.
- Develop a unified data capture system specific for health and wellbeing with a dashboard to communicate engagement and outcomes back to staff.
- Explore funding opportunities to create an embedded Health and Wellbeing Service with space and staff for each site.
- Establish a procedure and guidance for departmental interventions that have high mental health, stress and other related sickness.
- Develop proactive strategies to sickness deep dives such as the recent findings that mental health related absence is most prevalent in those aged 26 to 40.

- Establish support for managers to confidently and safely steer positive changes. Change is constant and can be rewarding and bring about opportunities for career development and quality in service provision. However, if it is handled badly, it can have a negative impact on staff health and wellbeing.
- Develop and improve procedures for reactive peer support-based resources. Following a potentially upsetting, traumatic or simply unusual incident at work, it is important to provide support through a robust process.

3.3 SMART objectives for these areas of work will be developed during Q4 as part of the development of the Healthy and Engaged Workplan for 2025-26.

## 3. IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:<br>**Choose an item** | |
| If yes - please select all relevant goals:<br>• Outstanding for quality, safety and experience ☒<br>• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐<br>• A beacon for research, development and innovation in our stated areas of priority ☐<br>• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐<br>• A sustainable organisation that plays its part in creating a better future for people across the globe ☒ | |
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)**<br>*For more information: STRATEGIC RISK DESCRIPTIONS* | 03 - Workforce Planning |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | **Select all relevant domains below**<br>Safe ☒<br>Timely ☐<br>Effective ☐<br>Equitable ☒<br>Efficient ☐<br>Patient Centred ☐ |

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| **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: | |
| If yes select the relevant goals:<br><br>• 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** | 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. |

## 4. RISKS

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

| TRUST BOARD | |
|---|---|
| **Academic Partnerships** | |
| **DATE OF MEETING** | 30th January 2025 |
| **PUBLIC OR PRIVATE REPORT** | Public |
| **IF PRIVATE PLEASE INDICATE REASON** | NOT APPLICABLE - PUBLIC REPORT |
| **REPORT PURPOSE** | INFORMATION / NOTING & ASSURANCE IN RESPECT OF THE TRUSTS COMPLIANCE WITH UNIVERSITY STATUS |
| **IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?** | NO |

| | |
|---|---|
| **Prepared By** | Nicola Williams, Executive Director Nursing, AHP & Health Science<br>Sarah Townsend, Head of Research & Development<br>Jennet Holmes, Head of Innovation<br>Gavin Bryce, Associate Director of Programmes |
| **PRESENTED BY** | Nicola Williams, Executive Director Nursing, AHP & Health Science |
| **APPROVED BY** | Nicola Williams, Executive Director Nursing, AHP & Health Science |

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| **EXECUTIVE SUMMARY** | This report is to provide the Trust Board with a summary of academic partnership working that has taken place during 2023/2024. Through 2024 effective collaboration with University partners has continued to grow across the following areas:<br>• Education<br>• Innovation<br>• Research<br>The paper summarises collaborations with Universities across Wales and beyond. |

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| **RECOMMENDATION / ACTIONS** | The Trust Board is asked to NOTE all the academic partnership working that has taken place during 2024. |

| **7 LEVELS OF ASSURANCE** | |
|---|---|
| | |
| **ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR** | Level 4 - Increased extent of impact from actions |

## 1. BACKGROUND

The Trust works closely with academic partners and in 2018 was awarded University status. The university approach is described as an organisational commitment, a 'continual process' that requires close working relationships. The following is a summary of what is required by organisations to have and maintain University status from an academic perspective during each period of assessment:

- Have strengthened the links they have with partner organisation(s).
- Demonstrate improved collaborative working and a shared strategic vision for university / Health Board / Trust activity.
- Strengthening formal arrangements on an ongoing basis with their principal partners, including reciprocal representation at a strategic level, enabling them to jointly discuss and consider the training, research and innovation agendas.
- University activity is demonstrably improving the quality of care and improving patient outcomes.
- University activity is promoted with confidence, strengthening workforce engagement, enhancing the reputation of Health Boards and Trusts and attracting people to work in Wales.

## 2. ASSESSMENT / MATTERS FOR CONSIDERATION

### 2.1 Deed of Association with the University of Wales and the University of Wales Trinity Saint David / Establishment of Velindre Oncology Academy

The Velindre Oncology Academy was formally launched in 2024. The Academy has been established for Velindre University NHS Trust, in line with several internationally renowned cancer services, to have a mechanism to provide both accredited and non-accredited, non-surgical oncology education, training and upskilling for the oncology workforce of Velindre University NHS Trust, Wales and wider. This is ensuring the Trust

and Wales oncology workforce can keep abreast of the rapidly developing oncology clinical landscape to support positive patient outcomes and experience. Prior to establishing the Academy such training was, in the main, only available outside of Wales.

Academic accreditation is a pivotal component in ensuring the success of the Academy so that course and module participants are able to gain appropriate academic credits for the education attainment achieved through the Academy up to Master's level.

In September 2023 a deed of association was signed between Velindre University NHS Trust, the University of Wales and the University of Wales Trinity Saint David (UWTSD). This deed provides the framework for working collaboratively to develop courses and modules in line with identified education requirements with MSc (Master Of Science)/BSc (Bachelor of Science – Degree) accreditation, as well as through the wider signatories of the Deed (colleges) vocational training. This provides the infrastructure for the Velindre Oncology Academy to be the principal provider of non-surgical oncology training for Wales and wider.

Robust collaborative working has taken place with UWTSD during 2024 through the development of a Curriculum Development Board. It is expected that the first course will be accredited by March 2025.

### 2.2 Establishing a Nursing and Allied Health Professional Cancer Research Culture and Programme – Partnership with Cardiff University

Since 2020 Velindre University NHS Trust has been working collaboratively through a Service Level Agreement with Cardiff University School of Health Sciences to develop the Velindre Cancer Service Nursing, AHP and Health Science infrastructure. For the first three years support was provided through a Professor in Nursing and Interdisciplinary Cancer Care.

During 2023 / 2024 the partnership was further enhanced, and the Cardiff University support infrastructure was shared across nursing, therapies and radiotherapy to broaden the impact (total of 0.5 multi-professional academic expertise). The outputs to date have been a growing interest and confidence in Nurses, AHPs & Scientists getting involved in research, an increase in the research competencies within these disciplines, increased generation of research questions, staff writing for publication, putting forward research funding bids, and seven staff starting on their research journeys from First into Research fellowships (4) to PhDs (3).

- Fellowship Schemes: The Velindre Healthcare Cancer Research Fellowship Scheme has empowered nurses, allied health professionals, and pharmacists to lead research projects and innovate within their fields.

- The Velindre Healthcare Cancer Research Fellowship Scheme empowers groups such as nurses and allied health professionals to be involved in undertaking research, aligning with workforce development goals.

An additional focus during 2024 was to align a research competency framework with career progression in line with the national Multi-Professional Enhanced, Advanced and Consultant Practice framework and to develop an infrastructure for Nurses, AHPs and Scientists to be Principle Investigators. This work has considerably raised the profile of research across these professions at Velindre.

### 2.3 Joint Academic Health Science Programme (JAHS)

Velindre University NHS Trust is a partner of the Joint Academic Health Science Programme (JAHS) established 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 and Vale University Health Board, and Velindre University NHS Trust JAHS aims to deliver transformative care, reduce health inequalities and create lasting improvements in healthcare for future generations. The nature of the lead and role for each organisation will be dependent upon their expertise, resources and the project being undertaken.

The JAHS Programme will leverage Cardiff University's world-class research expertise and Cardiff and Vale UHB and Velindre University NHS Trust (both cancer and blood service divisions) clinical knowledge to create a dynamic environment for translational health science. By combining academic and clinical strengths, the partnership aims to identify and collaborate with industry partners to accelerate the development and adoption of new medical technologies, digital tools, early interventions and preventive health strategies that will benefit patients across Wales and beyond.

### 2.4 Research

Significant research, development and innovation has taken place during 2024 which is detailed in the Research, Development and Innovation Annual Report. Velindre University NHS Trust demonstrates leadership and innovation in research activities that align with its strategic priorities and contribute to academic and clinical advancements. The following is a high-level flavour of the Trust's involvement in groundbreaking research achievements:

#### *2.4.1 Research Milestones*

- **New Treatment Development**: The Food and Drug Administration's (FDA's) approval of capivasertib, developed during the FAKTION trial, highlights Velindre's global impact in advancing breast cancer treatment.
- **Groundbreaking Clinical Trials**: Significant progress in major trials such as ARISTOCRAT for brain tumours and INTERLACE for cervical cancer. These trials have achieved record recruitment levels and are set to improve treatment standards worldwide.
- **Research Outputs**: Over 200 active studies, high recruitment success rates, and prominent representation at national and international conferences.
- **Research Papers (2023):**
  - Velindre Cancer Service 143 publications – 79 articles and 64 conference abstracts.
  - Welsh Blood Service: 31 publications – 11 articles and 20 conference abstracts. There were also 5 theses, 1 magazine article and 2 national guidance pieces.
- The Tessa Jowell Brain Research Centre has been renewed.

### *2.4.2 Collaboration and partnerships*

- The Trust has partnered with Cardiff University to develop the Cardiff Cancer Research Hub, which focuses on innovative approaches to cancer research in Wales.
- Contributions to the Health and Care Research Wales conference and media appearances on BBC and ITV have amplified the Trust's research visibility and impact.
- The Welsh Blood Service has a partnership arrangement with Cardiff Metropolitan University in respect of supporting staff to undertake their PHD.

### *2.4.3 Velindre University NHS Trust University Collaboration Examples*

| ***University*** | ***Nature of collaboration*** | ***Anticipated Outcome*** |
|---|---|---|
| Swansea University | Collaborative working Group established with Swansea University, South West Wales Cancer Centre, Velindre Cancer Centre and the Wales Cancer Research Centre to seek ways to increase opportunities for those pursuing a research career in medical radiation physics, leading to creation of this new scheme. | This programme will offer up to 5 predefined medical radiation physics projects for students on the MSc Medical Radiation Physics course at Swansea University beginning in 2025. All MSc dissertations will have a clinical focus potentially leading to the implementation of radiotherapy techniques and services that improve patient outcomes. |

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|---|---|---|
| Cardiff University | Cardiff University have developed an immunotherapy that harnesses antiviral T cells against epithelial tumours, with head and neck cancer a highly desirable target. The collaborative project that includes Velindre Cancer Service, and South-West Wales Cancer Service will evaluate the specific antiviral immune responses in patients pre- and post-current standard radiotherapy treatments and validate the immunotherapy in vitro as an adjuvant or neoadjuvant therapy to radiotherapy. | Exploration of possible enhanced patient outcomes. |
| National Software Academy (NSA) at Cardiff University | Digital collaborative project with NSA and the Welsh Blood Service to provide a digital solution for the donor travel look up to identify any travel to high risk countries which is required to confirm their eligibility to donate which is currently a manual process which given the complexity of this matter has a risk of error. | Prototype digital solution for WBS Travel Screening developed. Project has helped to shape understanding and solution for travel history digital screening. Benefits include:<br>• quicker, more efficient travel history assessment, therefore better donor experience<br>• reduced amount of time spent by donor in blood donation clinic<br>• reduced opportunity for error, improved data quality” |
| Swansea University | PhD student sponsorship from the Computing Foundry at Swansea University collaborating with Trust on Digital PROMs. PhD topic “Developing Data driven PROMs and Evaluations of Inclusive Digital Interventions to Support Patient Led Cancer Care Pathway”. The work was set up to look at the philosophy of patient centric healthcare using the methodology of participatory design and Digital Patient Related Outcome Measures (PROMs) as the technology platform. | The work undertaken was fed into the Value Based Healthcare programme to inform the Patient Related Outcome Measures work which is now in the implementation phase. |
| Cardiff University | Cardiff Cancer Research Hub (CCRH) – A formal collaboration between the Trust, Cardiff & Vale University Health Board and Cardiff University aimed at:<br>• Improving access to novel cancer treatment and therapies therefore improving quality of life<br>• Access to exciting new research and career opportunities | The following deliverables were achieved during 2024<br>• Two live Clinical Trials<br>• Other Clinical Trials in a pipeline<br>• A draft Partnership Agreement (following the heads of terms) |

| | | |
|---|---|---|
| | • Support in taking new discoveries from lab to clinic<br>• More integrated working between scientists and NHS Clinicians<br>• Enhanced reputation helping to attract research investment and top talent<br>• A sustainable cancer research pipeline<br>• The potential to generate a financial surplus that could be invested in local research and development activities<br>• Reduced environmental impact of patients travelling outside of Wales to Access Treatment<br>• Increased public awareness of cancer risk factors and symptoms | |

## 2.5 Innovation

The Trust innovation vision is to be an International Beacon for Innovation in Cancer and Blood Services. Its mission is to drive continuous improvement and breakthrough innovations in cancer and blood services by fostering a culture of innovation, creativity, collaboration, and excellence. There are four strategic objectives:

- Enhance patient outcomes and improve patient and donor experience
- Improve operational efficiency
- Strengthen collaboration: build strategic partnerships with academic institutions, industry, third sector, government/governmental support organisations and other healthcare organisations to accelerate innovation.
- Cultivate an Innovation Culture.

The following is a snapshot of collaborative innovation activity for 2024:

| Institute | Collaboration | Overview | Outcome |
|---|---|---|---|
| Swansea University | Intensive Learning Academy/Welsh Government/University Trinity St Davids | Head of Innovation PhD: 'The enablers and barriers to implementing an innovation management system within the Trust' Climb / spread and scale Academy and visibility of other MSc projects from across NHS Wales and social care. | • PhD pursued<br>• Secured funding for the whole Team to participate in the spread and scale academy<br>• Strategy development |

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| University Trinity St Davids / Swansea University | Developing an innovation training module for ESR (electronic staffing record) | Developed an innovation training module in conjunction with Innovation leads UWTSD and Swansea University | Module will be ready for piloting in March 2025 (to raise the awareness of innovation) capability/culture |
| University Trinity St Davids | To develop a micro credential MSc level for innovation in partnership with the Velindre Oncology Academy | As part of a suite of offering or as a standalone qualification – to raise awareness of innovation, capability and competence of workforce and potential income generation | This is in progress |
| Oxford University Innovations | Peer comparison in relation to industry partnerships/ collaborations | Exploring opportunities for innovation commercialisation | Intended outcome is to develop options to agree direction of travel for the Trust |
| Birmingham University | Partnership project for Small Business Research Initiative (SBRI) project | UK Research Initiative (UKRI) Future Flight Programme – successful bid for funding for a partnership with two industry partners to develop a Welsh NHS Medical Drone Delivery Network | Business case being developed and debate scheduled for the Senedd Feb re: drone infrastructure |

## 2 IMPACT ASSESSMENT

| **TRUST STRATEGIC GOAL(S)** | |
|---|---|
| Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:<br>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 | ☐ |

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|---|---|
| **RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)**<br>*For more information: STRATEGIC RISK DESCRIPTIONS* | 03 - Workforce Planning |
| **QUALITY AND SAFETY IMPLICATIONS / IMPACT** | **Select all relevant domains below** |
| | Safe ☒<br>Timely ☒<br>Effective ☒<br>Equitable ☒<br>Efficient ☒<br>Patient Centred ☒ |
| | Donor and Patient experience should be at the centre of everything we do at the Trust and all quality and safety activities. |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:**<br>*For more information:*<br>*https://www.gov.wales/socio-economic-duty-overview* | Not required |
| | |
| **TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT** | A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health |
| | If **Click or tap here to enter text** |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
| | |
| **EQUALITY IMPACT ASSESSMENT**<br>*For more information:*<br>*https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx* | Not required - please outline why this is not required |
| | This is reporting of activity |

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| **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

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| **ARE THERE RELATED RISK(S) FOR THIS MATTER** | No |