Bundle Public Trust Board Meeting - Velindre University NHS Trust 24 November 2022

1.0.0 10:00 - STANDARD BUSINESS
Led by Prof Donna Mead OBE, Chair

1.1.0 Apologies
Led by Prof Donna Mead OBE, Chair

1.2.0 In Attendance
Led by Prof Donna Mead OBE, Chair

1.3.0 Declarations of Interest
Led by Prof Donna Mead OBE, Chair

1.4.0 10:10 - ACTION LOG **To Follow**
Led by Prof Donna Mead OBE, Chair

1.4.1 Matters Arising
Led by Prof Donna Mead OBE, Chair

2.0.0 10:15 - CONSENT ITEMS

2.1.0 For Approval
Led by Prof Donna Mead OBE, Chair

2.1.1 Minutes from the Public Trust Board meeting held on 29.09.2022
Led by Prof Donna Mead OBE, Chair
- 2.1.1 PUBLIC TB MINUTES 29.09.2022_ES-LF- final review.docx

2.1.2 Chair's Urgent Actions Report
Led by Prof Donna Mead OBE, Chair
- 2.1.2 Chairs Urgent Action Report_November 2022.docx

2.1.3 Commitment of Expenditure Exceeding Chief Executive's Limit
Led by Matthew Bunce, Executive Director of Finance
- 2.1.3 November 2022 Trust Board_Commitment of Expenditure Cover Paper.docx
- 2.1.3 Appendix 1 Commitment of Expenditure - Donor Cards Contract.pdf
- 2.1.3 Appendix 2 Commitment of Expenditure - Foetal RHD Testing (2).pdf
- 2.1.3 Appendix 3 Commitment of Expenditure - International Courier Contract for NEQAS_ WBMDR.pdf
- 2.1.3 Appendix 4 Commitment of Expenditure - Private Patient Specialist Support.docx
- 2.1.3 Appendix 5 - Commitment of Expenditure - Oncotype Testing.pdf
- 2.1.3 Appendix 6 Commitment of Expenditure - Gov Notify v2.pdf

2.1.4 Trust Wide Policies
Led by Lauren Fear, Director of Corporate Governance & Chief of Staff
- 2.1.4a Approved Policies Update Nov v1.docx
- 2.1.4b Appendix 1 CF02 - Velindre Charity Travel and Expenses Reimbursement Policy_v4_Sept 2022.pdf
- 2.1.4c Appendix 2 CF03 - Velindre Charity Credit Card Policy_v4_Sept 2022.pdf
- 2.1.4d Appendix 3 IPC21 Management of Respiratory Infection_v4_Nov 22.pdf
- 2.1.4e Appendix 4 IPC10 Hand Hygiene_v6_Nov 22.pdf
- 2.1.4f Appendix 5 IPC00 Framework Pollicy_Infection Prevention Control_v6_Nov 22.pdf
- 2.1.4g Appendix 6 QS25 Preceptorship Policy_v4_Nov 22.pdf
- 2.1.4h Appendix 7 PP04 Asbestos Policy_v2_Nov 22.pdf
- 2.1.4i Appendix 8 PP05 Control of Contractors Policy_v4_Nov 22.pdf
- 2.1.4j Appendix 9 PP09 Water Safety Policy and Appendices_v2_Nov 22.pdf

2.2.0 For Noting
Led by Prof Donna Mead OBE, Chair

2.2.1 Transforming Cancer Services Communication and Engagement Update
Led by Lauren Fear, Director of Corporate Governance & Chief of Staff

2.2.1 Trust Board November TCS Communications_Engagement Report.docx

2.2.2 Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report

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

2.2.2 Highlight Report - PUBLIC TCS 22.09.22-LF.docx

2.2.2 Highlight Report - PUBLIC TCS 18.10.22 - CJ - SH v2.docx

2.2.3 Strategic Development Committee Highlight Report 13.10.2022

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

2.2.3 Highlight Report - PUBLIC SDC 13.10.22-LF - SH.docx

2.2.4 Quality, Safety & Performance Committee Highlight Report 10.11.2022

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

2.2.4 Public Quality Safety Performance Committee Highlight Report 10.11.22(v3VM).docx

2.2.5 Audit Committee Highlight Report 04.10.2022

Led by Martin Veale, Independent Member and Chair of the Audit Committee

2.2.5 Audit Committee Part A Public Highlight Report 04 October 2022-LF12480 (GJ).docx

2.2.6 Remuneration Committee Highlight Report 22.09.2022 & 25.10.2022

Led by Prof Donna Mead OBE, Chair

2.2.6a Highlight report 22.09.2022_.docx

2.2.6b Highlight report 25.10.2022_.docx

2.2.7 Welsh Health Specialised Services Committee Joint Committee Briefing 08.11.2022

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

2.2.7 WHSCC Joint Committee Briefing (Public) 8 November 2022.pdf

2.2.8 NHS Wales Shared Services Partnership Assurance Report 22.09.2022

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

2.2.8 Shared Services Partnership Assurance Report 22 September 2022 (003).doc

2.2.9 COVID 19 Inquiry Prep Group Highlight Report

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

2.2.9 COVID 19 Prep Group Highlight Report.odt

2.2.9 Covid-19 Inquiry Preparaton Group-ToR - Aug 2022.docx

TOR - Appendix 2 - Covid-19-Inquiry-Terms-of-Reference-Final.pdf

3.0.0 KEY REPORTS

3.1.0 10:20 - Chair's Update

Led by Prof Donna Mead OBE, Chair

3.1.0 Chair Update Nov 2022 v2 LF DM.docx

3.2.0 10:30 - Chief Executive's Update

Led by Carl James, Deputy Chief Executive

3.2.0 Chief Exec Report vFINAL.docx

4.0.0 ANNUAL REPORT

4.1.0 10:40 - Wales Infected Blood Support Scheme (WIBSS)

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

4.1.0a WIBSS - Annual report - cover.docx

4.1.0b WIBSS WALES INFECTED BLOOD SUPPORT SCHEME (WIBSS) ANNUAL REPORT 20212022 ver2.pdf

5.0.0 QUALITY, SAFETY AND PERFORMANCE

5.1.0 10:50 - Delivering Excellence Performance Report

Led by Cath O'Brien MBE, Chief Operating Officer

5.1.0 VUNHST SEPTEMBER PERFORMANCE COVER PAPER FOR Nov Trust Board v2 24.11.22_.docx

5.1.0 Appendix 1 VCC Performance Report - Sep 2022 v6_.docx

5.1.0 Appendix 2 WBS Sept2022 PMF Final Report.pdf

5.1.0 Appendix 3 Trust-wide WOD Performance Report - September 2022.pdf

5.2.0 11:20 - Financial Report Period September 2022

Led by Matthew Bunce, Executive Director of Finance

5.2.0a Month 6_Sept Finance Report Cover Paper - TRUST BOARD 24.11.2022.docx

5.2.0b M6 VELINDRE NHS TRUST FINANCIAL POSITION TO SEPTEMBER 2022 - TRUST BOARD 24.11.2022.docx

5.2.0c TCS PROGRAMME FINANCE REPORT Period ending Sept 2022.docx

5.3.0 11:30 - BREAK 11:30 - 11:40

5.4.0 11:40 - VUNHST Risk Register

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

5.4.0 EXTRACTS FOR REPORT - RISKS OVER 15 - WITH ACTIONS - 02.11.22 - FOR REVIEW.pdf

5.4.0 V01 - TB - Trust Risk Register Paper - 24.11.22 - Final.pdf

5.4.0 level 15 risks.pdf

5.5.0 11:50 - Trust Assurance Framework

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

5.5.0 V02 - TAF Review Paper - NOV 2022 - TB- Final.docx

5.5.0 V22 TAF DASHBOARD - UPDATED 16.11.2022.pdf

5.6.0 12:00 - Nurse Staffing Levels (Wales) Act 2016

Led by Nicola Williams, Executive Director of Nursing, AHP's & Medical Scientists

5.6.0 Nurse Staffing Levels.docx

6.0.0 LEGAL MATTERS

6.1.0 12:10 - Infected Blood Inquiry

Led by Cath O'Brien MBE, Chief Operating Officer

6.1.0 Trust Public Board Update COB Final 18.11.2022.docx

7.0.0 STRATEGIC

7.1.0 12:20 - Integrated Medium Term Plan (IMTP) Q1 and Q2 Progress and Accountability Conditions

Led by Carl James, Director of Strategic Transformation, Planning and Digital

7.1.0 Trust Board Cover Paper - Accountability IMTP Q1 Q2 Progress 2022-2025 version final.docx

7.1.0a Appendix A IMTP Account Conditions 2022.25 IQPD Q1 Q2 version 005 cj.docx

7.1.0bAppendix B IMTP Strategic Priorities VCC Service Delivery Framework 2022 Q 1 & Q2 Progress version 003.docx

7.1.0c Appendix C WBS IMTP Quarter Progress 2022 25 version 003.docxAP.docx

7.1.0d Appendix D Trust wide Programmes IMTP Quarter Progress 2022. 25 version vbhc sys rdi sus clin dig 006.docx

7.1.0e Appendix E Support Services IMTP Quarter Progress 2022. 25 version est dig wod 003.docx

7.2.0 Prioritisation Framework and Transformation Roadmap

Led by:
Carl James, Acting Chief Executive
Lauren Fear, Director of Corporate Governance & Chief of Staff

7.3.0 Prioritisation framework and roadmap - Final.odt

7.3.0 Prioritisation Framework and Transformation Roadmap - TB - 24.11.pptx

7.3.0 12:40 - Anti-Racist Wales Trust Action Plan

Led by Sarah Morley, Executive Directo of Organisational Development and Workforce

7.3.0 Board Anti-Racist Action Plan 24.11.22.docx

8.0.0 BUSINESS CASE

8.1.0 12:50 - Business Case for the Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS)

Led by Carl James, Director of Director of Strategic Transformation, Planning and Digital

8.1.0 20221124 Trust Board Public WHAISIT Business Case (cover paper).docx

8.1.0a 20221124 Trust Board Public WHAISIT Business Justification Case (appendix 1) Strategic Case.docx

8.2.0 13:00 - LUNCH 13:10 - 14:00

9.0.0 ANY OTHER BUSINESS

Led by Prof Donna Mead OBE, Chair
(Prior approval required by Chair)

10.0.0 CLOSE

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

MINUTES PUBLIC TRUST BOARD MEETING – PART A

VELINDRE UNIVERSITY NHS TRUST LIVE STREAMED
29 SEPTEMBER 2022 at 10:00AM

PRESENT	
Professor Donna Mead OBE	Chair
Stephen Harries	Vice Chair
Hilary Jones	Independent Member
Professor Andrew Westwell	Independent Member
Nicola Williams	Executive Director of Nursing, AHPs and Health Science
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director
Vicky Morris	Independent Member
Martin Veale	Independent Member
Sarah Morley	Executive Director of Organisational Development and Workforce
ATTENDEES	
Lauren Fear	Director of Corporate Governance and Chief of Staff
Carl James	Director of Strategic Transformation, Planning and Digital
Cath O'Brien MBE	Chief Operating Officer
Emma Stephens	Head of Corporate Governance
Kay Barrow	Corporate Governance Manager
Lenisha Wright	Business Support Officer, Secretariat

1.0.0	STANDARD BUSINESS	ACTION LEAD
	The Chair opened the meeting and welcomed everyone in attendance.	
1.1.0	**Apologies noted:** • Stephen Allen, Chief Officer, Community Health Council (CHC) • Gareth Jones, Independent Member • Steve Ham, Chief Executive • David Cogan, Patient Liaison Representative	
1.2.0	**Attendance noted:** • Katrina Febry, Audit Wales Lead • Brenda Chamberlain, Vice Chair Community Health Council	
1.3.0	**Declarations of Interest** There were no declarations of interest to **NOTE**.	
1.4.0	**ACTION LOG** Committee members confirmed there was sufficient information contained in the log to provide assurance that all actions identified as completed could be **CLOSED**. The Action Log was **APPROVED**.	

1.4.1	**Matters Arising** There were no matters arising.	
2.0.0	**CONSENT ITEMS**	
2.1.0	**For Approval**	
2.1.1	**Minutes from the Public Trust Board meeting held on 29 September 2022** The Trust Board **APPROVED** the Minutes of the meeting held on the 29 September 2022 as an accurate and true record.	
2.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chairs Urgent Actions taken between the 01/08/2022 – 21/09/2022 as outlined in Appendix 1 of the report.	
2.1.3	**Commitment of Expenditure Exceeding Chief Executive's Limit** The following was noted: • The date on **Page 2** of the cover paper was agreed to be amended to state **2025**. • It was noted that a full list of abbreviations will be provided by service leads as required to enable the inclusion of a complete glossary of terms for future reporting. The Trust Board **AUTHORISED** the Chief Executive to **APPROVE** the award of contracts summarised within this paper and supporting appendices and **AUTHORISED** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.	
2.1.4	**Trust Wide Policies** The following was noted: • The first paragraph on **Page 6** in the Equality and Diversity Policy will be removed. The Trust Board: • **APPROVED** the following Trust Workforce and Organisational Development (WOD) Policies: o WF05 Equality and Diversity Version 4 – Annexure 1. o WF44 Working Time Regulations Policy Version 3 – Annexure 2. • **AGREED** to adopt the following NHS Wales WOD Policies and Procedures for use within the Trust: o WF14 NHS Wales Special Leave Policy December 2020 – Annexure 3 o WF50 NHS Wales Pay Progression Policy Updated May 2022 (for go live in October 2022) – Annexure 4 o WF24 Procedure for NHS Staff to Raise Concerns (Whistleblowing) May 2021 – Annexure	

2.2.0	**For Noting**	
2.2.1	**Transforming Cancer Services (TCS) Communication and Engagement Update** The Trust Board **NOTED** the contents of the TCS Communication and Engagement Update report and the Appendix for the Summer Jamboree Event which received media coverage on ITV.	
2.2.2	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report 22.09.2022** A verbal update was provided highlighting the following: • Due to timing and delays, arrangements are being made to submit unutilised funds back to Welsh Government in the current financial year, which will be reverted back to the Trust in the new financial year. • Approval is awaited on the Integrated Radiotherapy Solution (IRS) and the Radiotherapy Satellite Business cases. The Highlight report will be circulated to the Board separately.	
2.2.3	**Quality, Safety & Performance Committee Highlight Report 15.09.2022** The Trust Board **NOTED** the key deliberations and highlights from the meeting of the Quality, Safety and Performance Committee held on the 15th September 2022.	
2.2.4	**Audit Committee Highlight Report 19.07.2022** The Trust Board **NOTED** the key deliberations and highlights from the meeting of the Audit Committee held on the 19th July 2022.	
2.2.5	**Local Partnership Forum Highlight Report 06.09.2022** The Trust Board **NOTED** the contents of the Local Partnership Forum Highlight Report from the meeting held on the 6th September 2022 and the actions undertaken.	
2.2.6	**Welsh Health Specialised Services Committee Joint Committee (WHSSC) Briefing 06.09.2022** The Trust Board **NOTED** the contents of the WHSSC Joint Committee Public Briefing.	
2.2.7	**NHS Wales Shared Services Partnership - Assurance Report 21.07.2022** The Trust Board **NOTED** the work of the NHS Wales Shared Services Partnership Committee Assurance Report.	
2.2.8	**Trust Seal Report - April 2022 to August 2022** The Trust Board **NOTED** the contents of the Trust Seal Register included in Appendix 1 of the report.	
3.0.0	**KEY REPORTS**	

3.1.0	**Chair's Update** The Trust Board **NOTED** the content of the Chair's update report.	
3.2.0	**Chief Executive's Update** The Trust Board **NOTED** the contents of the Chief Executive's update report and Appendix 1 confirming approval of the Integrated Medium-Term Plan 2022-2025 by the Minister.	
4.0.0	**QUALITY, SAFETY AND PERFORMANCE**	

4.1.0	**Delivering Excellence Performance Report July 2022**
	
	Cath O'Brien highlighted key points for the Velindre Cancer Service (VCS) and the Welsh Blood Services (WBS) July 2022 Performance Report.
	
	Velindre Cancer Service
	• To meet the challenges faced in July 2022, workforce capacity was effectively utilised to achieve performance goals.
	• Performance was below target in several key areas for July 2022 however considerable improvements have been made through August 2022.
	• The removal of support services by Rutherford has had significant impact for future planning assumptions. The teams have been working on alternative solutions to this during July and August 2022.
	• To address workforce challenges the following is being undertaken:
	  ○ Ongoing recruitment of key staff
	  ○ Ongoing assessment and planning to ensure the most efficient utilisation of staff
	  ○ A comprehensive piece of work into skill mix is underway
	• The LA6 commissioning will commence during January to March 2023.
	
	Discussion, comments and contributions are summarised below:
	• Assurance was given that patients were clinically prioritised during the reporting period.
	• Delays regarding repatriation is due to insufficient staffing capacity to run chairs at full capacity at Prince Charles Hospital. Assurance was given that work is underway to reach full chair capacity in the coming weeks.
	• There is a review of the Key Performance Indicators (KPIs) for waiting times. Assurance was given to the Board that the new measures will be patient and donor focussed with a true reflection on performance. It was clarified that the metric is under review to ensure it is more clearly patient and donor focused, rather than any attempt to dilute the target
	• The metric for outpatient clinic bookings is currently captured manually. A standardised process for data capturing is currently under discussion for improvements.
	• Regarding breaches, for example breast cancer patients (page 4), more narrative will be included in future reporting.
	• The team were praised for exceeding expectations with the treatment of Sepsis patients who were assessed and treated in a timely manner.
	
	Welsh Blood Service (WBS)
	• There were UK wide challenges in managing stock levels during the period. In the midst of considerable difficulty, the service managed to	

	keep operations running by working effectively with Health Boards to manage stock levels. • A blue alert, which means caution, was in place in July 2022 which was subsequently removed during August 2022, made possible through arrangements made for providing additional capacity. • There is focus on building stock levels through September 2022 in preparation for the coming winter months. • There were constraints in recruiting volunteers to the donor registry as visits to schools and colleges were not able to take place during Covid-19 restrictions. With the situation changing, a significant drive is underway to improve the donor registry during the autumn months. Discussion and comments are summarised below: • An action plan is in place with the support of workforce colleagues to address absenteeism due to sickness. • The current target has been exceeded for a number of years. These targets are historical and will be reviewed and refreshed with the new scorecard that will be implemented in the coming year. • The impact of the energy crisis on travel for donors is a concern. Work is underway to minimise any negative impact on donors. **Workforce and Organisational Development (WOD)** In presenting the report Sarah Morley highlighted the following: • The organisation has achieved a performance rating of 70% for Personal Appraisal Development Review (PADR). Further improvement is needed and WOD is working with line mangers toward improving the rating. • The Trust is above target for mandatory and statutory training. • Stress and anxiety makes up one third of the overall sickness. WOD are working with managers and leadership teams, on a case by case basis to help staff return to work using a person centred approached. • The appointed staff Psychologist is supporting the workforce team with a myriad of issues. Discussion and comments relating to WOD are summarised below: • Staff absence for reasons other than sickness will be reviewed to determine what information can reported in the future. • There are ongoing discussions in the national fora around sickness and absence. • Absence related to sickness is benchmarked against data from other organisations. Trust Board **NOTED** the contents of the July 2022 performance reports and the following attached Appendices: a) VCC May PMF Report b) WBS May PMF Report c) Workforce Monthly PMF Report d) Capacity and Demand Update	
4.2.0	**Financial Report Period ended August 2022** Matthew Bunce highlighted the following regarding performance, risks and assumptions:	

	• The revenue and capital position is in line with expectations as planned within the IMTP. • Capital expenditure is within the current funding provision from Welsh Government. • Public sector performance is within the 95% target. • The forecasted COVID response costs are around £1.1million. The assumption is that Welsh Government will continue to fund these costs minimising the impact of associated risk. • The assumption is that the increased energy costs which is a National pressure, is recoverable. • It is expected that the Trust will deliver on all its savings plans. Trust Board **NOTED**: • The contents of the August 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs. • The TCS Programme financial report for August 2022 attached as Appendix 1 of the report.	
4.3.0	**VUNHST Risk Register** In presenting the risk register, Lauren Fear highlighted the following: • The review of the Velindre Cancer Service risks outlined in section 2.1 remains a focus of the Senior Leadership Team (SLT) with workshops scheduled. There is commitment from the SLT to have all the actions recorded in Datix and completed by the next reporting period. • Audit Committee have endorsed the Risk Policy for Trust Board approval. • The Trust is responding to a draft report from Audit Wales following their audit on quality governance. The document shares insight and useful information on the overall approach to risk. Feedback will be shared during the next reporting cycle. Additional comments: • Regarding risks pertaining to recruitment, both the medium and long term staffing needs are being actively addressed. • Actions are progressing to address risks around digital and health care records. • Future cover papers to reflect a summary of the challenges and observations discussed at previous Committees. Trust Board: • **NOTED** the risks level 20, 16 and 15 reported in the Trust Risk Register • **NOTED** the on-going developments of the Trust's risk framework. • **APPROVED** the Trust Risk Management Policy in Appendix 2.	
5.0.0	**ANNUAL REPORTS**	
5.1.0	**Health and Safety Annual Report** In presenting the report, Carl James highlighted the following:	

	• This has been a positive year with good progress made in key areas including leadership, health and safety, systems and processes, and training and culture. • Key individuals within the Estates and Facilities teams continue to lead and drive processes forward. • Work is being done to address missed opportunities that could have prevented some of the incidents and injuries included in the report. • Training has improved and will continue to be a focus to achieve higher levels of compliance. Comments and observations: • A request was made that assurance is given to the Board that all electrical and water safety testing has been completed. • The reporting on violence and aggression patients and donors as a whole is low. It was noted that thresholds vary but that there is a good culture of reporting in both the WBS and VCC. The Board **APPROVED** the Health and Safety Annual Report **ACTION**: A note to be circulated to Board that all electrical and water safety testing has been completed and within compliance.	**CJ**
5.2.0	**Welsh Language Annual Report** In presenting the Welsh Language Annual Report, Sarah Morley highlighted the following: • This report is produced and published in line with regulation. • The report reflects the areas of work undertaken to achieve compliance with Welsh language standards. • A broader picture referred to as our cultural plan is provided to convey what it is that we are actually trying to achieve. Beyond Welsh Language standards and words framework, this is about providing the best environment for patients, donors and staff who want to engage through the medium of Welsh, in a bilingual country. • Governance processes and working groups are in place. • The appointed ambassador is the Chief Executive, Steve Ham and the appointed Independent Member champion is Gareth Jones. • Translations of all documents and communication is a challenge, for example, timely translations to ensure recruitment advertisements are progressed at required pace. Assurance was given that all of these issues are being looked at and prioritised. • All complaints and concerns received for example regarding the website being bilingual have been responded to. • The Quality, Saefty and Performance Committee Highlight report reflects the thorough discussions held around Welsh Language. Comments and observations: • The Chair noted that the report is authentic telling a story of where we are and how far we have to go. The WOD team were commended for this. • Future reporting will reflect the number of staff receiving Welsh Language training.	

	• Translation services in addition to Welsh may be required, however this goes beyond current statutory provisions. Amendment: • Last paragraph on Page two (Introduction by the Chief Executive) will be amended to read that the Trust Board supports the ethos of the new Cultural plan. • The penultimate paragraph on Page 3 will be amended to clarify that reference is made to caller requests to be spoken to in Welsh. The Trust Board **APPROVED** the Welsh Language Annual Report 2021-22	
6.0.0	**ESTATES**	

6.1.0	**Capital Scheme for Ventilation at Velindre Cancer Centre**
	
	In presenting the report Carl James highlighted the following:
	• In terms of background, the Business case presented to the Board in 2021 was approved with two conditions:
	  ○ A solution with minimal impact on inpatient wards
	  ○ Prevalence of COVID and impact on the treatment of patients
	• Prevalence of COVID and the flu season have made it challenging to find the right time to start the implementation work.
	• Interim arrangements are in place with no concerns of additional harm.
	• Based on value for money Executive Management Board arrived at the conclusion on balance, that it would be feasible to enhance the interim arrangements rather than continuing with the Capital Scheme.
	
	The following was clarified:
	• The matter under consideration is whether to proceed with the permanent £2.2million ventilation scheme or continue to implement existing arrangements.
	• A cost benefit analysis can only be done following the decision taken by the Board.
	
	The Board **APPROVED**:
	i. The Business Justification Case and planned capital ventilation scheme is not progressed.
	ii. The current solution is made permanent with the optimum option deployed following cost-benefit analysis.	

7.0.0	**ANY OTHER BUSINESS** There were no other business items.	
8.0.0	**DATE and TIME OF THE NEXT MEETING** Thursday 24th November 2022	

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	**CONSIDER** and **ENDORSE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Board Members – Via Email	12/10/2022	Approved
Trust Board Members – Via Email	17/10/2022	Approved

ACRONYMS	
EW	Enabling Works
EPSL	European Protected Species Ltd
MIM	Mutual Investment Model
nVCC	New Velindre Cancer Centre
PQQ	Pre- Qualification Questionnaire
SFIs	Standing Orders
SOs	Standing Financial Instructions

1. SITUATION/BACKGROUND

1.1 In accordance with Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Board, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and Chief Executive, supported by the Director of Corporate Governance & Chief of Staff, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Director of Corporate Governance & Chief of Staff must ensure that any such action is formally recorded, and reported to the next meeting of the Board for consideration and ratification. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.

1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

1.3 This report details Chair's Urgent Action taken between the **29/09/2022** – **15/11/2022**.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

The items outlined in **Appendix 1** have been dealt with by Chairs Urgent Action.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) 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.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Legal impact was captured within the documentation considered by the Board.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Financial impact was captured within the documentation considered by the Board.

4. RECOMMENDATION

4.1 The Board is asked to **CONSIDER** and **ENDORSE** the Chairs urgent action taken between the **29/09/2022** – **15/11/2022** as outlined in **Appendix 1**.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. Execution of NRW – TCAR2 European Protected Species Ltd (EPSL)

The Trust Board were sent an email on the **12/10/2022** to **APPROVE** delegation to the Chair and Chief Executive of Velindre University NHS Trust to sign the updated bespoke Access License, in order to ensure that the Trust is able to fulfill its EPSL obligations for the new Velindre Cancer Centre (nVCC), and for the Trust seal to subsequently be affixed to the License.

A number of clarifications / points were raised regarding the bespoke Access License in respect of:

- **Clause 4** Insurance
- **Clause 8** Indemnity
- **Clause 12** Waiver

These were subsequently addressed and necessitated some minor revisions to the wording of both **Clause 4, Clause 12** and the subsequent removal of **Clause 8** contained within the License. In addition, further minor revisions were agreed to confirm that:

- Use of the property is for a purpose rather than occupation
- The Licence will terminate if the EPSL is terminated

Recommendation Approved by:

- Donna Mead, Chair
- Stephen Harries, Vice Chair
- Steve Ham, Chief Executive Officer
- Hilary Jones, Independent Member
- Gareth Jones, Independent Member
- Vicky Morris, Independent Member
- Sarah Morley Executive Director of Organisational Development & Workforce

No objections to approval were received.

2. nVCC Enabling Works (EW) Contractual Matters

The Trust Board were sent an email on the **17/10/2022** regarding the nVCC EW Project(s) and a range of contractual matters that required new approvals relating to:

- WSP UK Ltd – professional services contract for the Enabling Works
- DLA Piper LLP– legal advice and support for the delivery of the nVCC Mutual Investment Model (MIM) Project covering Pre- Qualification Questionnaire (PQQ), dialogue and successful participant to financial close
- Mott MacDonald – technical support for the nVCC S73 planning application
- Nexus Security – security services during the tree clearance works

The Trust Board were requested to **APPROVE** the following:

- **WSP UK Ltd** – professional services contract for the Enabling Works
  - Issue a new contract for **£0.500m;**
- **DLA Piper LLP** – legal advice and support for the delivery of the nVCC MIM Project covering successful participant to financial close
  - Issue a new contract for the successful participant to financial close for **£0.500m**;

The Trust Board were requested to **APPROVE RETROSPECTIVELY** the following:

- **DLA Piper LLP** – legal advice and support for the delivery of the nVCC MIM Project covering PQQ dialogue
  - Further commitment to spend of **c£0.229m** for the ad hoc services that were included as an option in the original contract, however not included in the Board commitment of spend of £0.540m and to vary the revised contract sum of **£0.769m** (including the ad hoc services) by £0.385m (50% under procurement Regulation 72) to **£1.154m**, and
- **Mott MacDonald** – technical support for the nVCC S73 planning application
  - Issue a new contract for **£0.156m**; and,
- **Nexus Security** – security services during the tree clearance works
  - Issue a contract variation for **£0.074m**.

A number of points were raised in respect of the **retrospective approval** sought and the unsatisfactory position this placed the Trust Board.

Approval was given on the proviso that the Trust Audit Committee receive a comprehensive paper outlining the organisations compliance to its Standing Orders (SOs) and Standing Finacncial Instructions (SFIs) in these matters. A small amendment was also requested on **page 3** of the supporting paper issued to the Board to address an error on the spend listed.

Recommendation Approved by:

- Donna Mead, Chair
- Stephen Harries, Vice Chair
- Carl James, Acting Chief Executive Officer
- Vicky Morris, Independent Member
- Hilary Jones, Independent Member
- Andrew Westwell, Independent Member

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 24 November 2022 to 31 January 2023

DATE OF MEETING	24 November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	**APPROVAL**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Business Planning Group/local equivalent (WBS)	October & November 2022 *(Appendix 1,2,3 & 6)*	Endorsed
Senior Management Team (WBS)	October & November 2022 *(Appendix 1,2,3 & 6)*	Endorsed
Senior Leadership Team (VCS)	February 2022 *(Appendix 4 -* Cover Paper External Report & Action Plan) November 2022 *(Appendix 5)*	Endorsed Endorsed
Executive Management Board	October & November 2022 *(Appendix 1,2,3,5 & 6)*	Endorsed

Executive Management Board	March 2022 *(Appendix 4 -* Cover Paper External Report & Action Plan)	Endorsed
Audit Committee	May 2022 *(Appendix 4 -* Cover Paper External Report & Action Plan)	Noted

ACRONYMS	
BAU	Business as Usual
CE Mark	Conformitè Europëenne Mark
cffDNA	Cell Free Foetal DNA
EQA	External Quality Assessment
FTS (OJEU)	Find a Tender Service (Official Journal of the European Union)
GPs	General Practitioners
H&I	Histocompatibility and Immunogenetics
ITT	Invitation to Tender
IVD	In-vitro diagnostic
NEQAS	United Kingdom National External Quality Assessment Service
NICE	National Institute for Health Care Excellence
NIPT	Non-invasive prenatal testing
PHW	Public Health Wales
RAADP	Routine Antenatal Anti-D prophylaxis
RHD	Gene codes for RhD protein
RhD	Protein that expressed the 'D antigen'
SFIs	Standing Financial Instructions
UK	United Kingdom
VCS	Velindre Cancer Service
VUNHST	Velindre University NHS Trust
WBMDR	Welsh Bone Marrow Donor Registry
WBS	Welsh Blood Service
WHSSC	Welsh Health Specialised Services Committee

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 **24 November 2022 to 31 January 2023** are highlighted in this report and are seeking approval for the Chief Executive to authorise approval outside of the Trust Board.

1.4 In line with the review of the process for Commitment of Expenditure over the Chief Executive's Limit, all reports are now received by the Executive Management Board to ensure Executive oversight and scrutiny, to provide the Board with supporting recommendations and additional assurance as required.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendices 1-6** for the detailed appraisals undertaken for each of the expenditure proposals that the Trust Board is asked to **APPROVE**. The table below provides a summary of the decisions being sought from the Trust Board:

Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (Inc. VAT)
Appendix 1	WBS	Donor Card Contract	Start: 08/03/2023 End: 07/03/2026 Option to extend: 36 months + 12 months + 12 months	£210,000
Appendix 2	WBS	All Wales Foetal RHD Testing	Start: 01/04/2023 End: 01/04/2026 Option to extend: 24 months maximum as a 1+1 option for extensions	£875,097.60
Appendix 3	WBS	International Courier Contract for NEQAS/WBMDR	Start: 01/03/2023 End: 28/02/2026 Option to extend: 2+1	£378,000
Appendix 4	VCS	Private Patient Management Support	Start: 01/12/2022 End: 31/03/2023 Option to extend: 01/04/2023 – 28/02/2024 (Maximum term 11 months)	£278,616
Appendix 5	VCS	Oncotype Testing	Start: 01/12/2022 End: 31/11/2023 Option to extend: this is for a 12 month extension to the existing contract. A further extension is not permitted and a new procurement process and contract award will be required	£379,000

Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (Inc. VAT)
Appendix 6	WBS	Gov.UK Notify	Start: 01/01/2023 End: 31/12/2025 Option to extend: 36 months, until 31st December 2025	£544,392

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Due authority is being sought in advance of expenditure to ensure the compliant provision of goods/services to meet operational requirements.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Undertaken on a case by case basis, as part of the procurement process.
LEGAL IMPLICATIONS / IMPACT	If applicable, as identified in each case as part of the service design/procurement process.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Further details are provided in Appendix 1-4 of this report.

4. RECOMMENDATION

4.1 The Board is requested to **AUTHORISE** the Chief Executive to **APPROVE** the award of contracts summarised within this paper and supporting appendices **and AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	DONOR CARD CONTRACT
DIVISION / HOST ORGANISATION	Welsh Blood Service
DATE PREPARED	20th September 2022
PREPARED BY	Simon Davies
SCHEME SPONSOR	Jayne Davey

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Current contract for the supply of Donor Cards expires on March 7th 2023.

The current contract has been in place since March 2017. The current arrangements remain fit for purpose, these involve the manufacture of donor cards/key fobs, printing of letters and accompanying leaflets and distribution directly to the donor's home address.

All blood, platelet and bone marrow donors receive a donor card & key fob which provides them with a unique donor number and barcode which is then taken by the donor to their donation session and used to link their WBS ePROGESA record to their donation.

The donation cards for blood and platelet donors are provided at various milestones based upon the number of donations a donor has made.

The current contract is split into three parts,

1) Manufacture of Donor Cards
2) Printing of Donor Cards and accompanying materials
3) Postage

Donor cards remain an important tool for our service with the key benefits being;

- Enables donors to have a physical card/keyfob to carry around with their donor number, blood group etc.

- Supports improved clinic flow and operational productivity as saves time with donor registration
- Limits risk of donor miss matching on session
- Acts as a retention tool with different cards for certain donation milestones
- Donors booking appointments having registered with their donor number allows us to better understand and align blood group priorities in line with patient demand

Globally, general key fob cards have grown in popularity over the last couple of years and due to their convenience for end customers, are utilised by many commercial outlets and leisure facilities. There is also evidence to suggest that these can increase the uptake of schemes and programmes, ultimately benefiting both the card scheme provider and the end customer. There is also an expectation that they will support improved efficiencies at clinics, as donors will be more likely to have the key fob card available at clinic registration.

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

1.2 Period of contract including extension options:	
Expected Start Date of Contract	08/03/2023
Expected End Date of Contract	07/03/2026
Contract Extension Options **(E.g. maximum term in months)**	36 Months + 12 Months + 12 Months

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS
This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.

Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐

Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
Maintaining excellence in core service delivery, *facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality*	☒	☐
If not, please explain the reason for this in the space provided. N/A		

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

Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

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

3.1 Please state alternative options considered and reasons for declining
1) *Do Nothing* 2) *Digital app for membership (Via QR code)* 3) ***Renewal of donor card contract (Preferred option)*** *Option 1 – Doing nothing would mean that donors don't have any physical record of their Donor number, impacting donor engagement, significant impacts on clinic flow due to more manual searches of donor information leading to less productive clinic performance and a reduction in blood collection.* *Option 2 – This will be the future direction for the organisation once our technology solutions permit. Part of the Donor Engagement strategy 2022/23 - 2026/27 is to develop an application which would integrate a digital membership card and likely remove the requirement for a physical card. This solution is reliant upon EDRM which has now been paused for 2 years, with the likely development time for the application and links to donor information we are likely to be looking at 4-5 years.* ***Option 3 (Preferred option) – Renewing a contract for production and distribution of donor cards is the preferred option. This means we can continue our BAU distribution of cards to donors throughout their various donation milestones.***

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Donor cards have been a part of our service for decades, with the current style of card being in use for the past 7 years or so and have become a key benefit to our donors. In addition, the cards which include the unique donor number and barcode, linking the specific donor to their ePROGESA record has also helped to transform operational productivity in this time, allowing the team to swiftly identify a Donor on session.

The general use of key fob cards has grown in popularity in recent years and due to their convenience for customers, are utilised by many commercial outlets and leisure facilities. There is also evidence to suggest that these can increase the uptake of schemes and programmes, ultimately benefiting both the card scheme provider and the end customer.

Separate integrated key fob cards are also included in the new donor card contract as these are viewed as a good retention tool as they will act as a reminder to donors.

Donor feedback clearly indicates the pride donors have as the number of donations they have made grows and when they reach milestones in their donation journeys. The donor card reflects the amount of the donations they have made* (*at specific milestones) and serves as a tangible reminder of the donors contribution to the health and wellbeing of others. It provides an additional incentive for some to continue donating.

The unique donor record number is printed on the card and matches the donor's ePROGESA record, adding to accuracy of record selection for each donor event.

This process is currently BAU and the proposal is to agree a new contract for 3 years with a +1, +1 option on a like for like specification.

The current budget allocated for our existing Donor Card activity is £32,800 pa, (£190,000 for the 5 years, 3+1+1).

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
• Potential for increased clerical errors or extra time taken when teams are booking donors in if they are not able to scan cards – more of a manual process, having to ask/understand and confirm – language barriers etc.	*Limited mitigation, we know that currently when people don't have a donor card we see a significant increase in duplicate records as the record has to match exactly with ePROGESA i.e. David Jones on ePROGESA register on clinic as Dave Jones.*
• Without a card, a donor is unlikely to remember their donor number or know where to look for it.	*Would mean a manual search of the donor and the same risk as above applies.*
• This will increase the amount of temporary numbers on our appointment system as donors won't know their donor numbers –	*No mitigation for this*

in turn this will significantly impact our ability to correctly balance the collection of priority blood groups.	
• When we are able to introduce a WBS app, our intention would be for digital donor cards to be introduced. Removing physical donation cards in the interim would set us back by months in terms of development work.	*Limited mitigation – It becomes much more straight forward to transition to a digital card system if we are migrating current users and information than starting from scratch.*
• With cards already in circulation there will be a difference between those donors who have cards now and those going forward who won't have them. New donors could feel short aggrieved because of inconsistency in treatment.	*No mitigation, it will mean detriment to our donors. Either new donors who won't receive a card or existing donors who may be awaiting their next milestone card.*
• Potential for increased occasions for agents/teams explaining why we no longer issue cards – or to explain the above – Detriment to donor engagement.	*No real mitigation, would lead to less productive donation sessions and potentially a decrease in collection.*

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☒	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			

There is no national Framework Agreement in place that covers this requirement given its' specialist nature.

As the contract value exceeds current FTS(OJEU) threshold thereby necessitating FTS(OJEU) tender process. An Open Procedure tender will be followed to award a Framework Agreement to a sole supplier utilizing NHS Conditions of Contract.

6.3 What is the approximate time line for procurement?

Action	Proposed Completion Date
Specification/ITT Construction	14/10/2022
Completion & Submission of Trust Board Paper	02/10/2022
Dispatch of FTS/OJEU Contract Notice	24/10/2022
Publication of ITT	24/10/2022
Deadline for Clarification Questions by Bidders	11/11/2022
Deadline for ITT Responses	30/11/2022
Evaluation of ITT Responses	22/12/2022
Sign Off of Ratification Report	03/02/2023
Issue Award Decision Letters (standstill)	17/02/2023
Contract Award	20/02/2023
Contract Start	08/03/2023

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route

Head of Procurement Name:	Joanne Liddle, Assistant Head of National Sourcing – Clinical
Signature:	J Liddle
Date:	27/09/2022

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k) £175k**	**Including VAT (£k) £210k**
The nature of spend	**Capital** ☐	**Revenue** ☒

How is the scheme to be funded? Please mark with a (x) as relevant.	
Existing budgets	☒
Additional Welsh Government funding	☐
Other	☐
If you have selected 'Other' – please provide further details below:	

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Card manufacture, printing & postage costs	£32k	£33k	£34k	£71k	£170k	£204k
Setup costs	£5k				£5k	£6k
Overall Total	£37k	£33k	£34k	£71k	£175k	£210k

***Please note, these are estimated costs based upon the past 3 years expenditure. I have also overlayed proposed price increases from the current supplier and also factored in 2% inflation year on year for the 5 years of the contract.*

8. PROJECT MANAGEMENT (if applicable)

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

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

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:	WELSH BLOOD SERVICE.
Date:	29/09/2022.

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**	
Business Planning Group or local equivalent	06/10/2022	CPPG Out of Committee approval
Divisional Senior Management Team	13/10/2022	SMT Out of Committee approval
Executive Management Board	26/10/2022	

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

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Velindre University
NHS Trust

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	**ALL WALES FOETAL *RHD* TESTING**
DIVISION / HOST ORGANISATION	WBS
DATE PREPARED	31/10/2022
PREPARED BY	Chris Harvey
SCHEME SPONSOR	Alan Prosser

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The Welsh Blood Service (WBS), in partnership with Public Health Wales (PHW), are working to implement a high-throughput foetal *RHD* non-invasive prenatal testing (NIPT) service for Wales. The original proposition was to design and implement an in-house solution that would be comparable to the services available in NHS England and the Irish blood Transfusion Service. However, we are aware of the existence of two CE marked commercial kits available on the market and it is the intent of the WBS/PHW to enter into a tender process to purchase and validate a CE marked commercial kit to deliver this service (RE: 'SBAR FD Justification Devyser Kit v4.2' paper – available on request).

The implementation of NIPT for foetal *RHD* testing will enable NHS Wales to reduce the use of costly anti-D prophylaxis using anti-D immunoglobulin. This is routinely administered to all rhesus negative mothers (known as RAADP - Routine Antenatal Anti-D prophylaxis) and is derived from blood products. These products are in short supply and, although anti-D immunoglobulin is considered a safe product, there are inherent risks associated with the administration of any blood product to a patient. Offering foetal RHD testing to Rh negative mothers allows identification of those mothers carrying a RhD negative baby who will not require prophylactic anti-D. The NICE recommendations have advised targeted high-throughput NIPT for foetal *RHD* testing as a more cost-effective option than blanket anti-D prophylaxis with anti-D immunoglobulin.

Please note: The financial analysis, section 7 below, is based on the information from the company 'DEVYSER' for their list price of their supplied foetal *RHD* typing kit and true cost of service may not be known until after the tender process.

ACRONYMS	
WBS	The Welsh Blood Service
PHW	Public Health Wales
NIPT	Non-Invasive Prenatal Testing
RAADP	Routine Antenatal Anti-D prophylaxis
RHD	Gene codes for RhD protein
RhD	Protein that expressed the 'D antigen'
NICE	National Institute for Health Care Excellence
IVD	in-vitro diagnostic (IVD)
cffDNA	Cell Free Foetal DNA

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

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/04/2023
Expected End Date of Contract	01/04/2026
Contract Extension Options (E.g. maximum term in months)	24 months maximum as a +1+1 option for extensions.

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☒
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM-TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
If not, please explain the reason for this in the space provided. Not applicable		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐

Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☒
Demonstrate respect for the diverse cultural heritage of modern Wales.	☒
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☒	Integration	☒	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED

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

3.1 Please state alternative options considered and reasons for declining

Do nothing

Benefits:

- *Continued use of RAADP as the current pre-natal strategy*
- *Anti-D Ig is considered an exceptionally safe product*
- *No change in Health Board strategy, remains a cost-effective approach*
- *Removes risk of mistyping RHD inherent in any targeted routine antenatal Anti-D prophylaxis strategy. i.e., only administering to those D negative women identified as carrying a D positive baby*

Reason for declining:

- *NIPT is a cost-effective alternative to RAADP.*
- *Does not reduce the risks from the administering of unnecessary blood products e.g., Allergic reactions and exposure to unknown agents (prions)*
- *Limited availability of Anti-D Ig*
- *Currently, the NHS Wales pre-natal strategy is to offer RAADP only with no alternative choice available to prospective or currently pregnant mothers.*

Implement Service using a CE Marked Commercial Kit – Preferred Option

Benefits

- *Fulfils the medical devices regulatory requirements for in-vitro diagnostic (IVD) testing.*
- *Full support of commercial company.*
- *Consistent manufacturing process.*
- *Commercial batch release prior to laboratory batch validation.*
- *Reduced time to implementation - removed complexity of designing multi exon in-house kit and reduced validation requirements.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

Continue with tender process:

- *Fulfils the medical devices regulatory requirements for in-vitro diagnostic (IVD) testing.*
- *Full support of commercial company.*
- *Consistent manufacturing process.*
- *Commercial batch release prior to laboratory batch validation.*
- *Reduced time to implementation - removed complexity of designing multi exon in-house kit and reduced validation requirements.*

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
Continued use of RAADP as the current pre-natal blanket strategy resulting in continued unnecessary exposure to blood products.	*No mitigation exists*
Due to global delay in resuming blood donations and increased demand during the Covid-19 pandemic led to a shortage of immunoglobulin including Anti-D immunoglobulin.	*The lifting of the ban on the use of UK Plasma for fractionation from voluntary blood donations however manufacturing will take time to recover.*
Unable to meet NICE guidance for cost effectiveness.	*WHSSC supported the introduction of cffDNA testing with £85k consumable funding per annum from 2020/21 onwards, the price increase for consumables is resultant from requirements to utilise CE marked products only, WHSSC has supported this price rise with additional recurrent funding. Welsh Blood Service procured the capital equipment via the Velindre Trust Discretionary Programme and is also supporting service delivery via the use of existing resources.*

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.

Competition		Single source	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☒	Single Tender Action	☒
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☒	All Wales contract	☐

Please click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

The procurement strategy is to publish a Prior Information Notice to the market, to first understand if the two commercially available kits are suitable for the requirement. Following this an open procedure tender will be published to appoint a contractor.

If only a single commercial kit is found to be suitable for the requirement, this contractor can be appointed and a Voluntary Ex-Ante Transparency (VEAT) Notice published to outline why this route has been taken,

The timeline below is based on an open procedure tender being required.

6.3 What is the approximate time line for procurement?

Contracting Stage	Anticipated Date/Timescales	Responsibility
Briefing paper / Estimates return	November 2022	Service
Tender Issued	December 2022	Procurement
Tender Return	February 2023	Procurement
Evaluation	February 2023	Procurement/Service
Clarifications to Suppliers	February 2023	Procurement
Board Paper In	December 2022	Service

Board Paper Approval	December 2022	Board
Ratifications Out / Return	March 2023	Procurement
Publish Award (prior to 10 day standstill period)	March 2023	Procurement
Contract Start	April 2023	Procurement

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Rachel Evans
Signature:	R Evans R Evans
Date:	01/11/2022

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** 729,248	**Including VAT (£k)** 875,097.60
The nature of spend	**Capital** ☐	**Revenue** ☒

How is the scheme to be funded? Please mark with a (x) as relevant.	
Existing budgets	☒
Additional Welsh Government funding	☐
Other	☐
If you have selected 'Other' – please provide further details below:	

7. FINANCIAL ANALYSIS

7.1 PROFILE OF EXPENDITURE*

WHSSC supported the introduction of cffDNA testing with £85k consumable funding per annum from 2020/21 onwards, the price increase for consumables is resultant from requirements to utilise CE marked products only, WHSSC has supported this price rise with additional recurrent funding. Welsh Blood Service procured the capital equipment via the Velindre Trust Discretionary Programme and is also supporting service delivery via the use of existing resources.

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Revenue Budget	145.849	145.849	145.849	291.699	729.248	875.097
Overall Total	145.849	145.849	145.849	291.699	729.249	875.097

*based on a list price of £35.06/test (Kit + DNA extraction) and 4160 samples/year.

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	A project group has been established and the project will be managed using PRINCE2 methodologies.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement rules, standing orders and standing financial instructions have been complied with. Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name:	ALAN PROSSER.
Signature:	
Service Area:	DIRECTOR
Date:	11/11/2022.

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	02/11/2022
Divisional Senior Management Team	09/11/2022
Executive Management Board	16/11/2022

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	

HTW – Senior Management Team	

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	**International Courier Contract for NEQAS/WBMDR**
DIVISION / HOST ORGANISATION	WBMDR and NEQAS - WBS
DATE PREPARED	26/10/2022
PREPARED BY	Amy De'Ath
SCHEME SPONSOR	Tracey Rees

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

UK NEQAS for H&I and the Welsh Bone Marrow Donor Registry provide specialist services for laboratories and transplant centres, which requires the shipment of blood/stem cell products worldwide.

UK NEQAS for H&I operate an External Quality Assessment (EQA) Service for medical laboratories, which necessitates the regular distribution of blood samples to independently check the quality of their medical tests. UK NEQAS for H&I have customers in over 50 countries worldwide and as some of the samples deteriorate quickly. The service requires a courier to enable timely delivery of samples. The cost of courier delivery is recovered from participant laboratories.

The Welsh Bone Marrow Donor Registry are responsible for importing of donor samples/cellular products for transplantation into Welsh patients and the procuring of samples/cellular products from Welsh donors, for use by local and UK patients or exported internationally for global patients. This involves the time critical transport of samples from Welsh donors to transplant centres in the UK and worldwide. Samples are also required to be collected from donors/GPs/Hospitals anywhere in the UK and delivered to the WBMDR HQ. The cost of the delivery is charged at a fixed rate to the requesting transplant centre.

Please note: The financial analysis, section 7 below, is based on current supplier and true cost of service may not be known until after the tender process.						
1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒
1.2 Period of contract including extension options:						
Expected Start Date of Contract	01/03/2023					
Expected End Date of Contract	28/02/2026					
Contract Extension Options (E.g. maximum term in months)	2+1					

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☒
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN

Is this scheme included in the Trust Integrated Medium Term Plan?	Yes	No
	☐	☒

If not, please explain the reason for this in the space provided.
Not applicable

Business as usual

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES
This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

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

Prevention	☒	Long Term	☒	Integration	☒	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED
Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining

Do nothing – reason for declining: • *Catastrophic impact to WBMDR and NEQAS service.* • *Customers do not get the services they have paid for / expected.* • *National and International reputational damage which could undermine the ability to recover to normal levels of service.* • *Significant financial impact to WBS and the wider Trust.*
Bring in-House – reason for declining • *WBMDR/NEQAS staff are not trained in logistics.* • *WBMDR/NEQAS do not have the staff capacity to deal with the complexity of arranging multiple deliveries* • *The cost of arranging individual deliveries would be prohibitive for service delivery*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Continue with tender process: *Benefits of this option:* • Ability to maintain provision of services without interruption. • Complies with Procurement Regulations. The Current contract was tendered for in 2020, 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**

Unable to provide critical services in a timely manner. *Extension of current contract is outside of procurement law*	*Mitigation could include setting up multiple accounts with Courier companies but this would not provide a long term solution.* *No long term mitigation exists*

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☒	All Wales contract	☐
Please click here for link to Procurement Manual for additional guidance			

6.2 Please outline the procurement strategy
The procurement strategy is to release an open market tender, which will be published in all relevant journals, including Find a Tender and Sell2Wales.

6.3 What is the approximate time line for procurement?

Contracting Stage	Anticipated Date/Timescales	Responsibility
Briefing paper / Estimates return	30th November 2022	Service
Tender Issued	7th December 2022	Procurement
Tender Return	10th January 2023	Procurement
Evaluation	20th January 2023	Procurement/Service
Clarifications to Suppliers	27th January 2023	Procurement
Board Paper In		Service
Board Paper Approval		Board
Ratifications Out / Return	10th February 2023	Procurement
Publish Award (prior to 10 day standstill period)	14th February 2023	Procurement
Contract Start	1st March 2023	Procurement

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route

Head of Procurement Name:	Ian Emptage
Signature:	I.Emptage
Date:	8 November 2022

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** 315,000	**Including VAT (£k)** 378,000
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Revenue Budget WBMDR	25,000	25,000	25,000		75,000	90,000
Revenue Budget NEQAS - ***predicted***	80,000	80,000	80,000		240,000	288,000
Overall Total	105,000	105,000	105,000		315,000	378,000

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*Not applicable, there is no project wrap around the requirement*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement rules, standing orders and standing financial instructions have been complied with. Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name:	Alan Prosser
Signature:	
Service Area:	Welsh Blood Service
Date:	15/11/2022

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
Business Planning Group or local equivalent	16/11/2022
Divisional Senior Management Team	15/11/2022
Executive Management Board	16/11/2022

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	
HTW – Senior Management Team	

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	PRIVATE PATIENT MANAGEMENT SUPPORT
DIVISION / HOST ORGANISATION	Velndre Cancer Service
DATE PREPARED	10/11/2022
PREPARED BY	Matthew Bunce, Executive Director of Finance
SCHEME SPONSOR	Matthew Bunce, Executive Director of Finance

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The Trust procured the services of TPW to undertake a review of the Trust private patient services – commercial and regulatory audit. This was procured through the East of England NHS Collaborative Procurement Hub as a Direct Call-off in accordance with the contract for Private and Overseas Patient Income Recovery Services (Contract Reference Number: 2017004NC) (Lot 1) for which TPW were the sole provider appointed.

The TPW review took into consideration:-

(i) Business strategy

(ii) Analysis of current and potential market

(iii) Statutory and regulatory compliance; and

(iv) Strategic and operational management and processes, including commercial aspects such as the efficacy of private patient charging and billing income under recovery and potential pricing assessment.

The report clearly documents the outcome of the review and includes identified strengths, weakness and potential opportunities and threats which will be assessed and considered when developing the Private Patient Strategy as well as more immediate next steps.

Based on the report finings, a total of 28 recommendations were identified and categorised into three key areas: -

(i) Strategic Business Management and Governance

(ii) Commercial

(iii) Operational

Each Recommendation includes a Priority Rating (High, Medium and Low) to support and focus target dates for completion. A management response has been provided to each recommendation.

An Improvement Plan has been developed to implement each recommendation and monitor progress. A number of these actions require external expert support to progress, particularly in relation to commercial and pricing aspects of the service, as well as providing additional management capacity, education & development for Trust Private Patient staff.

Following the procurement of the income review work the Trust is now seeking to appoint Liaison Services to support the Velindre Private Patient Team by providing the following specialist private patient management services:

- Provide management and leadership to the Velindre Team
- Develop and train Velindre staff to ensure future reliance on consultancy services is reduced and strategic business governance is improved
- Provide advice to the Private Patient Team in developing a strategy and marketing plan and improve strategic governance
- Re-negotiate contracts with Insurers
- Develop a new pricing structure

Specialist Management Support Services

The Trust requires strategic management, operational and clinical governance support.

To assess what support is required Liaison Services will use the Trust Private Patient Improvement Plan, the findings from the TPW report (with TPWs permission) assessing the current service together with the income review being undertaken. The anticipated areas of support are:

- Provide advice to the Private Patient Team in developing a strategy and marketing plan and improve strategic governance
- Provide management and leadership to the Velindre Private Patient Team
- Develop a full directory of services
- Develop and train Velindre staff to ensure future reliance on consultancy services is reduced and strategic business governance is improved
- Re-negotiate contracts with Insurers
- Undertake an annual Optimisation Review
- Develop a new pricing structure / Tariff benchmarking - Liaison would provide a proposed set of pricing uplifts for use in the next Insurer annual pricing review
- Develop a plan for growth - to expand services, i.e. increasing the range of procedures, introduction of new services

Liason's private patients' consultant would work with the Trust Private Patient team to provide the support required at an average daily rate of £950 (some days charged at £1,250 and some days charged at £850).

The Executive Team will decide whether procurement of the contract extension for further consultancy services will proceed once the income review and 4 months of consultancy support has been completed as this will provide a good understanding of the further work required and support the Trust might require from Liaison in resource days and at what level of support

As well as support completing a full directory of service, the Trust requires consultancy support to deliver a range of actions identified in its improvement plan in operational, financial and clinical governance areas. Once Liaison has assessed the current service provided by the Trust, they would advise on the consultancy needed. These services include:

- develop a new pricing structure / Tariff benchmarking - Liaison would provide a proposed set of pricing uplifts for use in the next Insurer annual pricing review
- develop and train Velindre staff to ensure future reliance on consultancy services is reduced and strategic business governance is improved
- provide advice to the Private Patient Team in developing a strategy and marketing plan and improve strategic governance
- Contract Negotiation with Insurers
- Annual Optimisation Review
- Growth planning - to expand services, i.e. increasing the range of procedures, introduction of new services

To provide an indication of the possible value of the contract for consultancy work, at £950 per day, if assume 4 months @ 5 days per week = £82k and 3 days per week for 11 months extension - £111k.

Summary of Estimated Contract Charges (Excl. VAT)

Estimated Contract Value:	**Year 1 (2022-23)** **Consultancy Services - Full time support (5 days per week) for 4 months - Estimated charges**	**£82,333**
	Year 2 (2023-24) **Consultancy Services - Contract Extension - Part-time support (3 days per week) for 11 months -Estimated charges**	**£111,150**
	Overall Contingency @ 20%	**£38,697**
	Total Contract Value	**£232,180**

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

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/12/2022
Expected End Date of Contract	31/03/2023
Contract Extension Options **(E.g. maximum term in months)**	01/04/23 – 28/02/24 11 months

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
This investment will provide support to Trust Private Patient teams to implement the actions identified through the TPW report and upskill the Trust staff to enable the Trust to maximise the net surplus delivered from the private patient service to invest in NHS care. A paper was presented to the Trust QS&P Committee on the 10th of November 2022 which included options around the long-term strategy for the Private Patient Services. The Committee endorsed for Board approval the option to stabilise and enhance governance of the current Trust managed private patient service, with the aim in the future to expand and extend to optimise the service. In order to undertake the stabilisation and enhanced governance as well as commence the expansion and optimisation of the service the Trust is procuring consultancy support from Liaison		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

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

3.1 Please state alternative options considered and reasons for declining
There are limited options available Option 1 - Do Nothing – presents ongoing risk that the recommendations identified in the TPW report and reflected in the Private Patient improvement plan are not fully delivered due to the lack of knowledge, experience and skills in the VCS team, particularly in relation to commercial, marketing, governance and pricing Option 2 – Commission specialist Private Patient consultancy support to provide the knowledge, experience and skills to support delivering of the improvements and educate and develop the Trust Private Patient team. Option 3 – Recruit to a fixed term Private Patient Manager post with knowledge, experience and skills to support delivering of the improvements and educate and develop the Trust Private Patient team. **Option Appraisal:**

Option 1 is discounted as it will not enable the Trust to fully implement the recommendations in the TPW report and make the improvements required to make the private patient service sustainable.

Option 2 is preferred as it provides the best likelihood of successfully implementing all the recommendations in the TPW report and maximizing the improvements in the Trust action plan, at the same time improving the skills and knowledge of the Trust staff involved in the Private Patient service.

Option 3 would likely enable the Trust to implement all the recommendations in the TPW report, but there is low likelihood of attracting an individual with the private patient knowledge, experience and skills on a fixed term contract and if we could attract someone it could take up to 6 months to recruit them.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

The use of a private sector specialist in NHS private patient services will ensure the Trust is in a stronger position to recover private patient income more expediently. The Trust considers this short to medium term investment in a private sector partner that has the experience of those areas of income recovery it can challenge insurers based on previous experience or progressing successful claims, including legal challenges. This will deliver value in the short term by recovering income from insurers that could legitimately have been charged in the previous 6 months. In the medium to long-term the Trust private patient team will be upskilled to undertake this independently of the private sector.

The reason for procuring specialist private sector management to help the Trust implement the improvement recommendations identified in the review undertaken by TPW is due to the limited experience, skills and knowledge within the Trust private patient team in managing a commercial enterprise, contract negotiation, market pricing intelligence, marketing and the specialist regulations of NHS private patient services. Specific benefits will be:

- Negotiation and management of contracts with private healthcare insurers is not a common skill set in NHS management teams.
- The Trust does not possess market intelligence around NHS Private Patient cancer service pricing, which private sector services specialising in supporting NHS private patient service have access to, which will enable them to ensure the Trust sets its pricing at a level the market will bear.

- It is necessary to develop the private patient team to provide them with the commercial skills to enable them to become self-sufficient in managing a complex and specialist service.

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**
Present and ongoing risk that the Private Patient improvements identified in the TPW report are not fully delivered due to the lack of knowledge, experience and skills in the VCS team, particularly in relation to commercial, marketing, governance and pricing	Attempt to recruit to a fixed term Private Patient Manager post with knowledge, experience and skills to support delivering of the improvements identified in the TPW report and educate and develop the Trust Private Patient team.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.

Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

Following OJEU competition through the East of England NHS Collaborative Procurement Hub, Liaison Financial was appointed as a sole provider to Lot 11 (Managed Spend Reduction and Recovery Solutions) of its 'Analysis and Reconciliation Services Framework (OJEU Reference: 2019/S 239-586725).

The Trust will execute a 'direct call off' with the appointed provider using its own specification as is within the scope of Lot 11

6.3 What is the approximate time line for procurement?

3 weeks (completed)

Contracting Stage	Anticipated Date/Timescales	Responsibility
Briefing paper / Estimates return	Issue 13/11/22 Return 14/11/22	Procurement Trust Lead
Issue Call Off Order Form	19/11/22	Trust lead via Procurement
Tender Return	22/11/22	Procurement
Evaluation	25/11/22	Trust Lead & Procurement
Contract Ratifications Out / Return	Issued 27/11/22 Return 28/11/22	Procurement
Publish Award Letter and Contract for Signature	29/11/22	Procurement
Contract Start	01/12/22	Trust Lead

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route

Head of Procurement Name:	Helen James

Signature:	
Date:	15th November 2022

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£232k**	**Including VAT (£k)** **£279k**
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☒		
If you have selected 'Other' – please provide further details below: Income Review – additional income received following review Non Recurrent Reserves		

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (2022-23) (exc. VAT) £	Year 2 (2023-24) (exc. VAT) £	Total (exc. VAT) £	Total (inc. VAT) £
Consultancy Services - Full time support (5 days per week) for 4 months - Estimated charges	£82,333		£82,333	£98,800

EXPENDITURE CATEGORY	Year 1 (2022-23) (exc. VAT) £	Year 2 (2023-24) (exc. VAT) £	Total (exc. VAT) £	Total (inc. VAT) £
Option for Consultancy Services - Contract Extension - Part-time support (3 days per week) for 11 months - Estimated charges		£111,150	£111,150	£133,380
Total	**£82,333**	**£111,150**	**£193,483**	**£232,180**
20% Contingency			£38,697	£46,436
Overall Total	**£82,333**	**£111,150**	**£232,180**	**£278,616**

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	The project will be managed through VCS Programme and project management team and in accordance with Trust SOs & SFI's.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Matthew Bunce
Signature:	
Service Area:	Finance
Date:	10/11/2022

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
VCS SLT (Cover Paper External Report, External Report & Action Plan)	18th February 2022
EMB RUN (Cover Paper External Report, External Report & Action Plan)	7th March 2022
Audit Committee – For Noting (Cover Paper External Report, External Report & Action Plan)	3rd May 2022
EMB RUN (Phase 2 Consultancy Services)	16th November 2022

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	ONCOTYPE TESTING CONTRACT
DIVISION / HOST ORGANISATION	Velindre Cancer Service
DATE PREPARED	16/11/2022
PREPARED BY	Matthew Bunce, Executive Director of Finance
SCHEME SPONSOR	Matthew Bunce, Executive Director of Finance

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The Oncotype DX Breast Recurrence Score Test analyses the activity of a group of genes that can affect how an early-stage breast cancer is likely to behave and respond to treatment. The Oncotype DX Breast Recurrence Score Test is used in two ways:

- to help doctors figure out a person's risk of early-stage, estrogen-receptor-positive breast cancer coming back in a part of the body away from the breast (distant recurrence)
- to help figure out if a person will benefit from chemotherapy

The results of the Oncotype DX Breast Recurrence Score Test, combined with other features of the cancer, can help you make a more informed decision about whether or not to have chemotherapy to treat early-stage, hormone-receptor-positive, HER2-negative breast cancer.

So, the Oncotype DX Breast Recurrence Score Test is both a prognostic test, since it provides more information about how likely (or unlikely) the breast cancer is to come back, and a predictive test, since it predicts the likelihood of benefit from chemotherapy or radiation therapy treatment. Studies have shown that Oncotype DX Breast Recurrence Score Test is useful for both purposes.

The National Institute for Health and Care Excellence (NICE) recommends the test as an option for guiding adjuvant chemotherapy decisions in lymph node-negative and micrometastatic disease, but the test is not routinely used for NHS patients with node positive breast cancer.

The first results from RxPONDER were presented at the recent San Antonio Breast Cancer conference in 2020. The authors concluded that "postmenopausal patients with N1 breast cancer and Recurrence Score® result 0-25 did not benefit from adjuvant chemotherapy, and thus can

likely forego this treatment without compromising outcomes. On the other hand, premenopausal patients with N1 breast cancer and a Recurrence Score® result 0-25 did benefit significantly from adjuvant chemotherapy.

The Oncotype DX® test is expected to lead to cost savings when compared to standard clinical practice for patients with 1-3 positive lymph nodes by substantially reducing the proportion of patients receiving unnecessary chemotherapy treatment. A recently completed access program involving the collection of data on the use and impact of the test when used in clinical practice for node-positive (1-3 positive lymph nodes) patients found that testing reduced overall chemotherapy treatment recommendations from 70% without testing to 28% with testing; a 60% reduction in chemotherapy use. The Oncotype DX® test has a fixed, single, all-inclusive cost per patient tested. The reduction in the costs of chemotherapy are expected to more than compensate for the cost of the test.

Incorporating the Oncotype DX® test for patients with 1-3 positive lymph nodes is also expected to reduce chemotherapy-related outpatient appointments by 40% among tested patients (491 appointments saved per year), improve patient flow and increase the Trust's chemotherapy day case capacity (360 infusions and 857 infusion chair hours saved per year) by reducing unnecessary chemotherapy treatment. The modelling has not included the impact on unplanned hospital admissions related to chemotherapy complications, which may be reduced when the Oncotype DX® test is utilised for these patients.

As well as use for existing cohort of Breast Cancer patients it is proposed to use the Oncotype test for patients with early-stage oestrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative, lymph node-positive (N1,1-3 positive lymph nodes) breast cancer.

Summary of Estimated Contract Charges (Excl. VAT)

The estimated cost of extending the Ocotype testing contract for 12 months including expanding the scope of patients is £316k.

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

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/12/2022
Expected End Date of Contract	30/11/2023

Contract Extension Options **(E.g. maximum term in months)**	This application is for a 12 month extension to the existing contract. A further extension is not permitted and a new procurement process and contract award will be required

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐

Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☐	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

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

3.1 Please state alternative options considered and reasons for declining
Currently there is only one provider, Exact Sciences, that can provide Oncotype Testing Other providers are considering entering into the market to supply the test and Cardiff & Vale UHB were also considering establishing a Oncotype testing service, but none of these alternative suppliers are yet included on the Framework. Option 1 - Do Nothing – If the contract is not extended then the Trust would no longer be able to offer breast cancer patients this test. Option 2 – Extend contract – Extending the contract with the current provider for 12 months will enable the provision of this test to continue whilst the procurement process takes place to test the market for a new provider.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Oncotype DX testing, together with other prognostic tests, can help the medics determine how a patients' cancer will act and whether the benefits of chemotherapy or radiation therapy outweigh the side effects and costs. The test score can be interpreted with other markers such as age and tumor grade and size.

Studies have reported Oncotype DX testing altering the decision to administer chemotherapy in as many as 30% of doctors treating people with ER-positive and HER2-negative breast cancer.

Oncotype DX testing may be most beneficial for people with medium-risk cancer, where it's unclear if chemotherapy or radiation therapy would increase the chances of survival.

In the large TAILORx clinical trial, researchers compared the benefit of chemotherapy guided by gene testing in a group of 9,719 women with ER-positive and HER2-negative breast cancer. In women over age 50 with medium Oncotype DX scores, the researchers found no significant difference in overall survival between women who:

- received hormone therapy alone
- received hormone therapy and chemotherapy together

The researchers found some benefit of adding chemotherapy to treatment in women under age 50 with a medium score.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
Not extending the contract to enable access to Oncotype testing will lead to patients with early-stage, hormone-receptor-positive, HER2-negative breast cancer being treated with chemotherapy unnecessarily.	There is no mitigation to not providing this test. Potentially up to 30% Patients with early-stage, hormone-receptor-positive, HER2-negative breast cancer will undergo SACT treatment with no significant benefit in overall survival

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy
Extension of the existing contract by 12 months
6.3 What is the approximate time line for procurement?
NWSSP Procurement services will have negotiated the 12 month extension to the existing contract with the current supplier by the 30th November 2022. Extending the contract by a further 12 months is permitted as it is within the maximum 50% additional value stipulated in Regs 72 of the Public Contracts Regulations (2015). The extension will allow Procurement Services to undertake a competitive process which will take approximately 6 to 8 months to conclude.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Helen James
Signature:	
Date:	17th November 2022

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£316k**	**Including VAT (£k)** **£379k**
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☒		
If you have selected 'Other' – please provide further details below: Revenue recovery of cost as a recharge through NICE/HCD to respective commissioners for costs incurred. Offset by cost savings to Commissioners for reduced no of patients receiving adjuvant SACT treatment		

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 1st Dec 2022 – 30th Nov 2023 (exc. VAT) £	Total (exc. VAT) £	Total (inc. VAT) £
Oncotype DX® test for existing patient cohort	£150,000	£150,000	£180,000
Introducing the Oncotype DX® test for node-positive (1-3 lymph nodes) patients	£166,000	£166,000	£199,200
Total	**£316,000**	**£316,000**	**£379,200**

Laboratory services including testing is VAT exempt. The VAT accounting will be confirmed.

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	N/A This test is part of VCS clinical pathways and standard service offering. There are no specific management arrangements required.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Matthew Bunce
Signature:	
Service Area:	Finance
Date:	17/11/2022

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
VCC SLT (Chairs Urgent Action)	Out of Committee approval
EMB RUN (Chairs Urgent Action)	18/11/2022

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	Gov.UK Notify
DIVISION / HOST ORGANISATION	Corporate – Digital Services
DATE PREPARED	27th October 2022
PREPARED BY	David Mason-Hawes – Head of Digital Delivery
SCHEME SPONSOR	Alan Prosser – Director of WBS (for current WBS costs)

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The WBS Appointments System sends appointment confirmation and reminders by SMS and email, based on the communication preferences of the donor (which they select at booking). This service is enabled via an API (Application Programming Interface) connection between the WBS Appointments System and the '**Gov Notify**' service.

In the WBS (Donor Contact Centre) the adoption of Gov Notify replaced the previous (TextLocal) service, whose contract ended in May 2021. Gov Notify is a UK Government service, established by the Government Digital Service (GDS), specifically aimed (though not limited to) UK public sector organisations. As such, NHS and other public sector organisations have access to preferential rates and are (in some cases) allocated free SMS 'allowance' of 20,000 credits per financial year to encourage adoption of digital communication services for their users. As a Gov.UK service, it has already been subject to stringent information governance and information security reviews, prior to making it available for wider use.

Three separate Gov Notify 'services' have been established under the VUNHST account:

VUNHST – Donor Contact Centre

Outbound SMS (text messaging) and email services for Welsh donors via API connection to the WBS Appointment System (e.g. appt. confirmations/invites, reminders and cancellations).

VUNHST – WBMDR

A Gov Notify service has also been established to support the automated communication requirements of the WBMDR – i.e. SMS / email communications with non-blood Bone Marrow Volunteer donors.

Powys Teaching Health Board (Healthcare Research Wales – HCRW)

This service was originally established to enable the delivery of automated outbound SMS (text messaging) and email services for Welsh Covid-19 vaccine trial participants, via API connection to a version of the WBS Appointment System that had been deployed for use by HCRW. The service was used for appointment confirmations, reminders and cancellations. As the requirement to trial Covid-19 vaccines in Wales has diminished, this service remains in use with HCRW (albeit at far greater volumes) and has been re-purposed to support a range of HCRW-led trials / studies. This service is provided to HCRW under an SLA – any Gov Notify costs will be recharged to Powys tHB in full under the terms of this SLA.

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	1st January 2023 (renewal of existing arrangement)
Expected End Date of Contract	31st Dec 2025
Contract Extension Options **(e.g. maximum term in months)**	36 months, until 31st December 2025)

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☒
If not, please explain the reason for this in the space provided: System already in use as part of 'BAU'; however, there are future opportunities re: automation of communications across the Trust (e.g. VCC outpatient, therapies etc.) which align with broad aims and objectives of Trust and Digital strategies, as well as elements of the current IMTP.		

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

Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☐	Long Term	☐	Integration	☒	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED

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

3.1 Please state alternative options considered and reasons for declining

(a) Discontinue Service – discounted

This would have an immediate and negative impact on operational services within the Welsh Blood Services and HCRW – for example:

- Inability to text message (SMS) donors – already used extensively for appointment reminders/invites. Any move away from this approach would be a step backwards in terms of the wider (strategic) donor engagement plans for the WBS.
- Lack of SMS functionality may also result in increased DNA rates for blood donation appointments and an increase in donor concerns (due to degradation of service).
- Withdrawal of service would compromise HCRW use of the Gov Notify service and impact on national trials / studies.

(b) Undertake a market assessment / consider change of provider – discounted

Any short-term requirement to change service provider would require re-development of affected systems to align with a new solution. This in turn would divert resources away from and therefore impact on the agreed operational and strategic workplan, IMTP objectives etc.

(c) Extend current agreement (3 years) – preferred approach

Given the operational dependency on the Gov Notify service, this is the preferred approach.

The renewal of the current contract allows time to:

- Assess wider opportunities for services such as Gov Notify across the Trust, in particular for (e.g.) automation of appointment correspondence in the VCC.
- Enable the Digital Services time to undertake a further assessment of service providers who offer automated communication services, to assess their maturity and costs relative to the Gov Notify service. This assessment will be used to set a longer-term approach for automated communications services within the Trust.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
VFM is achieved through the continued digital (SMS) engagement with donors. Any move away from this approach would be a step backwards in terms of the wider donor engagement plans for the Trust. **Non-Quantifiable Benefits** • Ensure service continuity – see 3.1 • No impact on existing operational / strategic programmes of work where digital support is required. **Quantifiable** • For comparison, the total savings expected by moving to Gov Notify rather than continuing with previous TextLocal contract were approx. £25,000 in the 2021/22 financial year. • For the 2022/23 year, the estimated savings in using the Gov.UK Notify service rather than the TextLocal service would have been approx. £30,000.

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
a) Business critical operational services in WBS will be impacted. b) Would necessitate unplanned work between Digital Services, WBMDR and DCC teams, to review and migrate to another solution. c) HCRW Gov Notify services – provided under SLA with VUNHST – would be immediately impacted.	a) Seek approval on alternative approach to extend current agreement on a 3 years basis as per 3.1 (c).

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

Although there is deemed to be competition within the marketplace, a benchmarking exercise has been completed, through communication with other Trusts and HB'S, and further benchmarking through the G-Cloud framework. The original establishment of the agreement to use the Gov.UK Notify service was taken forward with support of Procurement and was confirmed on the basis that Gov.UK Notify offer the most competitive costing in respect of SMS messaging.

Competition is undertaken by the Cabinet Office to appoint a supplier to provide the Gov.UK Notify Service. This competition is undertaken in accordance with the Public Contract Regulation 2015. This satisfies the requirements for individual organisations to undertake separate competitions to appoint such providers.

The Trust would be executing a direct call off under a Central Government Service.

6.3 What is the approximate timeline for procurement?

- Approved by WBS SMT — Wednesday 9th November 2022
- Approved by EMB Shape — 21st November 2022
- Approved by Trust Board — 24th November 2022
- Contract signed — 22nd December 2022
- New contract start date — 1st January 2023

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Lena Boghossian
Signature:	Approved via email (audit record available on request)
Date:	09/11/2022

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £453,666	**Including VAT (£k)** £544,392
The nature of spend	**Capital** ☐	**Revenue** ☒

How is the scheme to be funded? Please mark with a (x) as relevant.

Existing budgets	☒
Additional Welsh Government funding	☐
Other	☒

If you have selected 'Other' – please provide further details below:

The above projected whole life cost includes a spend of approx. £25,000 per annum, relating to the *potential* extension of the Gov Notify service into other areas of the Trust, namely VCC (e.g. outpatients, therapies, inpatients/daycases). The budgets and spend plan(s) associated with the extension of the Gov Notify service into other areas of the Trust (namely VCC) would need to be confirmed before deploying the service.

In terms of the current services:

- WBS (DCC) costs are charged to W103.
- All costs for HCRW are re-charged in full to Powys tHB under the terms of the existing SLA.

Estimated **annual** costs are as follows:

- DCC – approx. £132,000 (excl. VAT)
- Powys tHB – approx. £150 (excl. VAT)
    - Reduced from £23k in 2021/22
- WBMDR – no costs anticipated (all use within 20,000 'free' SMS allowance).

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

At the time of writing, the total expenditure against the original contract was:

- 2020/21: £0
- 2021/22: £96,845 (excl. VAT)
- 2022/23 £67,182 (excl. VAT) as at 30th September 2022 – projected annual spend approx. £134k (excl. VAT)

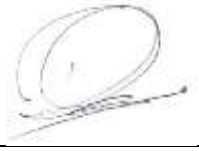
The projected further spending associated with a 3 year renewal is as follows:

EXPENDITURE CATEGORY	Year 1 22/23 (exc. VAT) £k	Year 2 23/24 (exc. VAT) £k	Year 3 24/25 (exc. VAT) £k	Total Future Years (2025/26) (exc. VAT) £k	Total (exc. VAT) £k	Total (inc. VAT) £k
REVENUE						
WBS DCC	33	132	132	99	396	475.2
WBS WBMDR	0	0	0	0	0	0
Powys tHB HCRW	0.038	0.15	0.15	0.12	0.46	0.55
VCC (TBC)	-	20.8	20.8	15.6	57.2	68.64
CAPITAL						
-	-	-	-	-	-	
Overall Total	33.04	152.95	152.95	114.72	453.66	544.39

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? e.g. PRINCE 2	Day-to-day operational management of the Gov Notify agreement is undertaken by the Digital Services team, on behalf of the DCC, WBMDR and HCRW. This generally relates to account administration / queries, operational support etc.

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:	09/11/2022

10. APPROVALS RECEIVED

Divisions	**Date of Approval:**
CPPG	n/a – no capital funding implications
Divisional Senior Management Team	09/11/2022
Executive Management Board	18/11/2022

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	n/a
HTW – Senior Management Team	n/a

TRUST BOARD

APPROVED POLICIES UPDATE

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lenisha Wright, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/09/2022 26/10/2022	ENDORSED FOR APPROVAL
Quality, Safety & Performance Committee	10/11/2022	APPROVED
Charitable Funds Committee	20/09/2022	APPROVED

ACRONYMS	
EMB	Executive Management Board
QSP	Quality, Safety & Performance Committee

1. SITUATION/BACKGROUND

1.1 In accordance with the "Policy for the Management of Policies, Procedures and other Written Control Documents", the Trust Board will receive all approved policy documents for information under the Consent Agenda.

1.2 The purpose of this report is for the Trust Board to note the policies that have been approved since September 2022 Trust Board.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Following approval at the relevant forum the policies below were uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

2.2 The list of Policies **APPROVED** since the September 2022 Trust Board are outlined below:

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
CFC002: Charitable Funds Travel and Expenses Reimbursement Policy	Executive Director of Finance	Charitable Funds Committee	20/09/2022	**1**
CFC003: Charitable Funds Credit Card Policy	Executive Director of Finance	Charitable Funds Committee	20/09/2022	**2**
IPC21: Infection Prevention and Control policy for the Management of Respiratory Infections	Executive Director of Nursing, Allied Health Professionals & Health Science	Quality, Safety and Performance Committee	10/11/2022	**3**
IPC10: Hand Hygiene policy	Executive Director of Nursing, Allied Health Professionals & Health Science	Quality, Safety and Performance Committee	10/11/2022	**4**
IPC00: Framework policy for Infection Prevention and Control	Executive Director of Nursing, Allied Health Professionals & Health Science	Quality, Safety and Performance Committee	10/11/2022	**5**
QS25: Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals	Executive Director of Nursing, Allied Health Professionals & Health Science	Quality, Safety and Performance Committee	10/11/2022	**6**
PP04: Asbestos Management Policy	Director of Strategic Transformation, Planning, Performance & Estates	Quality, Safety and Performance Committee	10/11/2022	**7**

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
PP05: Control of Contractors Policy	Director of Strategic Transformation, Planning, Performance & Estates	Quality, Safety and Performance Committee	10/11/2022	**8**
PP09: Water Safety Policy - The Management and Control of Water Quality	Director of Strategic Transformation, Planning, Performance & Estates	Quality, Safety and Performance Committee	10/11/2022	**9**

2.3 The following Infection Prevention Control policies are outside their review dates and are currently under a national review. As these policies are being reviewed nationally, the Quality, Safety and Performance Committee approved an extension to the renewal date for 12 months:

- IPC03 – Aseptic Non-Touch Technique
- IPC05 – National Infection Prevention and Control Manual
- IPC15 – Control and Management of Multi Drug Resistant Bacteria

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Trust has a defined process for the management of policies and written control documents. The purpose of which is to ensure staff are aware of their responsibilities with regards to Trust policy documents and to provide a 'model' guide and consistent approach for the development, management and dissemination of the Trusts documents
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	An Equality Impact Assessment has been completed as required for each of the respective Trust Policies outlined in this report.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the policies that have been approved since the September 2022 Trust Board.

Ref: CFC 002
Velindre UNHS Trust Charitable Funds Travel and Expenses Reimbursement Policy

Date to be reviewed:	September 2025	**No of pages:**	7
Author job title(s):	Head of Financial Planning & Reporting		
Responsible dept / director:	Executive Director of Finance		
Approved by:	Charitable Funds Committee		
Date approved:	20.09.2022		
Effective Date (live):	20.09.2022		
Version:	4		

Date EQIA completed:	24.10.2022
Documents to be read alongside this policy:	1. Velindre UNHS Trust Charitable Funds Scheme of Delegation and stages for the purchasing and Authorisation of Goods and Services. 2. Velindre UNHS Trust Charitable Funds Credit Card Policy. 3. Velindre UNHS Trust Charitable funds Travel and Expenses reimbursement procedure. 4. Management Procedure for Events Attendance & Structure. 5. Velindre Trust Standing Order and Standard Financial Instructions. 6. NHS Wales Travel and Subsistence Policy.

Current review changes:

1. The process for reimbursement of Travel & Expenses has been removed from the policy and now forms a separate procedure which was approved by the Charitable funds SLG on the 8tth September 2022 and will be available to staff on the Trust intranet site.
2. Travel Guidance and Requirements has been amended with reference added to the Management procedure for Events Attendance & Structure, and the NHS Wales Travel and Subsistence Policy which will provide latest guidance and rates of payment.
3. Guidance added on the ability to purchase alcohol at fundraising events.
4. Other minor narrative changes.

Executive Summary:
To ensure that adequate controls are in place and that expenditure relating to Velindre University NHS Trust is both appropriate and justified.

First operational:	Date July 2012				
Previously reviewed:	Sep 2015	Jun 2018	Sep 2022		
Changes made Yes:	Yes	Yes	Yes		

Contents

1. Policy Statement

1.1. The policy has been prepared to provide guidance on the reimbursement of Travel and Expenses paid through Velindre UNHS Trust Charitable Funds.

2. Purpose

2.1. The Board of Directors of Velindre UNHS Trust Charitable Funds recognises that board members, officers, and employees ("All Trust Members and Officers") of Velindre UNHS Trust Charitable Funds may be required to travel or incur other expenses from time to time in order to conduct business and to further the mission of Velindre Charitable funds.

The purpose of this Policy is to ensure that:

(a) Adequate cost controls are in place,
(b) Travel and other expenditures are appropriate.

It is the policy of Velindre UNHS Trust Charitable Funds to reimburse only reasonable and necessary expenses actually incurred by Personnel.

When incurring business expenses, Velindre UNHS Trust Charitable Funds expects All Trust Members and Officers to:

- Exercise discretion and good business judgment with respect to those expenses.
- Be cost conscious and spend Charitable Funds money as carefully and judiciously as the individual would spend his or her own funds.

3. Scope

This policy is to be read in conjunction with the following:

a. Velindre UNHS Trust Charitable Funds Scheme of Delegation and stages for the purchasing and authorisation of Goods and Services.

b. Velindre UNHS Trust Charitable Funds Credit Card Policy.

c. Velindre Trust Standing Order and Standard Financial Instructions.

d. Velindre UNHS Trust Charitable funds Travel and Expenses reimbursement procedure.

e. Management Procedure for Events Attendance and Structure.

f. NHS Wales Travel & Subsistence Policy

Users should refer to the Charitable funds section of the Trust Intranet site:

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/HA.aspx

4. Aims and Objectives

The aim and objective of this policy is:

4.1. To ensure that travel & subsistence expenses that are incurred on behalf of Velindre UNHS Trust Charitable Funds are both appropriate and justified.

4.2. To ensure that Velindre NHS Trust Charitable Funds complies with HM Revenue and Customs and National Insurance Regulations relating to the reimbursement of travel and subsistence allowances.

5. Roles and Responsibilities

5.1.1 The Charitable funds Committee and its Trustees has overall responsibility for the reimbursement of Travel and Expenses.

5.1.2 The Charitable funds committee delegates responsibility to individual fund holders.

6. Travel Guidance and Requirements

For travel guidance and requirements refer to the NHS Wales Travel and Subsistence Policy which is located on the Trust e-expenses system.

The NHS Wales Travel and Subsistence Policy provides guidance in the following areas and should be followed when claiming Travel and Expense reimbursement from Velindre Charitable funds:

Section 1 - Economy & sustainability of Travel
Section 2 - Company Vehicles
Section 3 - Mileage Allowances Eligible Business Mileage
Section 4 - Subsistence Allowances
Section 5 – Rail, air and other Travel

7. Non-reimbursable Expenditures

Velindre Charitable Funds maintains a strict policy that expenses in any category that could be perceived as of a personal nature, lavish, unreasonable or excessive will not be reimbursed, as such expenses are inappropriate for reimbursement by the Inland Revenue Regulations, Charity Commission Regulations, The Board of Trustees and The Charitable Funds Committee.

Expenses that are not reimbursable include, but are not limited to:

- Travel insurance. (This Expenditure will not be reimbursed unless evidence is produced that the Travel Insurance was purchased in order to work for Velindre Charitable Funds for a specific event).

- First class tickets or upgrades.

- When lodging accommodations have been arranged by Velindre NHS Charitable Funds and the individual elects to stay elsewhere, reimbursement is made at the amount no higher than the rate negotiated by Velindre NHS

Charitable Funds. Reimbursement shall not be made for transportation between the alternate lodging and the meeting site.

- Limousine travel.
- Movies, liquor, or bar costs.
- Membership dues at any country club, private club, athletic club, golf club, tennis club or similar recreational organisation.
- Participation in or attendance at golf or tennis tournaments, Car races or other sporting events, without the advance approval of the chairman of the board or his designee.
- Purchase of golf clubs or any other sporting equipment.
- Clothing purchases.
- Business conferences and entertainment which are not approved by the Charitable Committee of Velindre NHS Charitable Funds.
- Valet service.
- Car washes.
- Personal Toiletry articles.
- Personal services.
- Personal entertainment.
- Fines for traffic or parking violations.
- Laundry expense.
- Insurance for personal car.
- Excessive personal telephone calls.
- Charitable contributions.
- Political contributions.
- Briefcases and luggage.
- Finance charges from any source.
- Theft of personal property, including articles stolen from a personal car or rental car.
- Hotel/Motel cash bar, movies or health club/spa fees or exercise charges.

- Expenses for spouses, friends, or relatives. If a spouse, friend or relative accompanies Personnel on a trip, it is the responsibility of the Personnel to determine any added cost for double occupancy and related expenses and to make the appropriate adjustment in the reimbursement request.

- Any estimated or unexplained expenses.

- **The purchase of alcohol at fundraising events may be permitted but only with prior approval from both the Charity Director and the Chief Executive or Director of Finance in line with the Management Procedure for Events Attendance & Structure.**

8. Training

8.1 Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional Manager, and Heads of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are adhered to at all times.

9. Resources

9.1 The implementation and management arrangements associated with this policy do not present any significant resource implications to the Trust.

10. Implementation

10.1 This policy will be maintained by the Charitable Funds Finance Manager.

10.2 Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

11. Distribution

11.1 The policy will be available via the Trust Intranet Site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

12. Review

12.1 The Charitable Funds Finance Manager will review the operation of the policy as necessary and at least every 3 years.

13. Legislation

13.1 Charity Commission.
13.2 SORP.2019 (FRS 102)
13.3 Charities Act 2022

14. Further Information

14.1 **Contact**
Further information and support is available from the Charitable Funds Finance Manager on 02920 615888 x6619

14.2 **Key guidance**

Users should refer to the Charitable funds section of the Trust intranet site:

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/HA.aspx

Ref: CFC 003
Velindre UNHS Trust
Charitable Funds Credit Card Policy

Date to be reviewed:	Sep 2025	**No of pages:**	7
Author job title(s):	Head of Financial Planning & Reporting		
Responsible dept / director:	Executive Director of Finance		
Approved by:	Charitable Funds Committee		
Date approved:	20.09.2022		
Effective Date (live):	20.09.2022		
Version:	4		

Date EQIA completed:	24.10.2022
Documents to be read alongside this policy:	1. Velindre UNHS Trust Charitable Funds Scheme of Delegation and stages for the purchasing and Authorisation of Goods and Services 2. Velindre UNHS Trust Charitable Funds Travel and Expenses Reimbursement Policy. 3. Velindre UNHS Trust Charitable Funds Credit Card Procedure. 4. Management Procedure for Events Attendance & Structure. 5. Velindre Trust Standing Order and Standard Financial Instructions. 6. FCP 6 Velindre Trust Purchasing Card procedure.

Current review changes:

1. The process for use of the Credit Card has been removed from the policy and now forms a separate procedure which was approved by SLG on the 8th September 2022 and will be available to staff on the Trust intranet site.
2. Reference to Velindre Trust Purchasing Card Procedure (FCP 6), Management Procedure for Events Attendance & Structure, and Trust intranet page for Charitable Funds
3. Guidance added on the ability to purchase alcohol at fundraising events.
4. Other Small Narrative Changes

Executive Summary:
To ensure that adequate controls are in place and that expenditure relating to Velindre University NHS Trust is both appropriate and justified.

First operational:	Date July 2012				
Previously reviewed:	Sep 2015	Jun 2018	Sep 2022		
Changes made yes/:no	Yes	Yes	Yes		

Contents

1. Policy Statement

1.1. The policy has been prepared to provide guidance on the use of the Trust credit card paid via Velindre UNHS Trust Charitable Funds. To ensure that adequate controls are in place and that expenditure is both appropriate and justified.

2. Purpose

2.1. Within the boundaries set by the purpose of the charitable funds, "**it is extremely difficult to state categorically what items of expenditure should and should not be charged to a charitable fund because of the lack of any definitive guidance**". However, in order to comply with The Inland Revenue Regulations, The Charity Commission Regulations and other General Internal Procedures and Controls which adheres to best practice for the use of charitable funds then a written policy should be in force for payment or reimbursement of expenses.

3. Scope

This Policy is to be read in conjunction with the following:

A. Velindre UNHS Trust Charitable Funds Scheme of Delegation and stages for the purchasing and authorisation of Goods and Services Policy.
B. Velindre UNHS Trust Charitable Funds Travel and Expenses Reimbursement Policy.
C. Velindre Trust Standing Order and Standard Financial Instructions.
D. Velindre UNHS Trust Charitable Funds Credit Card Procedure.
E. Management Procedure for Events Attendance and Structure.
F. Financial Control Procedure (FCP 6) Purchasing Card Procedure

Users should refer to the Charitable funds section of the Trust intranet site:

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/HA.aspx

4. Aims and Objectives

The aim and objective of this policy is:

4.1. To allow Velindre NHS Charitable Funds personnel access to efficient and alternative means of payment for approved expenses, especially expenses related to business travel, small office supplies and sundries.

5. Roles and Responsibilities

5.1.1 The Charitable funds Committee and its Trustees has overall responsibility for the reimbursement of claims made through the Trust credit card.

5.1.2 The Charitable funds committee delegates responsibility to individual fund holders.

6. Policies

6.1 Velindre NHS Trust credit cards will be issued to appropriate staff, only following approval of the Finance Department in line with the Financial Control procedure (FCP 6).

6.2 Credit cards will only be used for business purposes. **Personal purchases of any type are not allowed.**

6.3 The following purchases **are not allowed:**

- Alcoholic beverages/tobacco products. **The purchase of alcohol at fundraising events may be permitted but only with prior approval from both the Charity Director and the Chief Executive or Director of Finance in line with the Management Procedure for Events Attendance & Structure.**
- Capital equipment and upgrades over **£500.00.**
- Construction, renovation/installation.
- Controlled substances.
- Terms or services on term contracts.
- Maintenance agreements.
- Personal items or loans.
- Purchases involving trade-in of Velindre Charitable Funds property.
- Rentals (other than short-term autos).
- Telephones, related equipment, or services.
- Any other items deemed inconsistent with the values of the Charitable Funds or any expenditure that does not comply with the principles established by the Inland Revenue, the Charity Commission and the Charitable Committee of being **"Reasonable" and "Appropriate"** ,able to be justified publicly and to be able to respond to freedom of information requests.

6.4 **Cash advances** on credit cards are *not* allowed without written permission from the Executive Director of Finance.

6.5 Cardholders will be required to sign an agreement indicating they accept these terms. Individuals who do not adhere to these policies and procedures risk revocation of their credit card privileges and/or disciplinary action.

7. Non-reimbursable Expenditure

Velindre Charitable Funds maintains a strict policy that expenses in any category that could be perceived as of a personal nature, lavish, unreasonable or excessive will not be reimbursed, as such expenses are inappropriate for reimbursement by the Inland Revenue Regulations, Charity Commission Regulations, The Board of Trustees and The Charitable Funds Committee.

Expenses that are not reimbursable include, but are not limited to:

- Travel insurance. (This expenditure will not be reimbursed unless evidence is produced that the Travel Insurance was purchased in order to work for Velindre Charitable Funds for a specific event).

- First class tickets or upgrades.

- When lodging accommodations have been arranged by Velindre NHS Charitable Funds and the individual elects to stay elsewhere, reimbursement is made at the amount no higher than the rate negotiated by Velindre NHS Charitable Funds. Reimbursement shall not be made for transportation between the alternate lodging and the meeting site.

- Limousine travel.

- Movies, liquor, or bar costs.

- Membership dues at any country club, private club, athletic club, golf club, tennis club or similar recreational organisation.

- Participation in or attendance at golf or tennis tournaments, Car races or other sporting events, without the advance approval of the chairman of the board or his designee.

- Purchase of golf clubs or any other sporting equipment.

- Clothing purchases.

- Business conferences and entertainment which are not approved by the Charitable Committee of Velindre NHS Charitable Funds.

- Valet service.

- Car washes.

- Personal Toiletry articles.

- Personal services.

- Personal entertainment.

- Fines for traffic or parking violations.

- Laundry expense.
- Insurance for personal car.
- Excessive personal telephone calls.
- Charitable contributions.
- Political contributions.
- Briefcases and luggage.
- Finance charges from any source.
- Theft of personal property, including articles stolen from a personal car or rental car.
- Hotel/Motel cash bar, movies or health club/spa fees or exercise charges.
- Expenses for spouses, friends, or relatives. If a spouse, friend or relative accompanies Personnel on a trip, it is the responsibility of the Personnel to determine any added cost for double occupancy and related expenses and to make the appropriate adjustment in the reimbursement request.
- Any estimated or unexplained expenses.

8. Training

8.1 Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional Manager, and Heads of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are adhered to at all times.

9. Resources

9.1 The implementation and management arrangements associated with this policy do not present any significant resource implications to the Trust.

10. Implementation

10.1 This policy will be maintained by the Charitable Funds Finance Manager.

10.2 Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

11. Distribution

11.1 The policy will be available via the Trust Intranet Site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

12. Review

12.1 The Finance Manager will review the operation of the policy as necessary and at least every 3 years.

13. Legislation

- Charity Commission
- SORP 2019 (FRS 102)
- Charities Act 2022

14. Further Information

14.1 Contact

Further information and support is available from the Charitable Funds Finance Manager on 02920 615888 x6619

15. Key guidance

1. Credit Card Financial Control Procedure (FCP 6)
2. Users should refer to the Charitable funds section of the Trust Intranet site:

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/HA.aspx

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: IPC 21

INFECTION PREVENTION AND CONTROL POLICY FOR THE MANAGEMENT OF RESPIRATORY INFECTIONS

Executive Sponsor & Function	Executive Director of Nursing and Service Improvement
Document Author:	Senior Infection Prevention & Control Nurse
Approved by:	Quality, Safety and Performance Committee
Approval Date:	10 November 2022
Date of Equality Impact Assessment:	August 2022
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	November 2025
Version:	4

CONTENTS

ABBREVIATIONS

ABHR	Alcohol based hand rub
AGP	Aerosol generating procedures
CPO	Carbapenemase resistant organism
ESBL	Extended-spectrum beta-lactamase
FRSM	Fluid resistant surgical mask
HCW	Healthcare Worker
ICD	Infection Control Doctor
IPC	Infection Prevention and Control
IPCT	Infection Prevention and Control Team
LRTI	Lower Respiratory Tract Infection
MERS	Middle East respiratory syndrome
OPD	Outpatients Department
PHW	Public Health Wales
PPE	Personal Protective Equipment
RSV	Respiratory syncytial virus
RTI	Respiratory Tract Infections
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
SARS	Severe acute respiratory syndrome
URTI	Upper Respiratory Tract Infection
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
WG	Welsh Government

1 POLICY STATEMENT

1.1 Respiratory Tract Infections (RTIs) can include infection of the sinuses, throat, airways or lungs. Upper Respiratory Tract Infection (URTI) affect the nose, sinuses and throat, Lower Respiratory Tract Infection (LRTI) affects the airways and lungs. This policy concentrates on infections affecting the lower respiratory tract.

Respiratory infections are common and can be seasonal. They principally cause the common cold in both adults and children. Most are fairly mild, self-limiting and confined to the upper respiratory tract. These can progress and cause more severe infections and even death, especially in the very young and the elderly and immuno-compromised. There is a wide variety of viral causes of respiratory infections including rhinoviruses, picornaviruses, enteroviruses, respiratory syncytial virus (RSV), influenza viruses types A, B and C, parainfluenza viruses and corona type viruses; Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV) including Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2). There are also a number of common bacterial infections that can be caused by organisms such as *Streptococcus pneumonia*, *Haemophilus influenza*, *Moraxella catarrhalis* and *Staphylococcus aureus*. Atypical pneumonias may be caused by Mycoplasma, (Mycoplasma Tuberculosis is covered in IPC Policy 18 Tuberculosis Management) and legionella.

Influenza epidemics occur mainly in the winter and can result in widespread disruption to healthcare and other services. The Trust provides a flu vaccination service for all frontline staff and encourages all staff to be vaccinated. The Welsh Government (WG) sets an annual minimum target for the vaccination of staff in direct contact with patients. During an influenza outbreak or pandemic, the priority will be to identify potentially infected patients, carry out a risk assessment and use the appropriate precautions. Velindre University NHS Trust will seek to minimise illness occurring within Healthcare Workers (HCWs), patients and their families. The priority for the Trust is to ensure that all staff who are in direct contact with service users and donors are offered and given vaccination. Any suspected cases must be isolated and reported to the Infection Prevention and Control Team (IPCT).

1.2 The purpose of this policy is to improve protection of HCWs and service users, to reduce the transmission of infection of; bacterial infections, viruses including seasonal influenza, emerging and re-emerging novel viruses. This policy is to be used in conjunction with mentioned Infection Prevention and Control (IPC) policies.

2 SCOPE OF POLICY

2.1 The purpose of this document is to ensure that staff know how to manage patients with respiratory infections in order to minimise the risk of transmission within the healthcare setting.

Implementation of this policy will minimise the avoidable spread of respiratory infections; patients with a respiratory infection are cared for appropriately.

This policy applies to all HCWs employed by Velindre University NHS Trust. It details responsibilities in respect of hosted organisations and must be used in conjunction with mentioned infection, prevention and control policies.

Copies of all Velindre University NHS Trust policies can be found on the Trust Intranet site. http://howis.wales.nhs.uk/sitesplus/972/home

Guidance on COVID-19 can be found in A-Z pathogens list (Coronavirus) in the National Infection Prevention and Control manual (NIPCM) using the following link:

https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/nipcm/a-z-pathogens/

3 AIMS AND OBJECTIVES

3.1 The aims and objectives of this policy are to:

- Minimise the effect and spread of respiratory infections to all of Velindre University NHS Trust Service users and staff.
- To encourage the uptake of seasonal Influenza Vaccination Programs as recommended by the WG.
- To identify any patients in risk groups who (due to a prolonged stay in hospital) require vaccination.
- Embed the importance of infection prevention and control into everyday practice.

4 RESPONSIBILITIES

4.1 Chief Executive

The Chief Executive has overall responsibility and accountability to the Trust Executive Management Board for the management, prevention and control of infection across the organisation. This includes the responsibility for the provision of resources and implementation of all measures needed to comply with infection control policies and procedures, associated legislation and relevant guidance.

4.2 Executive Director of Nursing, AHPs and Health Sciences

The Executive Director of Nursing, AHPs and Health Sciences has delegated corporate responsibility for Prevention and Control of Infection and is accountable for this to the Trust Executive Management Board. These responsibilities include ensuring that the organisation receives competent infection prevention and control advice and that adequate staff Infection Prevention and control training, and monitoring is in place.

4.3 Divisional Directors and Directors of Hosted Organisations

Directors have responsibility for the day-to-day management of Infection Prevention and Control within their service area. They are directly accountable to the Chief Executive for ensuring full compliance of Infection Control Policies. They must ensure that staff are made aware of the policy that appropriate equipment is available, and training is provided to ensure that HCWs adhere to the policy within their areas of responsibility. Hosted organisations who have staff working within

other Health Boards will also need to take account of the policies within the Health Boards they visit.

4.4 Consultant Microbiologist/Infection Control Doctor (ICD)

The Consultant Microbiologist / IDC has responsibility for the diagnosis, management, notification and escalation of infectious diseases to national bodies such as Public Health Wales (PHW) and Welsh Government. In consultation with the Consultant in Communicable Disease Control implement appropriate measures for diagnosis, infection prevention and control, contact tracing and transfer to regional centre as required in outbreak scenarios or when dealing with novel viruses in line with UK and national guidance.

4.5 Infection Prevention and Control Team

IPCT have responsibility for ensuring:

- The policy is implemented and monitored across the Trust.
- Ensure compliance with national initiatives or directives.
- The importance of infection prevention and control measures are embedded into everyday practice. Provide support and advice to clinical areas regarding the management of patients with or suspected to have RTIs (this may be detected via microbiological results but more commonly will be due to the patient's clinical symptoms).
- All controls are in place to minimise risk of spread to other patients, service users, donors, staff and visitors.

4.6 Ward/Department Managers

Will ensure:

- Staff are aware of the policy.
- Allow all staff access to attend any necessary training / educational sessions.
- Equipment is available when needed.
- Encourage and facilitate staff to attend and receive seasonal influenza vaccination.
- Staff have opportunity to be fit tested for an FFP3 respiratory mask.
- And should maintain a record of staff who have been fit tested.
- All employees refrain from coming to work if ill.
- Promptly inform IPCT of any suspected or confirmed cases of seasonal influenza or novel viruses.
- Ensure any patient or case of seasonal influenza or novel virus is isolated immediately.
- Comply with IPC precautions advised.
- Receive Seasonal influenza vaccination.
- Limit the movement of patients outside their room to those necessary for patient management/treatment. Whilst outside the isolation room the patient should wear a fluid resistant surgical mask (FRSM). Patients with respiratory symptoms or suspected/ confirmed influenza are not mix with other patients. They should be encouraged to practice good respiratory etiquette i.e. cover their mouth & nose with a tissue when sneezing or coughing, 'Catch it, Bin it, Kill it' and dispose of the tissue promptly in a bin and then practice hand hygiene by washing hands with soap & water or hand sanitiser.
- Visitors or service users who have 'flu like symptoms' or who are coughing and / or sneezing must be advised not to come to the hospital or to donate.

5 DEFINITIONS

5.1 Respiratory infections as a communicable disease

A respiratory tract infection (RTI) is an infectious process affecting any part of the upper and/or lower airways. Symptoms of RTI can include any of the following: fever, rhinorrhoea (runny nose), sore throat and cough, limb or joint pain, headache, lethargy, chest pain and breathing difficulty. Common causes of RTIs include viruses such as: rhinoviruses, SARS-CoV, SARS-CoV-2, seasonal coronavirus, influenza and RSV; and bacteria such as pneumococci (*Streptococcus pneumoniae*) and *haemophilus influenza*. Avian influenza and MERS-CoV are less common causes of RTIs and can lead to severe illness. Where either of these are suspected advice should be sought as a matter of urgency from a Consultant Microbiologist. The majority of RTIs are self-limiting, viral infections of the upper respiratory tract. Although RTIs can happen at any time, they are most common from September through till March. The peak activity for RTIs due to influenza occurs during the autumn and winter seasons in temperate regions. In some tropical countries, influenza viruses circulate throughout the year with one or two peaks during rainy seasons. Worldwide, the epidemics of influenza result in about three to five million cases of severe illness, and about 290,000 to 600,000 people die of respiratory diseases linked to seasonal influenza each year. Most deaths associated with influenza in industrialized countries occur among people age 65 or older.

Streptococcus pneumoniae and *haemophilus influenza* are components of the normal upper respiratory tract flora. Infections with these organisms are often secondary to a prior viral infection.

6 IMPLEMENTATION/POLICY COMPLIANCE

6.1 Velindre Cancer Centre (VCC)

6.1.1 In Patients admitted with Respiratory infections

- Patients admitted with confirmed or suspected RTIs should be isolated until diagnosis has been confirmed. Where single rooms are not available the IPCT may advise that suspected or confirmed cases with the same organism are cohorted in a single bay/ area.
- All adult patients with signs and symptoms of respiratory infection should receive active instruction on respiratory hygiene/ cough etiquette and importance of effective respiratory hygiene (Appendix 1).
- Throat swab will be required, sputum and nasal swabs may be required. The request form must include all relevant clinical information including possible clinical diagnosis.
- Display the relevant infection prevention and control notices.
- All respiratory equipment used on the patient should be changed or cleaned every 24 hours.
- Where viral respiratory infection is suspected in adults they should:
    - Be nursed in single room using respiratory / droplet precautions (Flow chart Appendix 3).
    - Be assessed by a member of the medical staff.

- The door must be kept closed and a respiratory precaution sign placed on the door.
- Staff should ensure that correct selection and use of appropriate Personal Protective Equipment (PPE) is observed, (Appendix 2).
- Carers / visitors should be reminded about the importance of patients remaining in isolation and potential infection risks.
- Patients should only remain in hospital if their clinical condition warrants this
- Visitors should themselves avoid contact with other patients in the ward.
- During an outbreak if cohorting has to be considered – Immuno-suppressed patients should not be nursed in the same area and should be admitted to single rooms.
- When clinical signs or history (travel to affected areas) suggest infection with novel or re-emerging respiratory diseases, such as MERS- CoV), SARS- CoV, SARS-CoV-2 or Influenza like viruses the patient must be placed in a single room prior to medical assessment and discussed with IPCT, ICD or microbiologist. Specific instructions regarding the use of PPE will be given at this time. (Over 65s and immune-suppressed patients are classified at risk of severe disease).

- Pandemic Influenza advice will be continually updated on the PHW/ Public Health England website and this should be accessed by Trust personnel.

http://www.wales.nhs.uk/sites3/home.cfm?orgid=379
http://www.HPE.org.uk/

6.1.2 Transmission

Influenza and respiratory Infections can be acquired by direct and indirect contact. Transmission occurs from person to person by close contact, predominantly by large droplet/ airborne respiratory secretions and/ or contamination of hands. Infected HCWs and visitors are potential sources of hospital acquired infection. Influenza can be transmitted prior to symptoms occurring, therefore respiratory hygiene should be encouraged at all times.

The pathogens that cause RTIs are spread through one or more of four main routes:

Visitors must be advised of the risks of infection and preferably avoid visiting.

Visitors who have had close contact with people who are coughing and/ or sneezing or show signs and symptoms of a respiratory illness, must be advised not to come into the hospital or come to donate.

Droplet transmission	Droplets can be generated from the respiratory tract during coughing, sneezing or talking. If droplets from an infected person come into contact with the mucous membranes (mouth/nose, eye) or surface of the eye of a recipient, they can cause infection. Close physical contact is required for transmission. These droplets remain in the air for a short period and travel about one metre, so closeness is required for transmission.
Airborne Transmission	Aerosol generating procedures (AGP) such as coughing can produce small droplets. These small droplets can remain in the air, travel more than one metre from the source and still be infectious, either by mucous membrane contact or inhalation.
Direct contact transmission	Infectious agents are passed directly from an infected person (who has for example coughed into their hands) to a recipient who then transfers the organism into their mouth, nose or eyes.
Indirect contact transmission	This takes place when a recipient has contact with a contaminated object, such as bedding, furniture or equipment which is usually in the environment of an infected person. Again, the recipient transfers the organisms from the object to their mouth, nose or eyes.
Infectious Period	The time period over which an infected person can spread the infection to someone else. Generally, in the early stages the infectious period is higher for example influenza day one after the onset of symptoms until 3-5 days later. In some groups this may be longer for example children and the immunocompromised patients with pertussis infection may remain infectious until three weeks after the paroxysmal phase of disease
Persistence in the Environment	Respiratory virus have been shown to survive in the environment for a short period of time for example influenza can be transferred from fomites to hands up to 48 hrs after initial cross contamination
High risk environment	Generally, where aerosol generating procedures are occurring in communal patient areas

The time between exposure to a pathogen and developing symptoms of infection by the pathogen is the incubation period. Some of the common pathogens for RTIs and their respective incubation times are:

Respiratory Pathogen	**Incubation Period**	**Period of infectivity**
SARS-CoV-2	1-10 days	10 days from symptom onset
Rhinoviruses	1-5 days	1 day before and 5 days after onset of symptoms
Pnuemococcus and *Haemophilus influenzaei*	1-5 days	Until 48 hours effective antibiotic treatment
Influenza and parainfluenza viruses	1-4 days 2-6 days	Adults 3-5 days from onset of symptoms Young children 7-10 days (May be longer in immunosuppressed patients)
Respiratory Syncytial viruses (RSV)	3-7 days	Whilst symptomatic

6.1.3 Infection Prevention & Control precautions

Strategies should be put in place to interrupt the modes of transmission detailed above for all cases whether clinically suspected or confirmed:

- Isolate patients in a single room where possible of if there are several cases, cohort of cases of suspected influenza maybe appropriate. Please discuss with the IPCT.
- Personal protective equipment (PPE) must be worn by any HCW before entering the isolation room, consisting of gloves, plastic apron and FRSM. Hands should be decontaminated with alcohol-based hand rub (ABHR) or soap and water prior to donning gloves.
- Any patient who is actively coughing should be asked to wear a FRSM (if able to tolerate) during examinations (and while visitors are present).
- Patient to be asked to wear a FRSM in communal areas / waiting rooms / during transfers to other areas of the hospital.

Below highlights the PPE required for staff and visitors before entering the room of a patient with suspected/known respiratory infection:

Staff Group	Plastic Apron	Long Sleeved Fluid Repellent Gown	Eye Protection (Visor/ Goggles)	Nonsterile disposable Gloves	FRSM	FFP3 Mask
HCW	√		√ (If risk of close contact with patient – within 1 metre)	√	√	
HCW involved in AGPs*		√	√	√		√
Housekeeper/caterer/porter	√		√ (If risk of close contact with patient – within 1 metre)	√	√	
Relatives/ Visitors						

- * e.g. CPAP, induction of sputum, intubation, open suctioning.

Refer to appendix 2 for correct PPE donning and doffing technique.

- If no ensuite facility is available, patient should use a dedicated commode within the isolation room i.e. not leave the room.

- Rooms should be cleaned daily.

- Visitors should be asked to stay within the isolation room with the door closed during their visit.

- Linen from affected patients should be placed in a red alginate (soluble) bag and tied. Then placed into a red ‘infected linen’ bag and tied with yellow hazard tape before being placed into a red cloth bag.

- All waste generated from isolation rooms must be disposed of as infectious (orange) waste.

6.1.4 Affected patients known or suspect in designated cohort wards

PPE must be worn by any HCW before entering a cohorted bay, consisting of gloves, plastic apron and FRSM. Hands should be decontaminated, prior to donning gloves, with ABHR or soap and water.

- Any patient who is actively coughing should be asked to wear a FRSM during examinations (if able to tolerate) and while visitors are present.

6.1.5 Treatment for known or suspected influenza

The full NICE guidance on the use of antiviral medicines can be accessed at: http://guidance.nice.org.uk/TA168 for treatment, and http://guidance.nice.org.uk/TA158 for prophylaxis

See C&V guidelines for treatment options:
https://viewer.microguide.global/CAVUHB/ADULT

Pregnant Staff (or others in defined risk groups)

- Vaccination is the first and most important measure in prevention seasonal influenza in individuals in risk groups.
- During a time of increased seasonal influenza activity, staff are at least equally as likely to be exposed to influenza outside of work as they are in the work setting.
- All staff, including those in risk groups must adhere to the required Standard and respiratory precautions when in contact with known or suspected influenza cases to minimise their risk of acquisition.
- The Trust may decide, despite vaccination and appropriate PPE for pragmatic reasons, to restrict those in risk groups from direct care for known or suspected influenza/ SARS-CoV-2 cases. Please contact Occupational Health for advice.

6.1.6 Discontinuing Precautions

- The majority of patients with flu will not be infectious beyond 5 days. Clinical response/ improving condition is associated with the reduction of viral load and decreased infectiousness. Precautions may be discontinued at day 5 following onset of symptoms/ treatment with antiviral drugs, providing there has been a satisfactory clinical response.
- Patients with severe immunosuppression may also shed the influenza virus for longer. Such cases should be discussed with IPCT or Virologist to determine appropriate interventions (See Appendix 4 for definitions of severe immunosuppression).
- With general bacterial infections specific precautions (other than standard precautions) may be discontinued if the patients stops coughing or the coughing is controlled and the patient able to use

tissues when coughing (follow respiratory hygiene), unless the patient has a multi-resistant organism such as an Extended-spectrum beta-lactamase or Carbapenemase resistant organism where advice should be sought from the IPCT.

- All re-usable equipment used for respiratory infections must be cleaned after use according to manufacturer's instruction or the decontamination policy.
  - Routine cleaning to be carried out by housekeepers using correct PPE.
  - Enhanced cleaning of rooms to be carried out when patients discharged.
  - Linen to be processed as infectious linen as per guidance.
  - Waste to be disposed of as per Trust guidance.

6.2 Outpatients Department (OPD)/ Ambulatory services

During the influenza season it is likely that patients and donors attend outpatient and donor services, therefore it is important to ensure that the appropriate actions are undertaken to avoid outbreaks.

6.2.1 OPD Setting

In addition to using standard precautions and effective hand hygiene practices. Staff should ensure the following additional precautions are in place;

- Patients, needing assessment whilst symptomatic, should proceed straight to a cubicle/ isolation room for assessment and leave immediately afterwards to avoid symptomatic people sitting in waiting areas and exposing other patients/ service users.
- Use respiratory precautions if experiencing high levels of patients with respiratory symptoms or undertaking AGP generating – contact the IPCT.
- Consider minimising spread of respiratory viruses in waiting area by providing FRSM for patient use.
- If patients telephone VCC or WBS who are experiencing symptoms, consider deferring appointments/ treatments if appropriate.
- Use PPE when examining patients with respiratory symptoms (Appendix 2).

6.3 Welsh Blood Service (WBS)

Due to the nature of this service it is essential to ensure that HCWs, as well as donors are protected:

- Whilst donations take place during the influenza season.
- At the time of a pandemic or outbreak of a novel virus or emerging and re-emerging types of influenza.

6.3.1 Protection of Donors at WBS

- Donors should be discouraged from attending if they have any flu like symptoms and should be asked to return home.
- If required, staff should use appropriate PPE when dealing with donors (See Appendix 2).
- Signage/ instruction to be provided on correct respiratory hygiene/ cough etiquette and supplies of tissues to ensure they cover their mouth and nose when coughing/ sneezing, to contain respiratory secretions. Provision should be made for the disposal of tissues into an appropriate clinical waste receptacle.
- Hand hygiene (refer to IPC policy 10 Hand Hygiene Policy and Procedure) must be carried out following contact with respiratory secretions or any other body fluids.
- Waste should be disposed of according to the Waste Policy (QS 20).
- HCWs should also be encouraged to use the correct respiratory hygiene/ cough etiquette when coughing or sneezing followed by hand decontamination.

All frontline staff are advised to have seasonal influenza immunisation to reduce the chances of acquiring influenza. Symptomatic staff should be advised to refrain from attending work for 5 days following onset of symptoms.

6.4 Response during a Pandemic (e.g. Novel Viruses including Coronavirus and Influenza)

Once a new (novel respiratory virus is able to infect and be transmitted between humans, a pandemic is likely to occur. Because people will have little or no immunity to the new virus, respiratory pandemics will affect a large proportion of the global population and put significant stress on health-care systems. It is evident that planning at the earliest possible stage will help in the response to the pandemic and will hopefully reduce its impact. It is a requirement that the Trust develops contingency plans to ensure that it is able to respond in the event of a pandemic. It is accepted that these plans will need to be kept under constant review having regard to developments within Wales, the United Kingdom and the world as a whole. Whilst certain elements of the planning will be specific to pandemic influenza, there may be many similarities to other circumstances which will challenge the smooth operation of the organisation (Refer to VCC Pandemic Influenza Response Procedure). It is the aim of this procedure to ensure that the VCC is prepared, as far as is reasonably practicable, to respond to an influenza pandemic.

HCWs must be prepared to identify and manage cases of suspected pandemic influenza to ensure safe and effective treatment for patients/ donors. It is important that guidelines for clinical management are prepared, that HCWs are trained, and that medicines, supplies and medical devices are available.

- Wherever possible avoid admitting of patients with confirmed or suspected respiratory infections/ viruses. Triage by phone and if admission is required refer to hospital where correct isolation facilities are available (discuss with IPCT).

- If admission is required, place in isolation with respiratory precautions in place. All staff entering the isolation room to wear appropriate PPE (which will include a FRSM) (See appendix 2).
- Any specimens taken are to be classified and labelled as 'high risk' and the laboratory contacted prior to the specimen being sent. Ensure that the virology form contains the onset of symptoms. (Refer to IPC policy 11 Transport of Specimens).
- The door to the patients' room must be kept closed at all times.
- If AGP treatments are required, an FFP3 mask and eye protection must be worn.
- Patient should only leave the room if clinical need dictates and should be asked to wear a FRSM, to prevent large droplets being expelled into the environment by the wearer.
- Hand hygiene is essential after contact with the patient or his/ her environment, and on leaving the patient's room in order to prevent transmission (Refer to IPC policy 10).
- All staff must be fit tested before using FFP3 masks.
- HCWs who are vaccinated or returning to work after illness should look after symptomatic patients where possible.
- At the appropriate time the WG will:
    - Issue guidance of prophylaxis for HCWs and at-risk groups.
    - Advise on appropriate vaccination.
- All PPE must be removed and disposed of as clinical waste prior to leaving the single room or cohort area with the exception of the FRSM and eye protection, which will be removed after leaving the room/cohort area followed by hand hygiene

6.5 Health Care Workers

6.5.1 Influenza Vaccination

Vaccination is the first and most important measure in preventing seasonal influenza. Velindre University NHS Trust encourages HCWs to take up the offer of the vaccine which is available free of charge and is recommended for all NHS HCWs with direct service user contact, from September to March each year. The immunisation needs to be repeated annually as the vaccine is adjusted in line with circulating influenza virus on an annual basis. It is the responsibility of individual employees to access this service in order to minimise the risk to service users (particularly those with frequent patient/ service user contact).

HCWs are 3 to 5 times more likely to get flu than people in other jobs. Due to repeated exposure of the virus, one in three health care staff is estimated to be infected by the flu in any season. You can pass on flu to vulnerable patients/ service users, your family, and colleagues even if you're not symptomatic.

The flu vaccine is effective in preventing influenza and could be the difference between life and death. The flu vaccine cannot give you flu. However, as it works by stimulating your body's immune system you may have some mild flu-like symptoms (immune response) for a day or two afterwards. This will be brief, and you cannot pass these symptoms on.

This is particularly important:

- For all HCWs
- For pregnant women
- For those in risk groups (Appendix 4)

6.5.2 HCWs with respiratory symptoms

HCWs with respiratory symptoms suggestive of flu should be advised to stay at home e.g. coryzal symptoms (cough, runny nose, muscle aches, fever etc.).

HCWs suspected to have or diagnosed with a communicable respiratory disease must inform the Occupational Health Service (in addition to their line manager) immediately before attending work.

Anyone who is suffering from persistent, unexplained respiratory symptoms, especially following foreign travel, must report to their General Practitioner and should not attend work.

In the event of new or re-emerging respiratory diseases, such as severe acute respiratory SARS, SARS-CoV-2, MERS and Pandemic Influenza advice will be given by Infection Control and the Occupational Health Service.

6.6 Policy Conformance/ Non-Compliance

If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

6.7 Implementation

This policy will be implemented and maintained by the IPCT.

The policy will be available via the Trust Intranet Site and from the IPCT. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

6.8 Audit and Monitoring

HCWs must report increases in admissions of respiratory infections to the IPCT.

If an outbreak is suspected the Outbreak policy (IPC14 Outbreak Management Policy) must be followed.

7 REFERENCES and further reading

Department of Health (2022) People with symptoms of a respiratory infection including COVID-19. Guidance for people with symptoms of a respiratory infection including COVID-19, or a positive test result for COVID-19. https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection including-covid-19

Department of Health (2022) COVID-19: managing healthcare staff with symptoms of a respiratory infection. Guidance for managing healthcare staff with symptoms of a respiratory infection including coronavirus (COVID-19), or a positive test result for COVID-19. https://www.gov.uk/government/publications/covid-19-managing-healthcare-staff-with-symptoms-of-a-respiratory-infection

Department of Health (2022) COVID-19: infection prevention and control (IPC). Guidance on infection prevention and control for seasonal respiratory infections including SARS-CoV-2. https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

The Health and Social Care Act. (2008) 'Code of Practice for the NHS on the Prevention and Control of Health Care Associated Infections and Related Guidance'. 2015 update. Department of Health.

HSE guidance on fit testing is available at http://www.hse.gov.uk/pubns/priced/hsg53.pdf

Loveday H.P. et al (2014) epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospital in England. Journal of Hospital Infection 86S1 S1-S70

NICE (2014) Infection Prevention and Control Nice Quality standard. https://www.nice.org.uk/guidance/qs61

Public Health England (2015) Infection Control precautions to minimise transmission of acute respiratory tract infection in healthcare settings. http://www.guidelines.co.uk/phe/infection (2019)

Public Health Wales (2022) Infection Prevention and Control Measures for SARS-CoV-2 (COVID-19) in Health and Care Settings - WALES. https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/guidance/infection-prevention-and-control-measures-for-sars-cov-2-covid-19-in-health-and-care-settings-wales/

Public Health Wales (2019) Managing Seasonal Influenza: Infection Prevention and Control Guidance in Healthcare Settings https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/guidance/accordians/docs/managing-seasonal-influenza-infection-prevention-and-control-guidance-in-healthcare-settings/

WHO (2008) Your 5 moments of hand hygiene [pdf] Available at: http://www.who.int/gpsc/tools/Five_moments/en/

8 GETTING HELP

8.1 Further information and support

IPCT: 02920196129

9 RELATED POLICIES

This policy should be read in conjunction with:

- IPC 04: Decontamination Policy
- IPC05: National Infection Prevention & Control Manual (NIPCM)
- IPC 06: Management of Occupational Exposure to Blood and High-Risk Body Fluids (needle stick injury)
- IPC 10: Hand Hygiene Policy
- IPC 11: Transport of Specimens
- IPC 16: Management, Prevention and Control of Legionellosis (including Legionnaires Disease)
- IPC 18: Tuberculosis Management
- QS 20: Waste Management

VCC Pandemic Influenza Response Procedure

10 INFORMATION, INSTRUCTION AND TRAINING

10.1 Training

All HCWs will undertake mandatory infection control training and must be fit tested as per Health and Safety Executive (HSE) requirement for wearing FFP3 masks.

11 MAIN RELEVANT LEGISLATION

Legislation considered in the development of this policy includes:

- Control of Substances Hazardous to Health Regulation (COSHH) 2002 (Updated January 2020) as amended Approved Code of Practice and Guidance
- Department of Health (2013). Infection Control in the built environment HBN 00-009
- Department of Health (2013) Environment and Sustainability Health Technical Memorandum - Safe Management of Health Care Waste, 07-01
- Green Book- re immunisation
- Health and Safety Executive Books ISBN 0-7176-2981-3
- Health and Safety at Work Act (1974)

Appendix 1 Respiratory Hygiene/Cough Etiquette / Droplet precautions

Respiratory Hygiene/Cough etiquette

- Respiratory hygiene/cough etiquette should be encouraged:
  - Ensure mouth and nose is covered with disposable tissues when coughing/ sneezing to contain respiratory secretions.
  - Use disposable tissues for wiping or blowing noses.
  - Provision should be made to enable disposal of tissues into an appropriate waste receptacle.
  - Decontaminating hands after coughing, sneezing and using tissue or following contact with respiratory secretions.
  - Ensure supplies are available for those patients who are immobile.

Droplet Precautions

- In addition to **Standard Precautions**, use **Droplet Precautions** for patients known or suspected to be infected with micro-organisms transmitted by droplets. Droplet transmission involves contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 µm in size) containing microorganisms generated from a person who has a clinical disease or is a carrier of the disease). Droplets can be generated by the patient coughing, sneezing, and talking or during the performance of certain interventions (e.g. nebulisers) or procedures.
- Transfer between departments/wards with the patient using a standard surgical mask if tolerated.
- Isolate patient in a single room where possible (if there are several cases cohorting may be used after discussion with IPCD).
- Eye protection if risk of splash to face/eyes from uncontrolled coughing or sneezing.
- Aerosol Generating Procedures use FFP3 masks. It is important to use appropriate FFP3 mask after fit testing.

Appendix 2 - Personal Protective Equipment

Appropriate PPE for care of patients with flu should be used; ensure the correct donning and removal is used to prevent inadvertent contamination. All contaminated clothing must be removed before leaving a patient care area. Disposable of fluid resistant surgical masks being removed last. All PPE must comply with relevant BS and EN standards.

Gloves

- Gloves are not required for the routine care of patients with flu; however standard infection control precautions must apply.
- Gloves must be worn when carrying out aerosol generating procedures.
- Gloves must be removed immediately after use and disposed of as clinical waste – wash hands following removal.
- If glove supplies become limited during a pandemic, priorities may need to be established. The priority for use will be for contact with blood or body fluids, invasive procedures and contact with sterile sites.

Aprons and Gowns

- Standard infection control precautions apply. Plastic aprons should be worn as single use items for one procedure or episode of patient care and then discarded and disposed of as clinical waste.
- Aprons must be worn when in close contact with patients or equipment.
- Gowns are not required for the routine care of patient with flu but should be worn:
  - for aerosol producing procedures
  - if extensive soiling of personal clothing or uniform with respiratory secretions is anticipated
  - there is a risk of extensive splashing of blood, body fluids, secretion, and excretions.
  - if gowns are worn, they should be fluid repellent and single use
  - must be worn only once then placed in the appropriate waste receptacle

Eye Protection

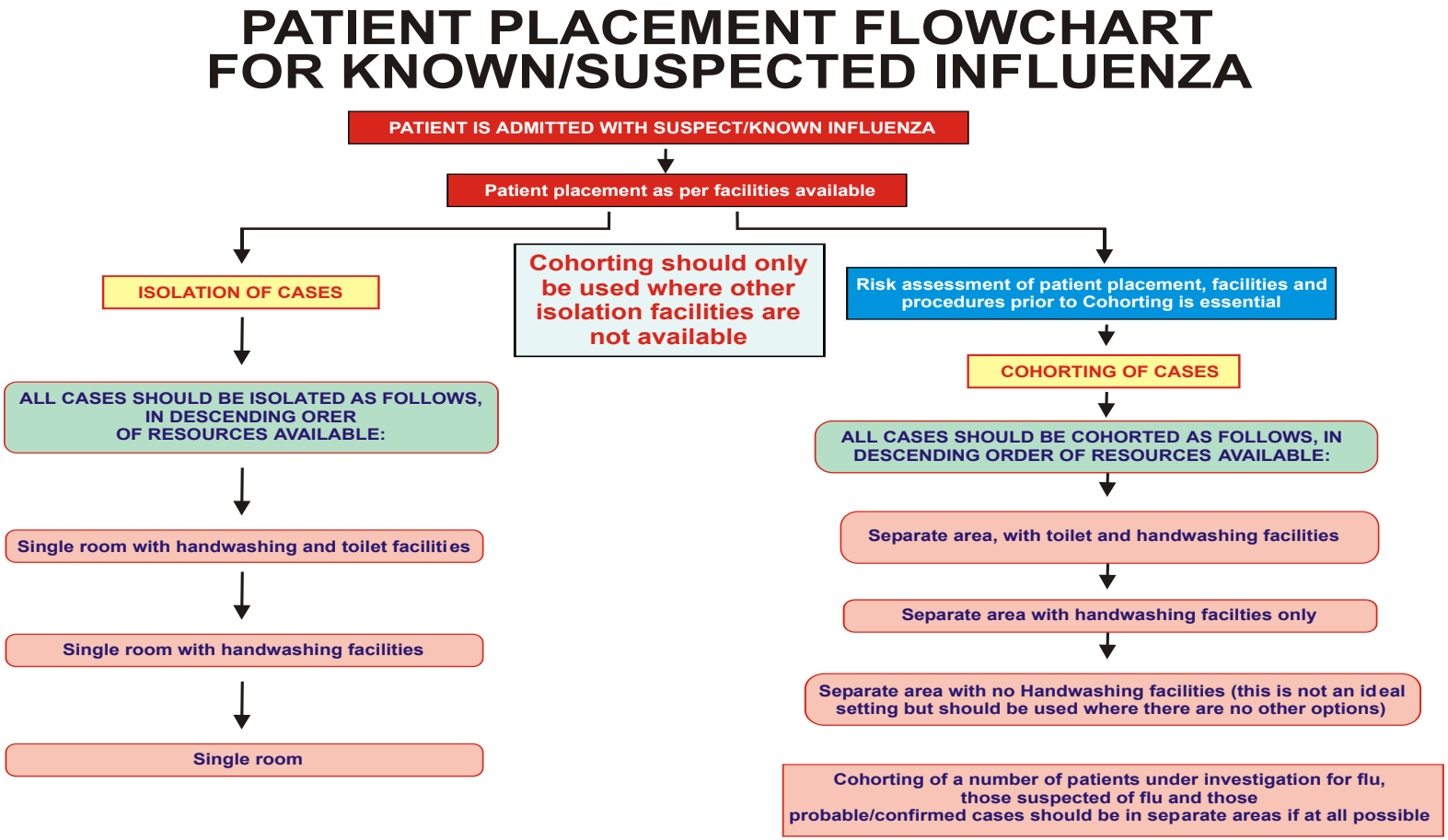
Protection can be achieved by using a fluid resistant surgical mask with integrated visor, full face visor or safety spectacles or equivalent.

- Eye protection should be considered when there is a risk of contamination of the eyes by splashes and droplets on the basis of an individual risk assessment at the time of providing care.
- Eye protection must always be worn during aerosol generating procedures.

Surgical Masks

- Select the correct type of mask for the task to be undertaken:
  - FFP3 (EN149:2001 FFP disposable respirator) – when performing procedures that will generate aerosols. (These should have been fit tested by H & S or by trained fit tester).
  - FFP2 can be used if FFP3 masks are not available.
  - Fluid resistant surgical masks - when entering an area and not performing aerosol generating procedures.
- **Wash hands following disposal of masks.**

Appendix 3 In Patient placement flowchart for known or suspected influenza.



Appendix 4 – Definition of Severe Immune Compromise and some issues related to vaccines

Severely immunocompromised people include those who have:

- active leukemia or lymphoma
- generalized malignancy
- aplastic anemia
- graft-versus-host disease
- congenital immunodeficiency
- recent radiation therapy
- solid-organ or bone marrow transplant patients, within 2 years of transplantation, or transplant recipients who are still taking immunosuppressive drugs
- chronic lymphocytic leukemia patients have poor humoral immunity, even early in the disease course, and rarely respond to vaccines. (Complete revaccination with standard childhood vaccines should begin 12 months after bone marrow transplantation. However, measles, mumps, and rubella (MMR) vaccine should be administered 24 months after transplant if the recipient is presumed to be immunocompetent. Influenza vaccine should be administered 6 months after transplant and annually thereafter)

People taking any of the following categories of medications are considered severely immunocompromised:

- **High-dose corticosteroid**s (>2 mg/kg of body weight or ≥20 mg per day of prednisone or equivalent in people who weigh >10 kg, when administered for ≥2 weeks, the immune response to vaccines may be impaired. Clinicians should wait ≥1 month after discontinuation of high-dose systemic corticosteroid therapy before administering a live-virus vaccine.)
- **Alkylating agents** (such as cyclophosphamide)
- **Antimetabolites** (such as azathioprine, 6-mercaptopurine)
- **Transplant-related immunosuppressive drug**s (such as cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil, and mitoxantrone)
- **Cancer chemotherapeutic agents**, excluding tamoxifen but including low-dose methotrexate weekly regimens, (Limited studies show that methotrexate monotherapy had no effect on the response to influenza vaccine, but it did impair the response to pneumococcal vaccine.)
- **TNF blockers** such as etanercept, rituximab, adalimumab, and infliximab blunt the immune response to certain vaccines and certain chronic infections. When used alone or in combination regimens with methotrexate to treat rheumatoid disease, TNF blockers were associated with an impaired response to influenza vaccine and to pneumococcal vaccine as well.

Severe Immune Compromise Due to Symptomatic HIV/AIDS

(Adapted from CDC Yellow book: https://wwwnc.cdc.gov/travel/page/yellowbook-home-2020)

Appendix 5 – Respiratory precautions

Canolfan Ganser Felindre
Velindre Cancer Centre

GIG CYMRU NHS WALES

Respiratory Precautions

STOP

Visitors:
Report to nurse in charge before entering this room.

Staff members:

Hands

Decontaminate hands before entering this room

Personal Protective Equipment

Wear disposable apron/gown, Surgical mask/FFP3 mask, eye/facial protection and gloves before entering this room.

Door

Keep door closed.

Before leaving

Decontaminate equipment prior to removal from room.

Discard gloves, apron/gown and eye/facial protection in healthcare waste bin. Decontaminate hands.

After leaving

Remove surgical mask/FFP3 mask and discard in healthcare waste bin.

Decontaminate hands.

Developed by the Infection control team 2018

Ref: IPC 10

Hand Hygiene Policy

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Scientists
Document Author:	Senior Infection Prevention & Control Nurse
Approved by:	Quality, Safety and Performance Committee
Approval Date:	10 November 2022
Date of Equality Impact Assessment:	6 June 2022
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	November 2025
Version:	6

CONTENTS

ABBREVIATIONS

ABHR	Alcohol based hand rub
ANTT	Aseptic Non-Touch Technique
BBE	Bare below the elbow
COSHH	Control of Substance Hazardous to Health
HCAI	Healthcare associated infection
HCW	Healthcare worker
IPC	Infection prevention and control
IPCT	Infection Prevention and Control Team
SCIPs	Standard Infection Control Precautions
WBS	Welsh Blood Service
WHO	World Health Organization

1. POLICY STATEMENT

1.1 Hands are the most common way in which microorganisms, particularly bacteria, can be transmitted and subsequently cause infection, especially in those who are most susceptible. In order to prevent the spread of microorganisms to those who are at risk of developing infections, hand hygiene must be performed properly at the correct times. Hand hygiene is considered to be the single most important practice in reducing the transmission of infectious agents, including Healthcare Associated Infections (HCAI), transmitted during care delivery.

1.2 Before selecting the appropriate hand hygiene procedure, consideration should be given to the potential/actual hazards that have been or might be encountered, the subsequent potential/actual contamination of hands, and any risks that may present as a result. The nature of the work, the interaction with the patient/client/resident and the vulnerability of individuals will often determine this.

1.3 It must always be assumed that every person encountered could be carrying potentially harmful microorganisms that could be transmitted. Hand hygiene is one of the ten elements of Standard Infection Control Precautions (SICPs) and undertaking them is an essential element to ensure everyone's safety.

1.4 The term hand hygiene used in this document refers to all of the processes, including hand washing and hand decontamination achieved using other products, e.g. alcohol-based hand rub (ABHR).

1.5 It is Velindre University NHS Trust policy to promote, provide and maintain a healthy and safe environment for the employees, patients, donors and visitors. The Trust's aim is therefore to promote hand hygiene within the clinical environment, in order to reduce the number of HCAIs to an absolute minimum, thus promoting patient safety via a zero tolerance to non-compliance or poor practice.

1.6 This policy aims to provide evidence-based guidance that will identify the responsibilities individuals, the correct application of the procedure and compliance requirement.

2. SCOPE OF POLICY

The policy applies to all staff, in all locations of Velindre University NHS Trust, including those with honorary contracts and student placements.

3. AIMS AND OBJECTIVES

3.1 The aim of this policy is to provide comprehensive guidance on all aspects of hand hygiene to help prevent the spread of HCAI. Objectives include:

Identifying correct provision of facilities
Use and provision of appropriate products
Required level of education and training for Trust staff, patients and visitors
Managers accountabilities and responsibilities
Necessary monitoring of compliance through audit and reporting

Use of quality improvements methods to improve and maintain hand hygiene compliance
Description of the required processes
Importance and responsibility of HCWs to decontaminate hands at the point of care in the reduction of HCAI.

4. RESPONSIBILITIES

It is the responsibility of every member of staff working in the health care setting to ensure adequate hand hygiene is performed where appropriate.

4.1 The Chief Executive

The Chief Executive has overall responsibility to ensure this policy is adhered to while the operational authority for appropriate and timely hand hygiene practice lies with the individual user and clinical/departmental managers. Compliance will be measured using observations and audits.

4.2 Executive Director of Nursing, Allied Health Professionals & Health Science

The Director of Nursing, AHP's & Medical Scientists has delegated Executive responsibility for Prevention and Control of Infection and is accountable for this to the Trust Executive Management Board. These responsibilities include ensuring that the organisation receives competent infection prevention and control advice and that adequate staff Infection Prevention and Control training, and monitoring is in place. This includes Hand Hygiene.

4.3 Departmental Managers/ Clinical Directors / Clinical Managers

Departmental Managers, Clinical Directors and Clinical Managers are accountable and responsible for:

- Ensure that all staff receives annual instruction/education on the principles of hand hygiene and SICPs
- Maintain accurate and up to date training compliance records.
- Ensuring this policy is easily accessible to all staff and that all staff are aware of the policy and its content.
- Monitoring compliance with this policy and taking immediate corrective action if non- compliance is identified.
- Ensure participation in surveillance and audit programmes at local level and provide active support for presentation and improvement of hand hygiene compliance results.
- Monitoring and enforcing Bare Below Elbow (BBE) standards in all clinical settings at all times.
- Ensuring there are sufficient, trained and competent hand hygiene champions within departments who can ensure staff remain compliant with training, training is recorded on ESR and monthly compliance audits are undertaken.
- Ensuring that adequate resources are in place for hand hygiene. This includes liaison with the estates and operational services teams.
- Providing sufficient approved hand decontamination products including paper towels, liquid soap, alcohol sanitiser and skin moisturiser.
- Making hand hygiene facilities readily available for all to use.

- Undertake a risk assessment to optimise patient/ donor and staff safety, consulting expert infection prevention and control guidance if/ as required related to application of this policy.
- Support staff to correct any action or intervention that may have resulted in transmission of infection.
- Ensure any staff with hand health concerns, including any skin irritation related to occupational hand hygiene or those who have become ill due to occupational exposure are appropriately referred e.g. Occupational Health, health and safety manager in the first instance.
- Ensure posters featuring when and how to perform hand hygiene are displayed.
- Ensuring appropriate use of gloves.
- Health and Safety should be informed where the cause is considered to be work related since it may require reporting under RIDDOR.

4.4 Clinical staff

- Apply the principles of SICPs. All staff have a responsibility to ensure that they undertake adequate hand hygiene and encourage others who have patient contact to do so.
- Ensure all other staff/agencies apply the principles of SICPs.
- Explain to patients, donors and visitors any infection control requirements such as hand hygiene.
- Encourage patients, donors and visitors to question lack of hand hygiene by HCWs.
- Always practice the 5 moments of hand hygiene.
- Always remain bare below elbow within clinical areas.
- Always practice hand hygiene in line with required standards.
- Understand and apply the principles in this policy.
- Attend mandatory or update infection prevention and control education sessions.
- Highlight to colleagues any breaches in hand hygiene practices observed.
- Communicate the hand hygiene/ infection prevention and control practices to be carried out by colleagues, those being cared for, relatives and visitors, without breaching confidentiality.
- Do not provide care while at risk of transmitting infectious agents to others; if in doubt, they must consult their line manager, occupational health department, infection prevention and control team (IPCT) or health protection team.
- Encourage patients/donors/visitors to decontaminate their own hands appropriately.
- Provide patients with opportunities and supplies for hand hygiene in particular after using toilets, before and after eating or drinking.
- Report to their manager inadequate facilities, equipment or products and deficits in their own knowledge or training.
- Report any incidents of non-compliance with hand hygiene that may have resulted in cross contamination.
- Report any illness which may be as a result of occupational exposure, to the line manager and the occupational health department (if applicable).

- Not provide direct patient/ donor care while infectious as this could cause harm. If in any doubt consult with your manager, General Practitioner, occupational health department or IPCT.
- Consider the elements of SICPs such as hand hygiene as an objective within staff continuing professional development ensuring continuous updating of knowledge and skills. Be aware of, and participate in, hand hygiene campaigns.
- Staff must inform managers immediately if their hands become sore.

4.5 Infection Prevention and Control Team (IPCT) will:

- Ensure this policy remains up to date with national/ best practice standards.
- Ensure training is available for all groups of staff. Set the training and education standards for hand hygiene and ensure delivery of a robust train the trainer programme for hand hygiene.
- Act as a contact for guidance and support when advice relating to hand hygiene is required.
- Investigate incidents of non-compliance relating to hand hygiene.
- Undertake regular validation hand hygiene audits within the Trust and feedback audit results to managers within a timely manner.
- Compliance with the principle of bare below the elbow forms part of the IPC hand hygiene audit and will be included in the audit feedback.
- Provide support and advice to staff on maintaining good hand skin health (Appendix 3).
- Provide advice on individual risk assessments for performing hand hygiene and the site and provision of ABHR.
- Provide advice on the provision, type and site of hand wash sinks and facilities.
- Provide support to departmental hand hygiene champions so that they can audit staff adherence to hand hygiene and BBE.
- Periodic validation of hand hygiene compliance.
- Provide hand hygiene educational and audit information for patients, donors, staff and visitors.
- Provide support on the wards/ departments to monitor standards and compliance, identifying areas of concern and risk, and escalating concerns so that appropriate management action can be taken to maintain the highest standards via the divisional IP&C Groups or Trust Infection Prevention Control Management Group (IPCMG) as necessary.

4.6 Patient, Donor and Visitor, involvement

- Patients, donors and visitors should be seen as partners in good hand hygiene practice though they are not the responsible for HCAI reduction. Therefore:
- They must be offered the opportunity to decontaminate their hands as they require but especially on arrival at clinical areas and after toileting and before and after consumption of food or drink.
- Those with invasive devices insitu should be encouraged to clean their hands frequently and be advised not to touch these sites whilst the devices are in place.

- All staff must ensure relatives and visitors are encouraged to decontaminate their hands when entering and leaving a ward or department. This can be achieved by using the ABHR at the entrance to wards and departments.
- Visitors should be given the opportunity and be actively encouraged to decontaminate their hands, either by washing with soap and water or alcohol-based hand rub:
    - Before/upon and after entering into certain units or closed wards
    - Before and after visiting patients in isolation
    - Before and after participating in any form of patient care or contact
- Hand hygiene compliance data should be displayed for patients, visitors and donors to view in the clinical areas.

4.7 Distribution

The policy will be available via the Trust intranet site and from the IPCT. Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5. DEFINITIONS

Hand hygiene - aims to remove transient micro-organisms carried on the hands (acquired by direct contact with the environment and/or with other people) and/or reduce resident micro-organisms (living permanently on the hands as part of normal flora).

Bare Below Elbow - is Welsh Government national standard requirement to improve the effectiveness of hand hygiene performed by HCWs. The effectiveness of hand hygiene is improved when: skin is intact, nails are natural, short and unvarnished; hands and forearms are free of jewellery (with the exception of a plain wedding band) and sleeves are above the elbow.

6. IMPLEMENTATION/POLICY COMPLIANCE

6.1 Best Practice

Hand hygiene is considered the most important practice in reducing the transmission of infectious agents that cause HCAIs.

Hand washing sinks must only be used for hand hygiene and must not be used for the disposal of other liquids.

6.1.1 Before performing hand hygiene

- Expose forearms (BBE).
- Remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene.
- Bracelets or bangles such as the Kara which are worn for religious reasons should be able to be pushed higher up the arm and secured in place to enable effective hand hygiene which includes the wrists;
- Ensure fingernails are clean and short, and do not wear artificial nails or nail products.
- Cover all cuts or abrasions with a waterproof dressing.

6.1.2 When to perform hand hygiene

Hand hygiene is considered the single most important infection control activity in all clinical or care settings.

Hands should be decontaminated at a range of times in order to prevent HCAI. The most important times during care delivery and daily routines when this should occur are described in ‘5 moments for Hand Hygiene'.

Even if gloves have been worn, hand hygiene must be performed before and after donning & doffing gloves. Hands can still become contaminated whilst wearing or on removal of gloves, and so must be cleaned appropriately.

It should also be noted that hand hygiene will have to be performed between tasks on the same patient.

The point of care is the crucial moment for hand hygiene. The point of care represents the time and place at which there is highest likelihood of transmission of microorganisms from the hands of HCW’s to patients and donors.

Hands need to be decontaminated at 5 Moments of Hand Hygiene recommended by the World Health organisation. These moments include:

- Immediately before each episode of direct patient contact/care.
- Immediately before performing any aseptic procedures on patients.
- Immediately after contact with body fluids, mucous membranes and non-intact skin.
- Immediately after touching a patient and immediate surroundings, when leaving the patient’s side that may result in hands becoming contaminated.
- Immediately after touching any object or furniture in the patient’s immediate surroundings, when leaving – even if the patient has not been touched.

In addition to the critical moments there are situations/occasions where hand hygiene should be performed to reduce the risk to patients/ donors and HCWs. Examples of additional situations when hands must be decontaminated are:

- Before commencing work/after leaving a work area.
- Before preparing, handling or eating food.
- Before and after handling/administering medicines.
- After handling contaminated laundry and waste, including sluice room activities.
- After visiting the toilet.
- Before and after leaving isolation rooms/bays.
- After cleaning equipment or the environment.
- Personal contamination e.g. blowing your nose, sneezing/coughing into your hand.
- After removing personal protective equipment including gloves.

- Wash hands with liquid soap and water if:
    - Hands are visibly soiled or dirty.
    - Caring for patients with vomiting and/ or diarrhoea.
    - Where infection with a spore forming organism e.g. Clostridium difficile or with a gastroenteritis virus e.g. Norovirus is suspected/proven, hand hygiene must be carried out with liquid soap and water although it can be followed by ABHR. In all other circumstances, use ABHRs for routine hand hygiene during care. Where running water is unavailable, or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first opportunity.
    - For how to wash hands, see Appendix 1.
    - For how to hand rub, see Appendix 2.

6.1.3 Hand care

Hand care is important to protect the skin from drying and cracking. Cracked skin may harbour microorganisms and broken areas can become contaminated, particularly when exposed to blood and body fluids. The frequent use of some hand hygiene agents may cause damage to the skin and alter normal hand flora. Skin damage and dryness is generally associated with the detergent base of the preparation and/ or poor hand washing technique e.g. application of soap to dry hands, or inadequate rinsing of soap from the hands. The irritant and drying effects of liquid soap and antiseptic soap preparations have been identified as one of the reasons why HCWs fail to adhere to hand hygiene guidelines (epic 3, 2014) (Appendix 3).

Hand creams can be applied to care for the skin on hands. However, only individual tubes of hand cream for single person use or hand cream from wall mounted dispensers should be used. Communal tubs must be avoided as these may contain bacteria over time, and lead to contamination of hands. Creams used should not affect the action of hand hygiene products or the integrity of gloves.

Cover all cuts and abrasions with a waterproof dressing.

- Dry hands thoroughly after hand washing, using disposable paper towels.
- Use an emollient hand cream during work and when off duty.

Report any skin problems and/ or sensitivities to the hand decontamination products supplied to your Manager and Occupational Health in order that appropriate skin care can be undertaken and the risks of harbouring microorganisms while providing care for others can be avoided.

6.1.4 Surgical hand antisepsis

Surgical scrubbing/rubbing applies to those undertaking surgical and some invasive procedures. The most commonly used products contain Chlorhexidine gluconate or povidone-iodine. Products containing these agents act by lifting transient micro-organisms from the skin and destroying both transient and some resident micro-organisms. These should be used when a prolonged reduction in numbers of resident flora are required for invasive procedures (surgical aseptic non touch technique (aseptic non touch technique (ANTT®)) requiring maximal sterile barrier precautions, e.g. central line insertion, surgery etc.).

Perform surgical scrubbing/rubbing before donning sterile theatre garments or at other times, e.g. before inserting central vascular access devices.

Remove all hand and wrist jewellery.
Single-use nail brushes must only be used for decontaminating nails.

ABHR can be used between surgical procedures if licensed for this use.

Follow the technique in Appendix 5 for surgical scrubbing.

Follow the technique in Appendix 6 for surgical rubbing.

6.2 Hand hygiene facilities

In order to reduce the associated risks of Legionellosis and *Pseudomonas aeruginosa* contamination a hand wash sink/basin should only be used for that purpose (Appendix 6) ABHR will be supplied and used in accordance with the World Health Organization (WHO) and:

Will be available at the point of care and either free standing for use on trolleys or wall mounted sited at key points in all clinical environments.

Will be available at entrances to all clinical environments and in areas within the facility which have been risk assessed as safe from theft or misuse e.g. canteen entrance, key entry points of the building or department that are observed.

Wall mounted containers will be kept clean as per operational cleaning schedule with particular attention paid to the outlet nozzle to prevent build-up of product.

ABHR supplies must be stored in accordance with COSHH regulations.

6.3 Bare below the elbow (BBE)

All staff will adopt a “bare below the elbows” dress code whenever they are engaged in a direct patient/ donor care activity (Trust Dress Code & Uniform Policy, (WF 42).

All staff must be BBE whenever they are in a clinical area where they can reasonably expect to come into contact with patients or the immediate patient environment. This includes inpatient wards (particularly when undertaking ward

rounds), theatres, outpatient departments, and outreach and donor sessions**.** All staff should be prepared to approach their colleagues if they are not complying with BBE.

It has been shown that contamination of jewellery, particularly rings with stones and/or jewellery of intricate detail, can occur (Trick et al 2013, epic 3, 2014). Jewellery and wrist watches must be removed when working in clinical care settings to prevent the spread of microorganisms by contact with contaminated jewellery.

Staff providing care and those in the clinical setting must remove jewellery at the start of the working day.

It is acceptable to wear plain bands however these must be moved/ removed when hand hygiene is being performed in order to reach the bacteria which can harbour underneath them and dried effectively.

Ensure nails are kept short (nail polish or false nails must not be worn).It has been shown that nails, including chipped nail polish, artificial nails can harbour potentially harmful microorganisms. (epic 3, 2014, CDC, 2016). Caring for nails helps prevent the harbouring of microorganisms, which could then be transferred to those who are receiving care.

Work clothes should not go past the elbow. Coats should be removed, and long sleeves should be rolled up exposing the wrists and elbows.

The wrists should be included when washing the hands; forearms should be included if they have been contaminated.

Ensure cuts and abrasions are covered with a waterproof dressing.

The wearing of plaster casts or splints can affect hand washing therefore the staff member cannot decontaminate their hands effectively and should not be undertaking clinical duties. A risk assessment with the manager and occupational health is required for staff working in clinical areas.

6.4 Hand hygiene supplies

The availability of supplies for hand hygiene is essential.

Hand hygiene products (e.g. liquid soap, antiseptic hand wash solution and ABHR), should preferably be wall mounted in easy to use, and easy to clean, dispensers that contain single use, disposable cartridge sets, particularly in clinical or communal care areas. In some non-acute community care settings free standing bottles of liquid soap are acceptable.

Wall mounted moisturising cream should be available in all clinical areas.

Nozzles of solution bottles/containers should always be clean and free of any congealed product. Bottles should not be reused and the ‘topping up’ of bottles that contain solutions should not occur.

Soft, user friendly disposable paper towels for hand drying, dispensed from a wall mounted, easy to use clean holder.

Supplies of paper towels and other hand hygiene supplies should always be stored in a clean dry area prior to use.

Foot operated waste bins must be available at point of hand hygiene.

Estates and operation services staff are important partners in ensuring that hand hygiene facilities are adequate and that supplies are mounted appropriately.

Any issues with the hand hygiene supplies should be brought to the attention of operational services manager.

6.5 General Good Practice

Effective communication between all members of the health care team is imperative for patient safety.

Health and safety issues, related to staff, patients/donors and visitors should also be considered in relation to products used for hand hygiene, e.g. drips or spillages from ABHR and any risks of slips, falls or ingestion of products. Risk assessments should be carried out locally to highlight/manage relevant issues.

Control of Substances Hazardous to Health (COSHH) and product data sheets should be referred to in order to ensure safe use of/exposure to products being used for hand hygiene.

Hand hygiene is an important part of respiratory hygiene/cough etiquette. Advice which can be given on this is to:

- Cover nose and mouth with disposable single-use tissues when sneezing, coughing, wiping and blowing noses.
- Dispose of used tissues in the nearest waste bin.
- Wash hands after coughing, sneezing, using tissues, or after contact with respiratory secretions and objects contaminated with them.
- Keep hands away from the mucous membranes of the eyes and nose. Certain patient/donor (e.g. the elderly, children) may need assistance with containment of respiratory secretions; those who are immobile will need a receptacle (e.g. a plastic bag) readily at hand for the immediate disposal of used tissues and offered assistance with hand hygiene. If staff are required or requested to dispose of used tissues, gloves must be worn, and hands decontaminated following removal of gloves.
- Any areas of broken skin on HCWs hands areas must be covered with a waterproof dressing.
- Patients unable to wash their hands should be offered assistance to do so, especially after toileting and before eating. This can be aided by the use of hand wipes available within the clinical areas.

6.6 Maintaining quality

Velindre University NHS Trust actively supports the WHO 5 Moments (Appendix 7) and other initiatives to improve and maintain standards of hand hygiene. Promotional materials produced by the Trust must be visible in all clinical areas and clearly displayed. Staff should act as role models and be able to demonstrate on-going commitment to hand hygiene.

Observational audits of compliance utilising validated audit tools e.g. WHO 'Your 5 moments for hand hygiene' (Appendix 7) are carried out by departmental staff and Welsh Blood Service (WBS) teams overseen and trained by the IPC team. The IPC team process and feedback the observational audit results at both Velindre Cancer Centre & WBS on a monthly basis. Audits of hand hygiene facilities and BBE are undertaken by the IPCT and WBS team and are reported via the Infection Prevention and Control Management Group (IPCMG). Departmental audits are undertaken and fed back through divisional IPC meeting in both WBS and VCC, as are IPCT validation audit results, and then to IPCMG. Results for VCC are also uploaded onto the Trust Performance Dashboard.

As a quality indicator, poor compliance will be highlighted and an action plan for improvement agreed with the manager of the area.

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8. GETTING HELP

8.1 Further information and support:

Velindre IPCT: 02920196129.

9. RELATED POLICIES

This policy should be read in conjunction with:

- Trust Dress Code & Uniform Policy, (WF 42) https://nhswales365.sharepoint.com/sites/VEL_Intranet/_layouts/15/Doc.aspx?sourcedoc=%7B99479538-AE6F-4068-BA79-7764DCFF5D91%7D&file=WF%2042%20Dress%20Code%20and%20Uniform%20Policy.docx&action=default&mobileredirect=true&DefaultItemOpen=1

- National Infection Prevention and Control Manual. Available at https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/nipcm/

10. INFORMATION, INSTRUCTION AND TRAINING

10.1 Training

All staff working in clinical areas need to be trained in hand hygiene.

11. MAIN RELEVANT LEGISLATION

The Health and Social Care Act. (2008) 'Code of Practice for the NHS on the Prevention and Control of Health Care Associated Infections and Related Guidance'. 2015 update. Department of Health.

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Appendix 1 – How to Wash Your Hands

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

0

Wet hands with water;

1

Apply enough soap to cover all hand surfaces;

2

Rub hands palm to palm;

3

Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

Rinse hands with water;

9

Dry hands thoroughly with a single use towel;

10

Use towel to turn off faucet;

11

Your hands are now safe.

World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES
Clean **Your** Hands

May 2009

Appendix 2 – How to use Alcohol Handrub

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

Apply a palmful of the product in a cupped hand, covering all surfaces;

Rub hands palm to palm;

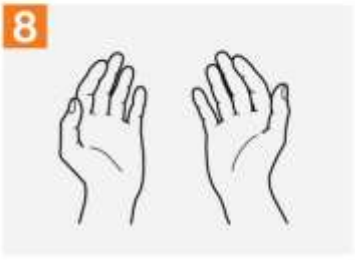
Right palm over left dorsum with interlaced fingers and vice versa;

Palm to palm with fingers interlaced;

Backs of fingers to opposing palms with fingers interlocked;

Rotational rubbing of left thumb clasped in right palm and vice versa;

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



Once dry, your hands are safe.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

May 2009

Appendix 3 - Hand Health and Skin Care

Care is required to protect the hands from the adverse effects of hand decontamination practice. The frequent use of some hand hygiene agents may cause damage to the skin and alter normal hand flora. Skin damage and dryness is generally associated with the detergent base of the preparation and/or poor hand washing technique e.g. application of soap to dry hands, or inadequate rinsing of soap from the hands. The irritant and drying effects of liquid soap and antiseptic soap preparations have been identified as one of the reasons why HCWs fail to adhere to hand hygiene guidelines (epic 3, 2014).

In order to achieve effective hand hygiene, it is important to look after the skin and fingernails. Sore hands are associated with increased colonisation by potentially pathogenic micro-organisms and increase risk of transmission. Damaged or dry skin leads to loss of a smooth skin surface and increases the risk of skin colonisation with resistant organisms such as Methicillin-resistant *Staphylococcus aureus* (MRSA). Continuing damage to the skin may result in cracking and weeping, exposing the HCW to increased infection risk, which can lead to sickness absence due to dermatitis.

Skin care, through the appropriate use of hand lotion or moisturisers added to hand hygiene preparations, is an important factor in maintaining skin integrity, encouraging adherence to hand decontamination practices and assuring the health and safety of HCWs. Only use the products available in the clinical areas, as these have been specifically designed not to interact with the soaps and ABHR.

To maintain skin health:

- It is essential that only approved soap products are used, and that staff carefully follow correct hand hygiene techniques.

- Drying (pat don’t rub etc.)

- Use ABHR containing an emollient.

- Staff with acute or chronic skin lesions/conditions/reactions or possible dermatitis **must** seek advice from the Occupational Health Department at the time that they have the problem.

- Cuts and abrasions must be covered with a water-impermeable dressing, prior to clinical contact.

- All clinical areas must ensure that adequate supplies of wall-mounted moisturiser are available for staff use. This is more cost-effective than sickness-absence due to damaged skin.

- Staff should regularly use moisturiser to maintain skin integrity. The most effective use of moisturiser is before breaks and at the end of a shift, when it can be left on the hands for a greater period of time.

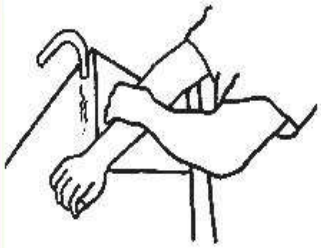
- Use gloves appropriately and change frequently.

Appendix 4 – Surgical Scrubbing

Step by step images for surgical hand preparation technique using antimicrobial soap

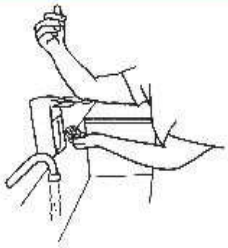
Undertake Appendix 1 prior to starting scrub.

1



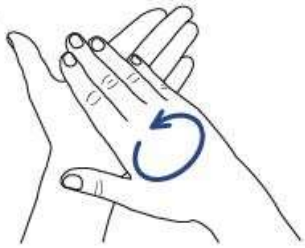
Wet hands and forearms*

2



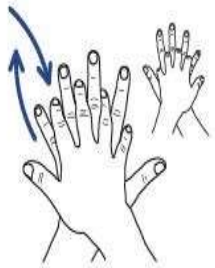
Put antimicrobial liquid soap onto the palm of each hand/arm using the elbow of your other arm to operate the dispenser

3



Rub hands palm to palm.
Steps 3 - 8 should take a minimum of 2 minutes

4

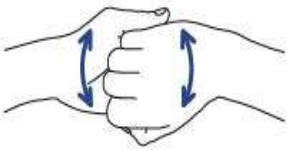


Right palm over the back of the other hand with interlaced fingers and vice versa.

5

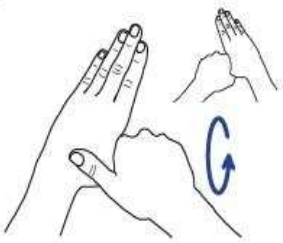
Palm to palm with fingers interlaced.

6



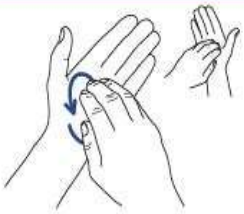
Backs of fingers to opposing palms with fingers interlocked.

7



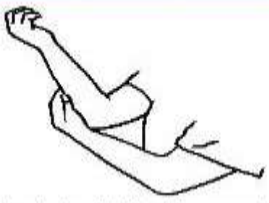
Rotational rubbing of left thumb clasped in right palm and vice versa.

8



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa.
Rinse hands between steps 8 - 9, passing them through the water in one direction only.

9



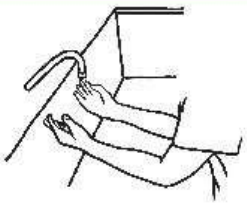
Put antimicrobial liquid soap onto the palm of your left hand using the elbow of your other arm to operate the dispenser. Use this to scrub the right arm for 1 minute using a rotational method keeping the hand higher than the arm at all times.

10

Repeat the process for the other hand and arm keeping hands above elbows at all times.

If the hand touches anything at any time, the scrub must be lengthened by 1 minute for the area that has been contaminated.

11



Rinse hands and arms by passing them through the water in one direction only, from fingertips to elbow. Do not move the arm back and forth through the water.

12

Hold hands above the elbow. Use one sterile, disposable towel per hand and arm. Blot the skin of the hand, then use a corkscrew movement to dry from the hand to the elbow.
The towel must not be returned to the hand once the arm has been dried and must be discarded immediately.

Appendix 5 – Surgical Rubbing

The hand rubbing technique for surgical hand preparation must be performed on clean, dry hands.

On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), hands must be washed with soap and water.

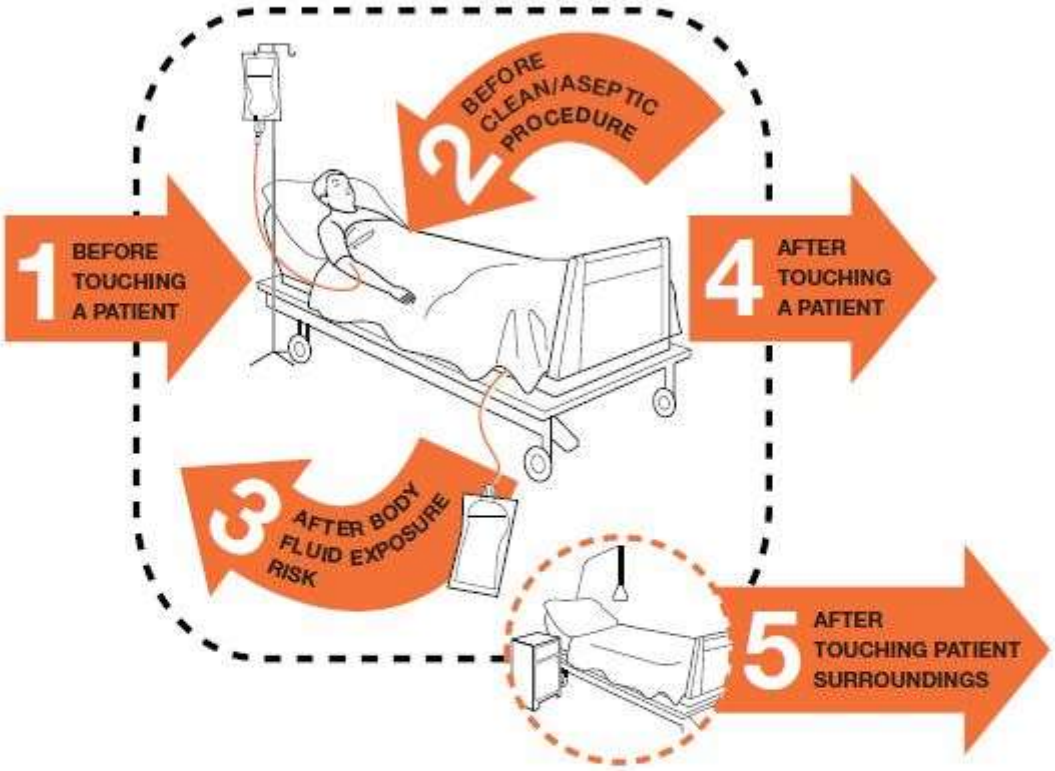
After the operation when removing gloves, hands must be rubbed with an alcohol-based formulation or washed with soap and water if any residual talc or biological fluids are present (e.g. the glove is punctured).

Surgical procedures may be carried out one after the other without the need for hand washing. provided that the hand rubbing technique or surgical hand preparation is followed (images 1-15).

Appendix 6 – Use of the Hand Wash Basin

- Hand washing sinks should not be fitted with plugs in order to avoid them filling with water, hand hygiene should be performed under running water.
- Mixer taps or thermostatic mixer valves are preferred to provide the correct temperature of water for performing hand hygiene.
- The tap must not directly expel/drain water straight down the plug hole. It should be sited appropriately to ensure water hits the sink basin as it flows out, otherwise aerosols from the drainage system can splash back onto the user.
- Do not dispose of body fluids or any other fluids in the clinical wash-hand basin – use the sluice in the dirty utility area.
- Do not use hand wash basins for storing used equipment awaiting decontamination or wash any patient equipment in hand wash basins.
- Taps can be wrist, elbow or automatically operated, Velindre Cancer Centre will replace automatic taps with wrist or elbow operated during clinical area development or refurbishment in accordance with its Water Safety Action Plan.
- Do not touch the spout outlet when washing hands.
- Hand wash sinks must not have an overflow.
- Use all hand wash stations regularly of flush in accordance with the Legionella management scheme.
- Ensure correct clean and dirty separation is maintained along with use of sink free zones for high risk procedure areas, for example, where intravenous drugs are being prepared.
- Hand wash sinks must conform to standards as uneven or damaged surfaces may harbour microorganisms.
- Hands free (i.e. pedal operated) waste receptacles should be close at hand.
- Designated hand hygiene sinks should be clearly labelled ‘hand hygiene only’.
- Advise patients that sinks should not be used for anything other than hand hygiene: i.e. not for cleaning teeth or drinking water and should not be used for storage of patients soap etc.

Your 5 Moments for Hand Hygiene



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

World Health Organization | Patient Safety
A World Alliance for Safer Health Care

SAVE LIVES
Clean **Your** Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

Ref: IPC 00

FRAMEWORK POLICY FOR INFECTION PREVENTION AND CONTROL

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Scientists
Document Author:	Senior Infection Prevention & Control Nurse
Approved by:	Quality, Safety & Performance Committee
Approval Date:	10 November 2022
Date of Equality Impact Assessment:	10 June 2022
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	September 2022
Next Review Date	November 2023
Version:	6

CONTENTS

ABBREVIATIONS

AMR	Antimicrobial Resistance
ANTT	Aseptic Non-touch Technique
HCAI	Healthcare Associated Infection
HCW's	Healthcare Workers
ICD	Infection Control Doctor
IPC	Infection prevention and control
IPCMG	Infection Prevention and Control Management Group
IPCT	Infection Prevention and Control Team
RCA	Root cause analysis
KPI	Key Performance Indicator
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1 POLICY STATEMENT

1.1 This policy outlines the overarching framework for the management and organisation of infection prevention and control (IPC).

Oncology patients are largely susceptible to infections. While all Healthcare Associated Infection (HCAI) are preventable, a consistent 'zero tolerance' approach to hospital acquired infection is required to adhere to a national strategy, best practice guidance and requirements of Healthcare standards for Wales.

HCAI refers to an infection that occurs as a result of contact with the healthcare system in its widest sense – from care provided in the home, to general practice, nursing home care, care in acute hospitals and interaction with supportive services. This broad description potentially could cover all patients who attend Velindre Cancer Centre and donors that attend a Welsh Blood Service donation clinic. A consistent approach and effective leadership within the organisation is required to prevent Trust acquired HCAI.

There are a wide range of effects of a HCAI which can range from short term discomfort to significant harm and can even lead to permanent disability or death. It can lead to an extended hospital stay, which not only can have consequences for the patient/family, but can disrupt the effective use of patient facilities. A HCAI can also be detrimental to the Trust, not only in terms of money but as a loss of reputation for the organisation.

The Infection Prevention and Control Team (IPCT) provides expert advice and support to all services of Velindre University NHS Trust, especially clinical and front facing services. It is important that the IPCT have clear lines of accountability for the effective management of the service to ensure integrated working practices across the Trust.

Please note:
COVID-19 may have an impact on Infection Prevention and Control (IPC) policy documents. Policies should be read in conjunction with the IPC organism specific policy, May 22.

IPC measures for Management of SarsCoV-2 in Healthcare Setting

2 SCOPE OF POLICY

2.1 This policy provides a framework and principles of best practice to ensure all Healthcare Workers (HCW's) are familiar with the structures in place for infection prevention and control management.

2.2 The responsibilities and programmes of work outlined aim to reduce risk and prevent HCAI and comply with National guidance and strategy.

2.3 This policy covers Welsh Blood Service, Velindre Cancer Centre and Corporate Services and applies to all staff and contactors working within these areas.

3 AIMS AND OBJECTIVES

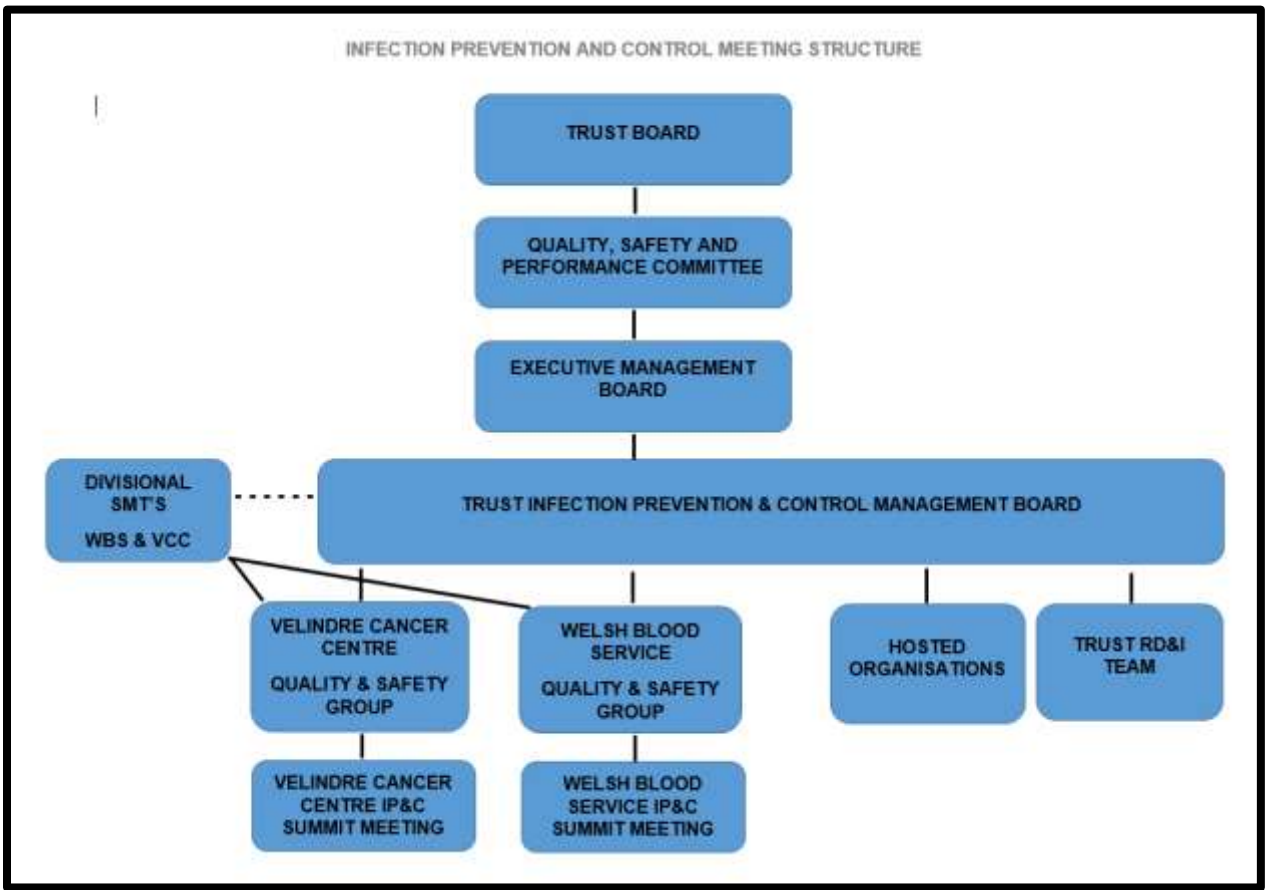
3.1 The policy objectives are to outline:

- Clear lines of accountability and responsibility in relation to Infection Prevention & Control
- Key processes and programme for infection prevention and control
- Reporting mechanisms for Infection Prevention & Control to the Trust Executive Management Board
- Key messages:
    - Infection Prevention and Control is **everybody's** responsibility
    - Departmental Leads/Managers are responsible for ensuring infection prevention and control training requirements, standards and practices are followed by all staff within their designated areas
    - Programmes for audit, training, surveillance and policy provision are managed as key strategies for infection prevention and control.

4 RESPONSIBILITIES

This framework has been developed to provide clarity throughout the Trust in relation to accountabilities and responsibilities for Infection Prevention and Control and related duties as part of the Trust governance and assurance processes. It focusses on accountabilities and responsibilities of both the Trust Infection Prevention & Control Team and those of local, Divisional and Senior Management Teams**.**

4.1 Infection Prevention & Control Reporting Mechanisms



MEETING	CORE IPC ACCOUNTABILITIES
Trust Board	To receive assurance and exceptions via the Quality, Safety & Performance Committee in relation to the Trust meeting its core IPC & decontamination accountabilities/responsibilities against national standards & legislative requirements. To ensure adequate resource and funding is directed to support the agenda for Trust wide IPC activities and performance.
Quality, Safety & Performance Committee	To receive clear evidence and timely advice from the Executive Management Board in order to be able to provide the Trust Board with accurate information to assist it in discharging its functions in meeting its responsibility with regard to IPC & Decontamination for quality and safety. This includes assurance against the Trust's stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales. To rapidly escalate any significant concerns and risks for patient harm or reputational risk for the organisation.

MEETING	CORE IPC ACCOUNTABILITIES
Executive Management Board	To receive highlight reports, performance reports and exceptions from divisions & the Infection Prevention & Control Management Group and agree any required Trust wide action / prioritisation. Receive any external Infection Prevention & Control / decontamination relation inspections / reviews. Monitor delivery of high level mitigation actions. Oversee any high level Infection Prevention & Control risks.
Trust Infection Prevention and Control Management Group	To have oversight of achievements, deficits and actions across all divisions for the Trust Infection Prevention & Control programme of work. Measure progress and performance so that Velindre University NHS Trust can provide evidence it is adequately executing its responsibilities in relation to the preventing and controlling infections & decontamination. Report and advise divisions of any new or emerging risks, policies or innovations and the associated actions required. Share learning so that all actions can be taken to prevent infection related avoidable harm to patients. Identify key risks to performance. Communicate and engage with independent member of the Board
Divisional Senior Management Team Meetings	Receive assurance that all Infection Prevention & Control / Decontamination standards are being adhered to across the Division. Receive and agreed definitive action to address any exceptions. Escalate any areas of high risk, patient / donor / staff risks or where division need support to progress.
Divisional Quality & Safety Groups	Receive the highlight / exception report – triangulate with additional Quality & Safety outcomes. Agree mitigation actions and identify areas good practice. Provide assurance / exceptions to the Senior Management Team Meeting.
Monthly Divisional Infection Prevention & Control Summit meetings	To monitor compliance with Trust and national Infection Prevention & Control policies, standards and the achievement of objectives against the Healthcare Associated Infection code of practice and national requirements for reduction expectations. To assess performance against the agreed work plan of each service/department within division in achieving its objectives and timescales. To support areas in meeting and maintaining the required standards. In particular: • Environmental standards • All relevant training & competency standards • Audit processes, outcomes & actions • Relevant Clinical practice standards (bundles) • Management of incidents or outbreak • Timely contribution to Root cause analysis (RCA) and Investigations of key Healthcare Associated Infections Provide assurance / escalation highlight report for Divisional Quality, Safety and Performance group & Trust Executive Management Board.

4.2 The accountability & responsibility of the Individual/team

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
Executive Director of Nursing, AHP, Health Scientists & Deputy Director of Nursing, Quality & Patient Experience	• To ensure the Trust has in place all the required governance arrangements, monitoring processes, policies, procedures, strategies, assurance systems and resources to effectively discharge its responsibility for IPC and decontamination. • Act as the Trust's named Executive lead for Decontamination in accordance with statutory requirements. • Represent the Board on HCAI at Welsh Government Meetings • Executive Lead for the Trust's multi-disciplinary Infection Prevention and Control programme • To assign a nominated deputy to act in their absence in accordance with Trust objectives • To represent the Board in national decision making via Nurse Directors/executive forum	• Operational delivery of Infection Prevention & Control / decontamination practices
Infection Prevention and Control Team	• Provide both a proactive and a reactive IPC service to the Trust operating Monday to Friday based on priorities • Develop and deliver a work programme for the team that addresses the Trust objectives and National agenda • Support divisions in the development of annual IPC work plans • Provide assurance to the Board on progress against the IPC work programme • Lead IPC through a coordinated multi-professional, evidence-based approach to the prevention and control of infection including HCAIs • Operational management of the Infection Prevention and Control Team • Provide specialist advice, support guidance in relation to all IPC systems & processes including water safety, decontamination, evidence based clinical practice, environmental cleanliness, ventilation,	• Owner of all identified healthcare associated associate infections • Responsible for individual staff performance in relation to flu vaccinations / hand hygiene/ PPE donning & doffing / IPC Level 2 training/ Fit Testing • Keeping staff training or flu vaccination records

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
	• Support the development of the Trusts' Vaccination programme • Development of Trust wide up to date IPC / decontamination related policy, procedure, guidance – supporting the implementation of national policy, best practice, requirements into practice • Trust wide oversight of urgent response and pandemic planning • Provide expert advice and leadership in the recognition and management of increased incidents/outbreaks across all areas of Velindre University NHS Trust in accordance with national and local guidance. • Provide expert advice in relation to IPC and emergency planning including planning for pandemics and new or re-emerging pathogens. • Monitoring and Trust oversight of Trust compliance of the IPC elements of National Decontamination Standards • Specialist advice and oversight into Trust environmental and clinical cleaning & decontamination standards • To develop and deliver relevant, robust IPC related training & development programme. To monitor compliance with IPC training requirements • Establishing robust 'service delivery level to board assurance monitoring & reporting arrangements • Develop and regularly review a robust Trust wide ward to board infection control & decontamination audit infrastructure • Oversee and support the co-ordination of internal & external IPC/Decontamination related inspections and reviews e.g. Healthcare Inspectorate Wales, Environmental Health Officer, NHS Wales Shared Services • Initiate and manage a comprehensive alert organism surveillance system for key pathogens	• Sole owner of FFP3 Fit testing records • Ensuring staff attend training • Operational delivery of IPC & decontamination standards • Management of non IPC clinical staff in relation to IPC practices

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
	including HCAI infection reduction expectations organism. • Provide comprehensive surveillance data reports and detailed analysis of that data for scrutiny to the Board. • Support departments and teams in the co-ordination and reporting of investigations into Velindre HCAI cases in accordance with the national and local requirements e.g. Serious Untoward Incidents, Putting Things Right. • Utilise Quality Improvements methodology in the systematic investigation of HCAI, IPC or decontamination incidents e.g. Route cause analysis • Provide expert advice and active involvement on all matters relating to infection prevention and control / decontamination for any new builds / refurbishment programme / introduction of new services. • Utilise existing incident reporting mechanisms e.g. Datix to document IPC related adverse incidents or near misses • Critically review Trust IPC Datix data to identify themes/trends/lessons learnt • Develop and lead on medical device decontamination work streams • Monitor and evaluate progress against performance measures / KPIs and report outcomes hierarchy structure for Trust Governance & assurance as stated above • Work collaboratively with the Infection Control Doctor (ICD) and Antimicrobial Pharmacist to promote antimicrobial stewardship • Organise and facilitate the Infection prevention & Control Management Group and required reporting / escalation / assurance to Trust • Oversee and monitor strategic and operational delivery of IPC / decontamination Health & Care Standards	

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
	• Oversee and review/revise all Trust IPC / decontamination related risks / risk register entries • Utilise quality improvement methods and risk assessment skills to support the identification of risk and risk and reducing actions • Work collaboratively and participate in national work streams and delivery groups.	
Infection Prevention & Control Doctor (Microbiology Consultant)	• Provide timely and expert advice to support the Trust in meeting its IPC/ decontamination responsibilities • Provide strategic leadership working as part of the Trust IPC Team to ensure operational delivery of required standards and translation of national policy into local context and delivery action • Actively engages in the development and production of Trust IPC policies/ procedures/ strategies /guidance through critical review and monitoring of effectiveness. • Provide specialist advice in supporting the strategic co-ordination of IPC activities within the IPC team and the divisions • Uses leadership and specialist knowledge of antimicrobials to support the Trust and the Antimicrobial Stewardship Meeting in setting the direction for antimicrobial prescribing goals, actions and standards • Provide guidance to clinical colleagues on appropriate antimicrobial prescribing by conducting regular antimicrobial ward rounds and via telephone consultation • To provide expert ICD advice on all aspects of HCAI & IPC including reactive responses to outbreak/incidents, emerging threats including pandemic Management • To work with the IPC team to critically evaluate and prioritise responses to local issues identified. • Interpret, translate and & contextualise national and local data to support decision making and prioritisation	• Delivery of the Infection Prevention & Control Programme

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
	• Provide local training for all disciplines of staff including medical staff • Provide expert advice in relation to Safe Water management Systems/ Ventilation & Decontamination • Support IPC team in implementing risk reduction and quality improvement measures. • Participate and give expert advice where necessary on HCAI investigations e.g. RCA	
Associate Medical Director Role for Infection Prevention & Control & Antimicrobial Prescribing / Sepsis	• To provide medical leadership at Velindre Cancer Centre in relation to IPC / decontamination and antimicrobial stewardship • Support the IPCT / Microbiology Consultant to drive the IPC / Antimicrobial Resistance (AMR)/ Sepsis agenda forward within the Trust • Role model for IPC campaign and initiatives e.g. World Health Organization 5 moments HH, vaccination programme etc. • Provide medical leadership at relevant IPC / antimicrobial Meetings e.g. Infection Prevention & Control Management group • Review IPC policies to ensure they can be operationally implemented / support develop of new / revised IPC / decontamination / antimicrobial related Policies / procedures / strategies & guidelines • Champion IPC – increase engagement with junior doctors to ensure support for RCAs for all HCAIs • Promotion and participation in national IPC events, such as HCAI/ AMR collaborative, Aseptic Non-touch Technique (ANTT) steering group as required and act as a role model and champion of Trust work • Share HCAI and IPC best practice with established networks e.g. medical directors forum, cancer network to highlight challenges • Ensure all required Infection Prevention & Control audits feature on the Trusts annual audit plan, oversee the outcomes and actions – ensuring completion of the cycle for improvement	• Lead the Infection Prevention & Control Agenda • Operational delivery of IPC

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
	• Senior leadership to the Trusts sepsis improvement programme • Champion & Drive IPC practices within VCC & support IPC Outbreaks meetings • Actively promote a 'zero tolerance' approach to HCAI	
Pharmacy	• Strategic direction, oversight and management of the Trusts antimicrobial improvement programme • Provides expert advice to support strategic initiatives related to antimicrobial guidelines and prescribing and provide assurance to the IPCMG and Medicines Management Group on antimicrobial prescribing metrics. • Support the ICD in discharging responsibilities for antimicrobial ward rounds/stewardship • Actively contribute antimicrobial knowledge to HCAI investigations e.g. RCA • Monitor progress against antimicrobial prescribing key performance indicators (KPI's) and champion antimicrobial prescribing across the Trust. • Collect Point Prevalence Survey data monthly and promote Start Smart the Focus & disseminate data to Public Health Wales. • Participate in national work streams to share best practice and knowledge gained to shape Trust policy • Ordering, delivery and co-ordination of influenza and COVID staff vaccinations	• Be responsible for inappropriate prescribing within the Trust
Divisional Directors / SMTs	• Responsible for Divisional delivery against all national & trust agreed IPC / Decontamination and antimicrobial standards – Monthly monitoring & reporting against all IPC / decontamination outcomes and process performance measures (including Senior Leadership Team oversight of infection rates, cleaning & decontamination standards, staff IPC related training, flu vaccinations, IPC audit compliance, fit testing etc.) – ensuring robust Data collection and validation mechanisms – service level-board reporting	• Lead the Infection Prevention & Control Agenda

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions

	• Ensure Division is meeting its IPC/Decontamination audit requirements and escalation of any areas on non / low compliance
	• Ensure all service developments / changes / redesign meets required IPC / decontamination standards
	• Having in place system & processes for identification & monitoring of IPC related risk and for taking appropriate action within Division for IPC risk reduction
	• Provide assurance to Trust Quality & Safety on Divisional progress against KPI's
	• Identify an Infection Prevention & Control SMT Lead & a champion from within each service area
	• Ensure Departmental engagement and ensure appropriate reporting on all aspects of Infection Prevention & Control
	• Ensure that every ward/clinical department has a designated infection control link nurse (or other registered practitioner).
	• Systems & processes for management of all outbreaks
	• Ensure all agreed IPC / decontamination actions are fully implemented
	• Ensure that RCA's of Healthcare associated infections are discussed at the relevant Governance meetings and the minutes of these forwarded to the DIPC's
	• Ensure that Infection control is a standing agenda item for Divisional meetings and, that as a minimum, the following are included:
	  ○ Review of infection prevention and control key performance indicators (KPI's)
	  ○ Outbreak reports/action plans
	  ○ Infection Prevention and Control audits where any element of the audit is less than 85%	

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions

Departmental / Ward / Team Managers	• Manage staff in line with HSE requirements – ensuring staff deliver in line with agreed IPC standards and work place is safe
	• Early identification of any patient / donor infection risk, seek advice and guidance as indicated & manage in line with standards / advice
	• Minimise risk of infection to both staff and patients / donors
	• Maintain robust staff IPC related records and manage any areas of non-compliance
	• Provide assurance, audits & monitoring in relation to key performance indicators;
	  ○ Fit Testing
	  ○ Hand hygiene compliance
	  ○ Hand Hygiene training compliance
	  ○ Staff influenza Vaccination uptake
	  ○ ANTT Training compliance (E-learning & competency assessments)
	  ○ Level 2 IPC Training compliance
	  ○ Environmental audits
	  ○ Decontamination audits
	• Ensure departmental representation to support staff influenza vaccination campaign, fit testing & hand hygiene training
	• Ensure departmental collaboration with IPCT on all RCA investigations
	• Ensure vaccination status of new starters is reported an held at local level	

Estates Department	Responsible for delivery of: • Leading the Trust and divisional water safety groups • Responsible person for the management of Water systems and water quality • Analysis of results and lead actions to correct water results that are out of acceptable parameters in collaboration with the IPC team • Compliance with national guidance for safe water management systems • Compliance assurance of in-house services & contractors	• Individually responsible for poor water management

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
	• Induction of contactors on IPC, including: dust management and water safety • Assessing and reporting compliance against Health Technical Memorandum –in relation to Safe Water Management, Ventilation & Building/ refurbishment etc., (Regularly liaise with infection prevention & control team to ensure safe processes) • Maintaining good building / estate repair though programme of repair/refurbishment and reactively through IPC environmental audit results. • Timely escalation of any issues or concerns arising on sites that would create a patient / donor or staff IPC risk • Consult IPC on planned or emergency work • Engage and consult IPCT for any new build or refurb at early stage in accordance with Infection Control in the Built environment • Ensure estates staff are compliant with IPC training and adhere to policy when working in clinical areas/dept.	
Operational Services Department	Responsible for delivery of: • Delivering the required level of cleaning to the require standards using the products relevant to the situation at the time • High standards of food safety for all aspects of in-house catering facilities • Compliance assurance & audit of in-house services and contractors. • Innovation and new technologies • Reactive services and proactive responses to managing environmental cleanliness e.g. during incident/outbreaks where there are infected cases on wards • Provides reports on standards of cleanliness and waste management. • Development and review of non-clinical polices such as Laundry, Waste Management and Cleaning.	

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
	• Management of all staff in line with HSE requirements, ensuring staff received relevant training and monitoring of compliance as per training needs analysis for the role	
All staff	All employees are responsible for: • Complying with Trust Infection Prevention and Control policies, procedures & guidelines and escalating any situation that prevents this occurring. • Maintaining their legal duty to take reasonable care of their health, safety and security and that of other persons who may be affected by their actions and for reporting untoward incidents and areas of concern. • Keep up to date with all IPC training requirements according to role • Identifying infectious conditions and circumstances that may lead to transmission of / outbreaks of infection that require specific controls to protect themselves, their patients or others, informing the IPCT of any such circumstances. • Ensuring safe working practices are implemented as outlined in Infection Prevention and Control policies.	

4.3 Governance and Quality Assurance

The key forum for management and governance for the infection control service within the Trust is the Infection Prevention, Control and Management Group (IPCMG). The IPCMG receive the highlight reports from the VCC and WBS monthly IPC summit meetings. Each department should have a designated lead for IPC who is reports and is answerable to the divisional IPC lead. Please see ***appendix 1*** for the IPCMG Terms of reference

The IPCT has primary responsibility for advising on aspects of audit and surveillance pertaining to the prevention and control of infection at Trust level. The IPCT produces an Annual Report and an Annual Programme which are ratified by the Trust IPCMG and received by the Trust via the Quality and Governance Committees.

4.4 Distribution

The policy will be available via the Trust intranet site, Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5 IMPLEMENTATION / POLICY COMPLIANCE

5.1 Infection Prevention and Control Programme

The main aim of the Infection Prevention & Control programme is to plan, manage, co-ordinate and deliver a proactive infection prevention service for the Trust while being reactive to incidents and outbreaks as they arise. The main components of an effective programme include:

- Providing infection prevention and control of infection advice to all divisions and departments of the Trust
- Incorporating divisional infection control needs within the Trust infection control programme
- Providing education and training on the prevention and control of HCAI to all levels of HCW's
- Providing bespoke education on the management of infections as they arise
- Undertaking surveillance of infections, facilitating and validating data received
- Producing, implementing, and auditing compliance with infection prevention policies
- Liaising, communicating and advising with staff on matters relating to infection prevention and control during working hours, with advice available on a 24-hour basis from Public Health Wales microbiology service
- Developing infection prevention and control policies for the Trust in accordance with Legislation, National guidance, strategy, Quality frameworks and evidence based medicine
- Advising Divisions and hosted organisations on guidelines and procedures with relation to infection control.
- Implementing Welsh Government directives with regard to surveillance and strategic direction
- Implementing and developing the Health Care Associated Infection Strategy for Wales

5.1.1 Education

Education of all Trust staff is undertaken either by using nationally agreed e-learning programmes, delivered by members of the Infection Prevention & Control Team or using materials developed or advised by the Infection Prevention & Control Team. Where possible blended learning, including classroom teaching, e-

learning and opportunistic workplace methods will be utilised. The level of training is determined by a Training Needs Analysis of the role being undertaken. As a minimum ***all healthcare workers, regardless of their role undertake Infection Prevention and Control Level 1 training within 4 weeks of starting employment.***

- ***Level 1 training*** focuses on precautions and procedures undertaken by those providing direct patient / service user care or working within a clinical environment.
- ***Level 2 training*** is update training undertaken every 2 years to ensure clinical healthcare workers are kept up to date with current research, guidelines, policies and projects.
- ***Level 3 training –*** Massive Open Online Course (MOOC) which is targeted at registered practitioners and senior staff in supervisory roles who are responsible for ensuring compliance with good IP&C practices e.g., ward and Departmental clinical managers.

5.1.2 Training availability

- Both Level 1 and 2 training are available as e-learning if classroom session not available
- Junior and locum doctor induction is provided per intake
- The ICD updates consultant colleagues at Consultant meetings while the Antimicrobial Pharmacist will input into the doctor training programme.
- Additional targeted training will be provided as required for specific groups including porters, domestics, volunteers etc. and as required to respond to a new infection prevention problem or to meet a particular need.

5.1.3 Surveillance

Surveillance is a key component of the infection control programme. The aim of surveillance is to collect continuous timely data on organisms and patient information to identify infection rates and trends. It assists the early detection of outbreaks or increased incidence of infection, informs changes in clinical practice and assists the targeting of preventative methods. Types of surveillance undertaken include:

- Daily surveillance - Identification, monitoring, advising on and recording of ‘alert’ organisms as provided by the laboratory reports received daily.
- Routine surveillance – collection, analysis, dissemination and feedback of data on condition/infections among patients and staff, to allow the appropriate action to be taken.

- Targeted and enhanced surveillance - undertaken following risk assessment, which may identify high-risk areas of practice, to enable the monitoring of procedures and processes to identify potential problems and areas for improvement.
- Mandatory Surveillance - as identified by the Welsh Government and managed by HARP.
- National projects – voluntary participation in 'all Wales' surveillance 'projects of targeted areas/organisms.

Surveillance data may be used within a framework of performance management in an attempt to assess the effectiveness of the Infection prevention and Control standards being deployed.

5.2 Audit and monitoring

The Infection Prevention & Control Team's annual programme framework has been updated and there is now one audit programme covering both division.

Both nationally recognised and locally developed tools (to address targeted areas) are used to audit policy, standards and guidelines for the environment and clinical practices. Results are reported to the departmental and local managers and summarised in the quarterly team report and annual reports submitted to Divisional Senior Leadership Teams, Trust Executive Management Board and Quality, Safety & Performance Committee.

6 GETTING HELP

Further information and support

IPCT: 02920 196129 or bleep 205.

Microbiology at UHW on 02920 744825

7 RELATED POLICIES

The national related Infection Prevention & Control policies can be found here:

http://howis.wales.nhs.uk/sitesplus/972/page/51445

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

INFECTION PREVENTION & CONTROL MANAGEMENT GROUP

Terms of Reference & Operating Arrangements

Version:
Date Reviewed
Review Date:
Agreed by: Infection Prevention & Control Group
Approved by: Executive Management Board Date to be inserted
Approved by Quality, Safety & Performance Committee Date to be inserted

1. INTRODUCTION

1.1 These Terms of Reference and Operating Arrangements are based on and compliant with the Health and Care Standard 2.4 for Infection Prevention & Control & Decontamination providing strategic leadership and direction on infection prevention and control activities across the Trust to ensure the risks posed by transmission of avoidable infections is minimised.

2. PURPOSE

The Infection Prevention and Control Management Group (IPCMG) is integral to the achievement of the Trust's infection, prevention and control objectives. The purpose of the Group is to ensure that Velindre University NHS Trust is adequately executing its responsibilities in relation to the preventing and controlling infections and therefore taking all actions to prevent infection related avoidable harm to patients. This includes:

2.1 Ensure systems for assessing, reducing, reporting and monitoring infection risks across the Divisions / Trust are robust.

2.2 Ensure robust governance structures for monitoring decontamination services within Divisions / the Trust, including arrangements for decontamination of reusable medical devices.

2.3 Agree Trust wide Infection Prevention and Control (IP&C), decontamination and infection / antimicrobial surveillance, audit programmes and assurance and monitor compliance in respect of these.

2.4 Oversee the development and regular review of all Trust IP&C, decontamination, antimicrobial & surveillance policies, guidelines and procedures. This will include receiving and endorsing adoption of relevant national IP&C related policies, procedures and guidelines.

2.5 Ensure there is a robust implementation plan in place corporately and across Divisions for all local & national IP&C policies, procedures and guidelines and monitor through audit the implementation across the Trust.

2.6 Receive all IP&C, Decontamination, antimicrobial related external / internal audits / reports / peer reviews and be responsible for ensuring the development of robust improvement actions and overseeing through to completion all such action plans. Reporting any exceptions through to Executive Management Board / Trust Quality, Safety &

Performance Committee.

2.7 Ensure appropriate Outbreak Management mechanisms in place and ensuring national outbreak standards are met, robust reporting in place and oversee completion of all post outbreak recommendations / actions to completion.

2.8 Endorse and monitor all IP&C, decontamination & antimicrobial related risks as logged on Trust / Divisional Risk Registers, ensuring that all such risks are being appropriately managed / escalated.

2.9 Oversee the regular review and oversight of Health and Care Standard Infection Prevention and Control (IP&C) and Decontamination. Including endorsing annual self-assessment, agreeing actions and overseeing completion of related action plan.

2.10 Develop and monitor robust Trust wide and Divisional IP&C assurance framework with KPIs that are monitored and reviewed at least annually.

2.11 Ensure there is a robust IP&C training programme in place that meets national and local standards and requirements, oversee compliance with this.

2.12 Review progress against the annual Staff Influenza Vaccination Campaign / COVID vaccine programme.

2.13 Ensure appropriate processes and procedures in place to respond to pandemics such as influenza / COVID.

2.14 Receive outcomes of all RCA investigations from all healthcare associate infections ensuring appropriate remedial actions have been taken

2.15 Oversee processes for the identification and dissemination of good practice / lessons learnt both from internal events and external to the Trust.

2.16 Oversee compliance with all PPE standards across the Trust

2.17 Agree the IP&C Annual Work Programme

2.18 Oversee compliance with Water quality standards including compliance with national guidance and the Trust's Legionella Policy

2.19 Oversee adherence to national cleanliness standards

2.20 Oversee compliance with all Decontamination standards

2.21 Oversee and ensure appropriate action taken from all IP&C HCAI Surveillance Data and monitor compliance against all nationally agreed Infection reduction / improvement goals

2.22 Oversee Divisional compliance with all IPC, Decontamination, water safety and antimicrobial standards ensuring that appropriate divisional action is being taken to mitigate risks.

2.23 Oversee the implementation of a robust antimicrobial resistance action plan

3. DELEGATED POWERS AND AUTHORITY

3.1 The Infection Prevention & Control Management group formally reports into the Trusts Executive Management Board, following which to the Trusts Quality, Safety & Performance Committee. A highlight report will be provided following each meeting that will be supplemented by any papers identified as being required at the meeting. All such reports will be approved by the meeting chair prior to submission.

4. MEMBERSHIP

4.1 The core membership of the Committee, is set out below:

Chair: Executive Director of Nursing, AHPs and Health Science

Vice Chair: Deputy Director of Nursing, Quality & Patient Experience

Co-Option: Additional members maybe co-opted onto a meeting as relevant to the agenda with prior agreement of the Chair / Vice Chair.

Secretariat: Administrator for Infection Prevention & Control Team

Membership

All members are expected to attend each meeting. In the event of being unable to attend it is the member's responsibility to arrange for a deputy to attend who has full authority to act and make decisions on behalf of the member.

Table 1

TITLE	ROLE & RESPONSIBILITES	REPORTING REQUIREMENTS
Executive Director of Nursing, AHPs & Health Scientists	Chair of Meeting. Leadership and strategic focus in meeting compliance. Overall Executive responsibility for infection prevention & control. Provide assurance / escalation to Trust Board members.	National information / requirements Feedback from Quality & Safety / Board Proposed strategy / direction

Deputy Director of Nursing, Quality & Patient Experience	Vice Chair of Meeting. Leadership and strategic focus in meeting compliance. Provides report to Quality & Safety Group Board.	As above
Senior Nurse for Infection Prevention and Control	Organisation, oversight and management of meeting Identify any areas of concern re non-compliance with Code of Practice/ Health & Care Standards 2.4 / work plan and inform members of risks/ hot spots. Drafting all post meeting reports Quality checking all divisional reports / documents Develop and ensure delivery against IPCMG work plan	Provision of IPCT reports, to include KPIs/ surveillance, audit and training activity, staff influenza campaign& preparedness, incidents and complaints, policy/ procedure review, risk register and produce annual report.
Infection Prevention and Control Nurses/ Respiratory Trainer	To present on specific elements of the IPCT report, including surveillance of infectious conditions and incidents, issues arising on the management of incidents and outbreaks, audit, DoH guidance, policy/procedure review and link champion training activity.	Datix Report-Incidents & Outbreaks Influenza Report Service Improvement
Consultant Microbiologist	Expert resource from Public Health Wales and to provide infection control advice to the group and inform on national and local initiatives in driving policy and management of infectious conditions.	Reports to be provided on an adhoc basis e.g. Updates on: Antimicrobial Prescribing Alerts/ outbreaks across Wales
Principal Pharmacist	Expert advice to support strategic initiatives e.g. Anti-microbial guidelines.	Antimicrobial compliance report at each meeting

(Decontamination)		
Consultant Nurse (HARP Team)	Expert advice to support strategic national initiatives.	As required
Assistant Medical Director, IPC	To provide medical leadership in respect of IPC/antimicrobial stewardship agenda.	As required.
Trust Health and Safety Manager	To act as an advisory from a Health & Safety perspective across the Trust in relation to infection prevention and control.	To provide bi-annual reports on Health & Safety Issues relating to Infection Prevention & Control.
Workforce Development Manager	Support development of IPC associated training & workforce requirements in accordance with national standards	

5. IPCMG MEETINGS

5.1 **Quorum**

The Chair / Vice Chair, Microbiologist, Anti-microbial Pharmacist, Infection Prevention & Control Nurse and a senior decision maker from each Division must be represented in order for a meeting to proceed.

5.2 **Frequency of meetings**

Meetings shall be held at least quarterly and otherwise as the IPCMG Chair deems necessary.

5.3 **Papers**

- Draft meeting notes and action log MUST be circulated to all members within 10 days of a meeting taking place.
- No verbal or tabled reports will be accepted. If an event occurs that requires reporting to the IPCMG after papers have been circulated a late paper is to be submitted after agreement with the meeting chair.
- All papers are to be provided to the meeting Secretariat at least 10 days prior to the meeting.
- The agenda and papers will be circulated at least 7 days in advance of the meeting.
- All papers should be submitted to the Senior Nurse for Infection Prevention and Control and Secretariat. The agenda will be approved by the Chair prior to issue.

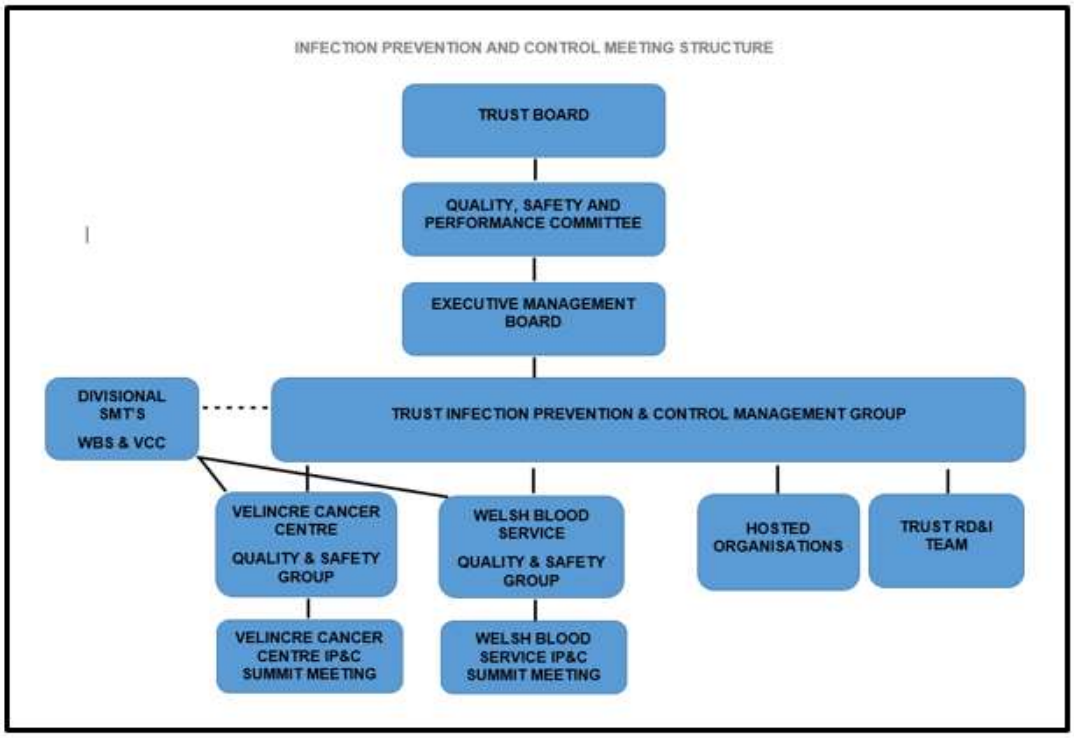
6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 The IPCMG reports to the Trust's Executive Management Board and in turn to the Trusts Quality, Safety & Performance Committee by means of a highlight report after each meeting. Additional reports /papers will be provided as appendices as determined by the Group.

6.2 The IPCMG shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 There will be formal reporting mechanisms to and from Divisions into IPCMG. This will be achieved via the Divisional representative. A formal Divisional assurance paper will be provided to the IPCMG for each meeting. The reporting organogram is detailed below:



8. REVIEW

8.1 These terms of reference and operating arrangements shall be reviewed in 12 months.

QS 25

Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals

Date to be reviewed:	October 2023	**No of pages:**	12
Author job title(s):	Clinical Educator Welsh Blood Service (WBS) and Velindre Cancer Centre (VCC) Advanced Health Professional (AHP) Preceptorship Lead		
Responsible dept / director:	Executive Director of Nursing, AHP and Health Scientists		
Approved by:	Quality, Safety and Performance Committee		
Date approved:	10 November 2022		
Version:	4		

Date EQIA completed:	22 September 2015
Documents and website information to be read alongside this policy:	Personal Appraisal Development Review (PADR) policy Preceptorship Framework for Newly Registered Nurses (Update awaited), Midwives and Allied Health Professionals (Department of Health (DH) 2010) All Wales Core Principles for Preceptorship Nursing and
Current review changes: This policy has been reviewed as required by date but will be re reviewed when new Framework published.	

Executive Summary:
The policy is for Newly Registered Practitioners in Nursing and Allied Health Professionals (AHPs), Managers, Preceptors and educationalists employed by Velindre University NHS Trust. The policy is intended to support the transition from Pre-registration student to autonomous practitioner**.**

First operational:	July 2008				
Previously reviewed:	Aug 2011	Feb 2016			
Changes made yes/no:					

Contents

1. Introduction

The transition from pre-registration student to autonomous practitioner can be a stressful and challenging experience for many newly registered nurses, midwives and allied health professionals. Although new registrants (preceptees) are competent and knowledgeable, at the point of registration, they require support and guidance from experienced professionals to assist them to integrate into their new roles and new teams. The Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals (Department of Health (DOH) 2010) articulates the benefits of preceptorship programmes stating,

> *"Newly registered practitioners who manage the transition successfully are able to provide effective care more quickly, feel better about their role and are more likely to remain in the profession"*
>
> *(DOH, 2010:4)*

Preceptorship enables a period of structured transition that provides the foundations for professional development and prepares preceptees to be safe, confident and competent practitioners.

2. Policy Statement

Velindre University NHS Trust is committed to supporting preceptorship of new registrants so that their transition from undergraduate student to registered professional is a positive experience that enables them to provide high quality safe and effective care for service users.

This policy is mapped to the following standards:

- Fundamentals of Care (Welsh Government (WG) 2003 standards 1,2,3,5
- Health & Care Standards 2015 (2, 3, 4, 6)
- Health and Care Professions Council (2016) Standards of Conduct, Performance and Ethics
- Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals (DH 2010)
- The Core Principles of preceptorship (WG 2014)
- NMC (2016) The Code: Professional Standards of practice and behaviour for nurses and midwives

3. Definitions/Glossary of Terms

Definitions, in the context of this policy, in relation to preceptorship are outlined below:

3.1 Preceptorship

Preceptorship focuses on supporting the development and growth of newly registered staff with a formal agreement amongst individuals to engage in a time limited relationship, typically 6 months to 1 year. This time is an orientation period whereby newly registered staff are familiarised with policies, procedures, clinical skills and consolidate competencies. Preceptorship is defined as follows:

"A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning"
(DH, 2010: 11)

Preceptorship does not exclude the preceptee accessing other support, which may include clinical supervision, mentoring, coaching.

3.2 Preceptor

A registered practitioner with the responsibility of supporting a newly registered practitioner (preceptee) through preceptorship. There are currently no formal qualifications required to undertake the preceptor role, but the preceptor would normally be expected to have gained competence and experience within the same area of practice of the preceptee they are supporting and have undertaken formal assessed mentorship training or a preceptor preparation workshop.

3.3 Preceptee

A newly registered nurse or allied health professional who is entering employment in Velindre University NHS Trust for the first time following professional registration with the Nursing and Midwifery Council, Health Care Professionals Council or other appropriate professional bodies.

4. Scope

This policy applies to preceptees working as registered nurses or AHP's and their preceptors. It is also applicable to other individuals such as managers and supervisors who support the preceptorship process.

5. Aims and Objectives

This policy will provide clarity for preceptees, preceptors and line managers within Velindre University NHS Trust regarding preceptorship. This policy will:

- Identify robust processes for preceptorship for newly registered nurses and AHP's working in Velindre Cancer Centre or the Welsh Blood Service

- Ensure a consistent and equitable approach for the provision of preceptorship programmes

- Support preceptees to develop skills, knowledge, competence behaviours and experience that will enhance their personal development and support high quality patient/client/service user care

6. Benefits of Preceptorship

The benefits of preceptorship programmes contribute not only to preceptors and preceptees but enhance the overall patient/client/service user experience (DH 2010). The model of preceptorship is tripartite between preceptee, preceptor and manager. This model will be supported by other individuals e.g. education leads, practice educators, clinical supervisors.

The benefits of preceptorship include the following:

6.1 For the Preceptee

- Develops confidence, skills and abilities through provision of support
- Ensures professional socialisation into the working environment
- Increase job satisfaction leading to improved patient/client/service user satisfaction
- Feels valued and respected by the organisation
- Develops understanding of the commitment to working within the profession and regulatory body requirements
- Facilitates personal responsibility for maintaining up to date knowledge
- Enhances skills, and a caring and compassionate philosophy

6.2 For the Preceptor

- Professional development
- Job enrichment
- Supports lifelong learning
- May enhance future career aspirations
- Will promote respect for dignity, equality and diversity through the development of core values and behaviours

6.3 For the Organisation

- Enhanced quality of patient/donor/service user experience
- Enhanced recruitment and retention and positive organisational reputation

- Reduced sickness and absence
- Enhanced staff satisfaction
- Reduced risks of complaints
- Opportunity to recognise succession planning to meet the leadership agenda
- Identify staff that require further/additional support
- Will promote respect for dignity, equality and diversity through the development of core values and behaviours
- Improved standards of care and governance

7. Roles and Responsibilities

The preceptorship process is based on mutual relationships between individuals as outlined below.

7.1 Programme Facilitator/s

Programme facilitator/s within nursing and AHPs in their respective service areas, will:

- Plan and manage programmes and where applicable liaise with a range of individuals with various areas of expertise that may provide updates throughout the programme. Learning opportunities may range from blended learning, taught sessions/study days, reflective activities
- Ensure that any learning opportunities are current and reflect the needs of newly recruited registrants and the organisation
- Evaluate the preceptorship programme and notify key stakeholders e.g. service leads/team leaders/speakers/professional leads of key findings
- Record and maintain data bases and registers of attendance by preceptees
- Ensure that line managers and preceptors are notified of any nonattendance by preceptees
- Maintain an up-to-date list of preceptors

7.2 Preceptees

From the moment of registration practitioners are autonomous and accountable for their acts and omissions, as regulated by the NMC and HCPC**.** During preceptorship preceptees will be building their confidence and further developing competence to practice. Therefore, engagement with and completion of programmes are instrumental in supporting their development.

Consequently, it is an expectation that preceptees will:

- Commence a preceptorship programme on recruitment to Velindre Cancer Centre or the Welsh Blood Service and reviewed on an individual basis
- Take responsibility for individual learning and development and commit to learning by completing preceptorship programmes within 6 months to 1 year.
- Notify Preceptor and Line Manager / Professional Lead if any difficulties are experienced in accessing or completing any part of the programme
- Use this time to develop their portfolio towards NMC revalidation (nursing only)
- Engage in various learning activities, such as e-learning, reflection and working with others
- Engage fully in the preceptorship programme and respond appropriately to constructive feedback
- Maintain responsibility for documentation of preceptorship processes and learning resources e.g. assessment workbooks
- Liaise with the named preceptor to complete any learning resources e.g. competency record documents and present this as evidence to their reviewer during the Personal Appraisal Development Review (PADR) process
- Apply and develop the knowledge and skills already learned and develop competences that relate to the role

7.3 Preceptors

A named preceptor will support each registrant throughout the programme. If they are not available, for example due to sickness, then another preceptor will be appointed. This will be arranged locally between registrant and line managers. Preceptors have a responsibility to support new registrants with their transition from student to registered practitioner and the role of the preceptor is clearly stated in the Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals (DH 2010) and the All Wales Core Principles for Preceptorship (WG 2014).

Preceptors will:

- Support the preceptee with their professional development
- Share individual knowledge and experience with the preceptee
- Maintain responsibility for documentation of preceptorship processes and learning resources e.g. assessment workbooks
- Recognise and respect cultural and individual diversity

- Discuss individual practice with the preceptee and provide regular and constructive feedback

- Have insight, compassion and empathy with the preceptee

- Facilitate the development of the preceptee through reflective learning

- Act as an exemplary role model

- Facilitate protected time to undertake preceptorship activities such as meetings between preceptor and preceptee

- Ensure sufficient supernumerary status in order to undertake a meaningful induction into the organisation

- Allow the preceptee to work alongside them whilst completing their preceptorship competencies where possible

7.4 Line Managers

Managers within their respective service areas will:

- Ensure, in conjunction with programme facilitator/s, that all preceptees are allocated a preceptor and ensure all relevant parties are informed

- Ensure that preceptors are suitably selected, ensuring they meet their required attributes
- Liaise with programme facilitator/s to ensure that preceptors and preceptees have appropriate documentation and are aware of their roles and responsibilities

- Ensure that preceptors and preceptees are given adequate protected time to achieve preceptorship requirements.

- Support preceptors and preceptees as appropriate

8. Standards for Preceptorship

The standards for preceptorship will ensure that the benefits that have been identified can be most effectively delivered for all newly registered nurses and allied health professionals, regardless of their work environment or the design of preceptorship arrangements. The following standards are viewed as core principles or preceptorship (DH 2010) and will be implemented, managed and evaluated within Velindre Cancer Centre and The Welsh Blood Service.

Standards for Preceptorship
Systems are in place to identify staff requiring preceptorship
Systems are in place to monitor and track preceptees from their appointment through to completion of the preceptorship period e.g. a competency framework or protocol
Preceptors are identified from the workforce within relevant clinical area
Organisations have sufficient numbers of preceptors in place to support the number of preceptees employed
Organisations demonstrate that preceptors are appropriately prepared and supported to undertake the role and that the effectiveness of the preceptor is monitored through appraisal
Organisations ensure that their preceptorship arrangements meet and satisfy professional regulatory body
Organisations ensure that preceptees understand the concept of preceptorship and fully engage
An evaluation framework is in place
Organisations ensure that evidence produced during preceptorship is available for submission for verification by the NMC/HCPC if selected for audit

8.1 Structured Preceptorship

Structure preceptorship within Velindre cancer centre and the Welsh Blood Service will be documented in the preceptorship protocol or competency framework.

8.2 Preceptorship Protocol

Preceptorship programme will be managed and facilitated in partnership with Educational Leads for Departments and the Trust Education and Development Departments Velindre University NHS Trust.

Programmes will be mapped to Standards for Health Services in Wales.

Preceptorship programme will include underpinning knowledge and assessment of competencies. A blended learning approach will underpin the preceptorship programme to maximise effective use of preceptors' and preceptees' time to enhance development of skills and knowledge. Teaching and learning activities can take place in classroom environments and work areas. Methods may include:

- Formal classroom sessions/study days
- 1:1 tutorials/support from peers
- Group discussions
- Reflections
- Work based learning
- Action learning sets
- Self-directed learning
- Shadowing
- Portfolio development

The period of preceptorship will typically last for 6-12 months and during this time the preceptor and preceptee will meet at least bi-monthly to plan, assess and map competencies.

Throughout the preceptorship period preceptees will remain accountable for their own practice within the context and limitations of their knowledge as set out in their professional codes of practice and escalate any concerns regarding competency and abilities.

8.3 Learning Records

Preceptorship learning records will be held by the preceptee and a record of completion and will be held by the relevant training department.

8.4 Evaluations

Clinical Educators/facilitators will be responsible for evaluating programmes. The content of programmes will be updated and amended, as required and based on evaluation and feedback. Evaluations will be shared with staff who contribute to teaching and learning activities e.g. speakers at study days/sessions.

8.5 Certification

Certificates of completion will be awarded to preceptees by Clinical Educators and will provide evidence at PADR.

8.6 Preceptor Preparation

A preceptor development session will be offered to all identified preceptors. The expectation is that a practice assessor or for AHPs a senior practitioner with team leading responsibilities would usually be a mentor/sign-off mentor and would draw on their generic skills in this capacity. In clinical areas where there are no trained mentors, preceptors will be required to attend preceptor preparation training. However, there are critical additional aspects about being a preceptor for new registrants which distinguish this role as different to mentorship of pre-registration student

- Giving constructive feedback
- Setting goals and assessing competency
- Facilitating problem solving
- Active listening skills

- Understanding, demonstrating and evidencing reflective- practice ability in the working environment
- Prioritising care
- Demonstrating appropriate clinical decision making and evidence-based practice
- Recognising their own limitations and those of others
- Knowing what resources are available and how to refer a newly registered practitioner appropriately if additional support is required, for example, pastoral support or occupational health services
- Being an effective and inspirational role model and demonstrating professional values, attitudes and behaviours
- Demonstrating a clear understanding of the regulatory impact of the care that they deliver and the ability to pass on this knowledge
- Providing a high standard of practice at all times

8.7 Personal Appraisal Development Review (PADR)

In some circumstances the preceptor may not necessarily be the preceptee's reviewer. However, it is extremely important that the preceptor, reviewer and preceptee's manager maintain effective communication in order for the PADR to be a valuable experience for the preceptee. Regular communication between all parties means that the PADR process would hold 'no surprises'.

9. Equality

All preceptorship programmes will be inclusive with the integration of a range of teaching and learning methods to cater for individual preceptee's needs e.g. disabilities, dyslexia. The Trust realises that some staff may require additional support due to specific needs, as such the Trust will aim to meet reasonable adjustments and take account of protected characteristics under the Equality Act.

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. Staff members who are pregnant or on maternity will be signposted to the Trust policy to support them.

10. Monitoring and Effectiveness

This policy will be reviewed using the following indicators:

- Percentage of new registrants successfully completing the preceptorship process annually
- Preceptee evaluation forms
- Feedback from facilitators at taught study days
- Feedback from preceptors and line managers

The results of the monitoring will inform an annual review of preceptorship which will be undertaken by the relevant education lead for each professional group.

11. Further Information

For further information on this policy contact:

Clinical Educators
Welsh Blood Service and Velindre Cancer Centre.
Velindre University NHS Trust

12. Review

The Education leads will review the operation of the policy as necessary and at least every 3 years, However, in the first instance 12 months as new Framework publication is expected.

13. References

DH (2010), Preceptorship Framework for newly registered nurses, midwives and allied health professionals.

Health Care Professionals Council (HCPC) (2016), Standards of conduct, performance and ethics.

NMC (2015), The code: Professional Standards of practice and behaviour for nurses and midwives.

Velindre University NHS Trust (2016) PADR policy

Welsh Government (2014), NHS Wales Core Principles for Preceptorship

Welsh Government (2015) Health and Care Standards.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

REF: PP 04

ASBESTOS MANAGEMENT POLICY

Executive Sponsor & Function:	Director of Strategic Transformation, Planning and Digital
Document Author:	Assistant Director of Estates, Environment & Capital Development
Approved by:	Quality, Safety and Performance Committee
Approval Date:	10 November 2022
Date of Equality Impact Assessment:	13 April 2022
Equality Impact Assessment	Approved
Review Date:	November 2025
Version:	2

Contents

ASBESTOS MANAGEMENT POLICY

1. POLICY STATEMENT

1.1 It is the Policy of Velindre University NHS Trust referred to as the "Trust" to do all that is reasonably practicable to protect employees, visitors, contractors and others from health hazards arising from the presence of asbestos-containing materials at all the sites within their property portfolio. This policy is specifically for Trust properties including leased areas. This Policy is a legal requirement and its requirements will be achieved by the implementation of an Asbestos Management Plan to ensure full compliance with all statutory requirements of current relevant legislation, codes of practice and guidance notes.

2. PURPOSE

2.1 To ensure that the Trust and its hosted bodies comply with their Statutory duties under the Health and Safety at Work Act 1974 (as amended) and Control of Asbestos Regulations 2012

3. SCOPE

3.1 This policy applies to all properties owned and maintained by the Trust, including properties leased, rented or occupied under lease or any other occupancy agreement.

The policy covers the maintenance of all ACM (Asbestos Contained Materials) within The Trust, to ensure a safe environment for both patients, staff and the public.

4. AIMS AND OBJECTIVES

4.1 The Trust is committed to:

- Identify, as far as is reasonably practicable, the locations of all asbestos-containing materials which present a potential risk of exposure to asbestos dust or debris
- Arrange for risk assessments to be conducted of the identified materials which represent a potential risk and review these assessments at least annually or as dictated by the risk assessment or when changes occur
- Establish and operate an action plan for managing and controlling risks from asbestos, including emergencies
- Ensure all contractors working on Trust properties are made aware of the presence and locations of asbestos-containing materials
- Monitor compliance with the action plan
- Review risks and the performance of the risk control measures, revising risk assessments and the action plan

as appropriate
- Conduct annual audits of compliance
- Provide copies of all asbestos survey data, including registers and make these available to Consultants, Contactors and Trust staff planning or undertaking work and obtaining acknowledgment of this information being read and understood
- Maintain records and carry out regular reviews / audits
- Employ only competent, adequately asbestos awareness trained personnel and licensed asbestos contractors.
- Appoint responsible persons and provide adequate training for The Trust's Managers and employees.
- Communicate any asbestos issues / requirements with internal staff & contractors where exposure to the areas is an issue.

4.2 The management of Trust properties regards the provision and maintenance of the above as a mutual objective for management and employees at all levels within the organisation

5. ROLES AND RESPONSIBILITIES

5.1 The Trust has a management responsibility to ensure inspection, service and maintenance activities are carried out safely without hazard to staff, patients or members of the public.

5.2 The Duty Holder

- Oversee asbestos management provision across all properties and assets, including sufficient resources.
- Oversee the implementation of all procedures and safe systems of work regarding asbestos throughout all properties and assets in liaison with the Health & Safety Departments.
- Receive training on Asbestos Containing Materials (ACMs).
- Ensure all relevant parties are informed of the asbestos management system and their responsibilities.
- Ensure periodic re-inspection surveys are undertaken at least annually.
- Ensure that all work carried out on asbestos containing materials complies with current regulations and best practice.
- Review agreed roles and nominate as appropriate.
- Ensure adequate instruction and training is provided to enable persons to fulfil their responsibilities with regards to asbestos management

5.3 Nominated Asbestos Manager (NAM) / Deputy NAM

- Oversee asbestos management provision across The Trust.
- Inform all relevant parties of the asbestos management plan and their responsibilities.
- Oversee the implementation of all procedures and safe systems of work regarding asbestos throughout the Trust in liaison with the Health & Safety Department.
- Review agreed roles and nominate as appropriate.
- Receive training on ACMs.
- Ensure re-inspection surveys are undertaken at least annually using the approved Consultant.
- Ensure the Asbestos register is updated following any asbestos works.
- Ensure all work carried out on asbestos containing materials complies with current regulations and best practice.
- Oversee the coordination of air monitoring of the enclosure and surrounding area during asbestos works.
- Ensure an assessment of the hazards and risks from asbestos containing materials is undertaken and recommended appropriate control measures defined.
- Keep staff and managers informed about asbestos hazards and control measures that are relevant to their work, department and staff. Implement appropriate procedures to ensure appropriate management of asbestos remedial works and/or further survey etc. where day to day maintenance activities are affected by the presence of asbestos i.e. task-driven remedial works.
- Identify persons requiring specific information and instruction in asbestos work and coordinate appropriate training.
- Ensure adequate instruction and training is provided to enable persons to fulfil their responsibilities with regards to asbestos management.
- Ensure all records are maintained in accordance with the regulatory requirements and codes of practice for asbestos work.
- Act as the main point of contact for all questions and queries relating to asbestos.

5.4 Nominated Asbestos Co-ordinator (NAC)

- Oversee asbestos management provision across respective properties.
- Inform all relevant parties of the asbestos management system and their responsibilities.
- Oversee the implementation of all procedures and safe systems of work regarding asbestos throughout the Trust in liaison with the Health & Safety Department for

respective properties.

- Receive training on ACMs.
- Ensure re-inspection surveys are undertaken at least annually for respective properties using the approved Consultant.
- Ensure that following any asbestos works all information is returned to the NAM so that the Asbestos register can be updated.
- Ascertain that all work carried out on asbestos containing materials complies with current regulations and best practice.
- Oversee the coordination of air monitoring of the enclosure and surrounding area during asbestos works.
- Ensure an assessment of the hazards and risks from asbestos containing materials is undertaken and recommended appropriate control measures defined.
- Keep staff and managers informed about asbestos hazards and control measures that are relevant to their work, department and staff.
- Implement appropriate procedures to ensure appropriate management of asbestos remedial works and/or further survey etc. where day to day maintenance activities is affected by the presence of asbestos i.e. task-driven remedial works.
- Identify persons requiring specific information and instruction in asbestos work and coordinate appropriate training.
- Ensure adequate instruction and training is provided to enable persons to fulfil their responsibilities with regards to asbestos management.
- Ensure all records are maintained in accordance with the regulatory requirements and codes of practice for asbestos work and information is copied to the NAM.

5.5 Employees

- Report any defects to suspect materials which are damaged or disturbed. Also any suspect ACM’s (in any condition) and any defects or concerns they may have related to asbestos issues or remedial works to their superior.
- Make full and proper use of any control measures provided.
- Attend asbestos awareness training when so requested;
- Keep work areas clean and immediately report any damage that occurs to suspect materials.
- Ensure that Protective equipment including RPE is used when entering potentially contaminated areas and only when agreed and supported by the Asbestos Manager or Deputy.

5.6 Licensed Contractors

- Carry out all works in full accordance with all current relevant legislation and Approved Codes of Practice.
- Provide statutory notifications to the relevant enforcing authority
- Provide detailed method statements and risk assessments
- Dispose of any waste in accordance with the Hazardous Waste Regulations 2005 and provide consignment documentation /waste carrier's license.
- Ensure all staff are fully trained and have the appropriate medical record
- Provide adequate insurance cover
- Signed Permits to work

5.7 Non-licensed Contractors

- Provide adequate insurance cover for working with ACM's
- Provide detailed method statements and risk assessments
- Only Competent persons to undertake the works (evidence of adequate training).
- All operatives have been face fitted and issued with RPE (evidence to be made available)
- Signed Permit to Work
- Dispose of any waste in accordance with the Hazardous Waste Regulations 2005 and provide consignment documentation/waste carrier's license.

6. TRAINING

6.1 Asbestos Awareness

This is a course or e-learning covering the properties of Asbestos, its effects on health, the types, use and likely occurrence of asbestos and ACMs in buildings and plant, the general procedures to be followed and how to avoid the risks of asbestos. This is a requirement under Regulation 10 of The Control of Asbestos Regulations (CAR 2012) and should be provided to all those with the potential to disturb asbestos during their routine activities. *This course should be completed by the Duty Holder, NAM, Deputy NAM, NAC and all other employees liable to disturb ACM in their daily working activities.*

6.2 Asbestos Management

This is a course which helps those who commission works to understand their roles and responsibilities, the procedures and their legal responsibilities. *This course should be completed by the Duty Holder, NAM, Deputy NAM and NAC.*

6.3 Asbestos Awareness Refresher

This is an annual refresher of the Awareness course (detailed above) that is required under Regulation 10 of CAR 2012. This is not a repeat of the original but a Refresher looking in detail at updates and specific areas where gaps have been identified over the previous year. *This course should be completed by the Duty Holder, NAM, Deputy NAM and NAC.*

6.4 BOHS P405 Managing Asbestos in Buildings

This course is to provide a practical knowledge and the skills to be able to manage asbestos in buildings and to provide a basic knowledge of asbestos removal procedures. *This course should be completed by the NAM, Deputy NAM and NAC.*

7. EQUALITY

7.1 A summary of the outcome of the EIA must be present on the front cover of the document:

Either
This policy has been screened for relevance to equality. No potential negative impact has been identified.

Or
This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

8. IMPLEMENTATION

8.1 The Trust expects those tasked with managing asbestos to:

- Diligently discharge their responsibilities as benefits their position.
- Have in place a clearly defined management structure for the removal, control and monitoring of asbestos.
- Have in place a programme for the assessment and review of asbestos on site
- Develop and implement appropriate protocols, procedures, action plans and control measures to mitigate asbestos risks, comply with relevant legislation and, where practicable, codes of practice and guidance.
- Develop and disseminate appropriate action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and

environment.

9. POLICY CONFORMANCE / NON-COMPLIANCE

9.1 If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trust's Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

10. LEGISLATION

10.1 Relevant legislation includes:

- Incident Reporting and Investigation Policy (PP01)
- Risk Assessment Policy (PP06)
- Health, Safety and Welfare Policy (PP18)
- Waste Management Policy (PP20)
- Fire Safety Policy (PP23)
- Control of Substances Hazardous to Health Policy (PP33)
- Risk Management Policy (PP35)
- Asbestos Policy (PP04)
- Control of Contractors Policy (PP05)
- Infection Prevention and Control Policy (IPC00)
- Standards for Health Services in Wales – Environment (Standard 12)
- WHTM 07-01 - Safe Management of Healthcare Waste (2013)
- Environment (Wales) Act 2016
- Planning (Wales) Act 2015
- Wellbeing of Future Generations (Wales) Act 2015
- Environmental Protection Act 1990
- The Waste (England and Wales) Regulations 2011
- The Environmental Permitting (England and Wales) (Amendment) Regulations 2018
- The Hazardous Waste (England and Wales) Regulations 2005
- The Controlled Waste (England and Wales) Regulations 2012
- Welsh Government Towards Zero Waste Strategy
- The Air Quality Standards Regulations 2010
- Modern Slavery Act 2015
- Welsh Government Ethical Employment in Supply Chains Code of Practice 2016
- A Green Future: Our 25 Year Plan to Improve the Environment (HM Government) 2018

Ref: PP05

Control of Contractors Policy

Executive Sponsor & Function:	Director of Strategic Transformation, Planning and Digital
Document Author:	Trust Health and Safety Manager
Approved by:	Quality, Safety and Performance Committee
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Version:	4

Contents

Introduction

1. Policy Statement

The Velindre University NHS Trust Board recognises its health and safety responsibilities both as an employer and as a service provider. Velindre University NHS Trust (the 'Trust') is committed to creating, as far as reasonably practicable, a safe environment for contractors to provide their services whilst not putting at risk patients, donors, staff, visitors, Trust property and equipment, and the contractor's own employees.

2. Purpose

To ensure that Contractors undertaking services on Trust premises do so in a safe and controlled manner.

3. Scope

The Control of Contractors Policy covers all areas where services are provided by an external contractor. A contractor is defined as;

"*A contractor is anyone you ask to do work for you who is not an employee" as defined in HSE Managing Contractors HSG159.*

This excludes temporary or agency staff.

The policy applies to work undertaken by contractors at Velindre University NHS Trust, Divisions or Hosted Organisations". Contractors may be engaged by Estates, IT, Operational Services, Departments etc.

Responsible Manager is defined a manager who has arranged the work, engaged the contractor and is responsible for the control of contractor arrangements for the work carried out. All work carried out by contractors must have an identified Responsible Manager.

Additional procedures apply to contractors who are procured in accordance with the Construction (Design and Management) Regulations 2015 (CDM 2015) for schemes notifiable to the Health and Safety Executive. Non-notifiable construction schemes will need to address the requirements within the Construction (Design and Management) Regulations 2015 (CDM 2015) and this policy.

4. Aims and Objectives

The aims and objectives of this policy are to establish the steps to be taken by Velindre University NHS Trust to assess the competence and resources of contractors and to manage the health, safety and environmental element of their service provision to the Trust.

This policy is overarching, all Divisions and Hosted Organisations will implement procedures to support this policy. The policy sets minimum requirements for the control of contractors.

To fulfil the Board's legal duty of care to all its employees, patients, donors and others to provide a safe working environment.

5. Roles and Responsibilities

5.1 Executive Lead

The Chief Executive has overall responsibility and is accountable to the Trust Board for the management of Contractors within the organisation.

5.2 Director of Planning, Performance, Estates and Capital

The Director of Planning, Performance, Estates and Capital is responsible as part of their Board responsibility for health and safety for ensuring that management systems are in place for the implementation, communication, monitoring of this policy.

5.3 Deputy Director of Planning, Performance, Estates and Capital

The Deputy Director of Planning, Performance, Estates and Capital is responsible for the operational implementation, communication, monitoring and review of this Policy.

5.4 Directors of Divisions and Hosted Organisations

Directors of Divisions and Hosted Organisations are responsible for ensuring that the policy is implemented, communicated and monitored within their Division/Hosted Organisation and suitable procedures are in place to enable its implementation, communication and monitoring.

5.5 Heads of Department

Heads of Department are responsible for ensuring that this policy and local procedures for control of contractors are followed and that a Responsible Manager is appointed for all work undertaken by contractors. Heads of Department must also ensure liaison with key stockholders e.g. with Estates, Operational Services to ensure communication and coordination of any work undertaken.

5.6 Responsible Managers

Responsible Managers are responsible for the operational management of contractors and for following the requirements of this policy and local procedures.

The Responsible Manager must plan any necessary communications about the work and any liaison with key stakeholders e.g. Estates or Operational Services.

5.7 The Estates Department

The Estates Department is responsible for managing Asbestos on Trust premises and for the provision of the Permits to Work specified in this policy. The Estates Department may in some instances have a role with regard to coordination of work of contractors on site and for providing additional information and support.

5.8 All Staff

All staff must adhere to this policy and any associated Divisional/Hosted Organisation operational procedures. Staff must report any incidences of concern in relation to contractors working on Trust premises and must not to put themselves or others at risk whilst carrying out their duties

6 Management of Contractors

The following areas must be addressed by all Divisional control of contractors procedures;

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6.1 Selection of Contractors

The Employing Division/Hosted Organisation must satisfy itself that it holds suitable and sufficient information regarding the competency and health and safety performance of any contractor it may employ.

Contractors invited to work at the Trust must be made fully aware of the standards of health and safety to which the Trust operates and expects. Only competent contractors are to be employed on Trust premises. Competency is defined as;

- with relevant related professional qualifications, and or relevant related accreditation;
- sufficient experience of the tasks to be undertaken and awareness of the risks involved;
- experience to carry out duties in relation to the work, to recognise limitations and take appropriate action to prevent harm to those carrying out the work and affected by the work;
- in possession of relevant insurance cover for the works being completed.

An assessment of competence should be carried out prior to a contractor being appointed and should be documented using (Form *)

Works must not be sub-contracted without prior written agreement from the Responsible Manager. Sub-contractors will need to comply with the same criteria as above for "*Selection of Contractors".*

6.2 **Information for Contractors**

Contractors must be briefed on the works required and the risks associated with works on Trust premises. Information should be provided such as, but not limited to;

- detailed description of what work is required
- location of the works to be completed (precise location), along with a description of the functionality of the space and adjacencies to it
- standards/legislative compliance that the works will be expected to be completed to (if applicable)
- available working hours i.e. during normal working day 9:00 until 17:00 or to reflect the working arrangements at the site.
- here work is undertaken on the fabric of the building which may disturb asbestos information about asbestos contained in the Asbestos Register together with a copy of the Trust Asbestos Management Plan. (if applicable). Any work on the fabric of the building which may disturb asbestos must be referred to the Estates department for authorisation prior to work commencing.
- presence of radiation in building (if applicable)
- any other information that will enable the contractor to understand the risks associated with undertaking works on Trust premises

6.3 **Permits to Work**

Advice must be sought from the Estates Team at least 10 days before any of the following work commences, as Permit to Works will be required.

- confined space (work undertaken by external contractors)
- electrical work on fixed installations where physical isolations are required
- excavation
- work on mains gas supplies
- hot work
- work on roofs, erection/striking of scaffolding
- Work on the fabric of the building which may disturb asbestos.

Other work on-site may require additional Permits to Work from other Departments, this must be identified and documented in the local control of contractors procedures.

6.4 **Actions prior to commencement of Service/Works**

Prior to any work commencing on site the contractor must provide a suitable and sufficient risk assessment and method statement/work instruction at least 10 days before planned work commences. The risk assessment and method statement should be checked for suitability by the responsible manager prior to work starting and a record kept using Form *.

The Responsible Manager must plan any necessary communications about the work and any liaison with key stakeholders e.g. Estates or Operational Services.

Contractors must not deviate from the agreed risk assessment and method statement without prior agreement from the Responsible Manager and the risk assessment and method statement being amended accordingly.

Contractors are responsible for ensuring that all their employees working on site are aware of the contents of the risk assessment and method statements.

All risk assessments and method statements/work instructions must be signed by, dated and agreed by, contractor's staff carrying out the works.

The method statements should address any specific Personal Emergency Evacuation Plans (PEEP's) and specific requirement needs for the contractor's workforce.

Contractors must provide evidence of relevant licensing and qualifications for their staff that will be working on site. They must also provide evidence of compliance with legal requirements for equipment used on-site for e.g. calibration records, LOLER certification.

If the service/work provision is subcontracted to a third party/supplier, the Responsible Manager should ensure that the persons actually conducting the work have either;

- Produced their own relevant risk assessment and method statement which must be submitted to the Trust at least 10 days before work commences for checking.
  Or
- Formally agreed to, signed and dated, the previously submitted risk assessment and method statements and comply with as their method for completing the works/services

6.5 **Arrival on-site and Induction**

All contractors must sign in when arriving at site and must be provided with contact details for a Trust site contact for the duration of their works.

All contractors employees must receive a Trust Health, Safety and Environment induction appropriate to the site operations. The frequency of inductions must be risk assessed in accordance with site operations, but the minimum refresher induction should be every year. If a contractor has not been to site for three months they must receive a repeat induction. Inductions must repeated more frequently if there is a significant change or addition to the information provided.

The contractor is responsible for ensuring that if additional staff start work on-site during the works, they also receive an induction. Relevant qualification and training details must be provided for any additional staff. They must also be made aware of and sign the risk assessments and method statements.

A signed and dated record of inductions is to be kept for future auditing purposes.

6.6 Monitoring and Review of Contractors

During the period of work, the Responsible Manager or their nominated deputy shall monitor the performance and controls exercised by the contractor. The frequency of these checks should be in proportion to the associated risks, and as a guide should be conducted at least once per day for low-risk activities, e.g. grass cutting/gardening, or basic building maintenance/decorating. Where works are of higher risk, e.g. hot works, confined spaces, working at height etc. the frequency should be increased, but as a minimum must be at least once per day. A record must be kept of all monitoring undertaken (see Form *).

Suggested activities and compliance to monitor should include but not be limited to:

- all required PPE being worn
- work being conducted in line with agreed methods
- compliance with site/location safety rules and safe working conditions
- safety devices/barriers/screens etc in place
- relevant Permits to Work in place, being adhered to and understood
- all the work party signed in and received induction
- any impact on others or the surrounding area
- housekeeping under control and acceptable
- anything changed since the last monitoring visit e.g. has the job content changed, have the hazards or environmental impacts changed

If any significant non-compliance issues are identified, the works must be stopped and made safe and the contractor brought in to discuss the future service/works delivery.

Once the works have been completed, or annually for long term routine contractor works, a review should be conducted, considering as a minimum:

- compliance with safety rules and safe working conditions
- compliance with statutory regulations for all equipment/plant used.
- compliance with agreed method statement(s) including Permit to Work systems.
- compliance with the scope of work, quality of workmanship, materials and finished work.
- overall safety and environmental performance and responses to rectify non-compliances.

- records on the above shall be recorded and forwarded to the Divisional representative responsible for contractors who will use this information as part of the contract review/ tender list process.

7 Arrangements for planned work undertaken out of usual working hours or in response to an emergency.

Arrangements for planned work that is undertaken outside normal working hours must ensure that the requirements of this policy and of Divisional/Hosted Organisations Control of Contractors procedures are followed. Arrangements must be in place for the supervision and monitoring of the work carried out.

The risk assessments for the work must reflect the work undertaken and must identify and mitigate any additional risks caused by the work being carried out outside usual working hours. Consideration should also be given to the contractors' familiarity with the site

Key Stakeholders must be identified and informed that the contractors are on site.

The Responsible Manager remains responsible for the work and must ensure that the contractors have the appropriate contact details and that suitable arrangements are in place to supervise and monitor the contractor and to manage emergency situations.

If an unplanned event results in the need for a contractor to carry out work on an emergency basis, the Estates or other (depending on local arrangements) on-call manager must be contacted in first instance. It is the responsibility of the on-call manager to determine the action to be taken and to escalate any issues/actions as appropriate. Where there is an approved list of contractors specifically for out of hours and emergency work, this should be consulted.

The Estates or other (depending on local arrangements) on-call manager may ask an Estates Technician or other (depending on local arrangements) to attend site to assess the problem and provide information for the on-call Manager. Local lone working procedures must be in place for technicians attending site out of hours. The on-call manager must decide if the technician should stay on-site to supervise the contractors. If additional support is required the on-call manager should attend site or make additional arrangements. The contractors attending site must have contact details of who they should contact if they require additional support.

Where possible unplanned work on the fabric on the building should be avoided. However, if it is unavoidable the on-call manager must ensure that for sites where asbestos is present, the Asbestos Register is interrogated and that documented information including the Asbestos Management Plan is shared with the contractor undertaking the work. Local procedures should be in place to facilitate this.

8 Equality

8.1 The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its Employees reflects their individual needs and does not discriminate against individuals or groups.

8.2 The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

8.3 The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation

9 Training

9.1. Managers will be provided with information and training on this Policy.

10 Implementation

10.1 This Policy will be maintained by the Planning, Performance, Estates and Capital Department

10.2 Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

11 Audit and Monitoring

11.1 The Planning, Performance and Estates Department will review the operation of the policy as necessary and at least every 3 years.

12 Policy Conformance / Non Compliance

12.1 If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trust's Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

13 Distribution

13.1 The policy will be available via the Trust Intranet Site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

14 Review

14.1 The Assistant Director of Estates, Environment and Capital Development will review the operation of the policy as necessary and at least every 3 years.

15 Documentation

15.1 Related Documentation

1. Pre Tender information
2. Pre-appointment assessment of Contractor competence
3. Assessment of Risk Assessments and Method Statements
4. Contractors Induction
5. Pre start checks document
6. Contractors monitoring records
7. Contractor review
8. Authorisation to work document

16 Further Information

16.1 Further information and support is available from the Assistant Director of Estates, Environment and Capital Development

17 References

17.1 HSE Managing Contractors HSG159

Ref: PP 09

WATER SAFETY POLICY
The Management and Control of Water Quality

Executive Sponsor & Function:	Director of Strategic Transformation, Planning and Digital
Document Author:	Assistant Director of Estates, Environment and Capital Development and Estates Manager
Approved by:	Quality, Safety and Performance Committee
Approval Date:	10 November 2022
Date of Equality Impact Assessment:	13 April 2022
Equality Impact Assessment Outcome:	Approved
Review Date:	November 2025
Version:	2

1. AIM

1.1 General considerations:

Velindre University NHS Trust (the Trust) accepts its responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulation 2002 (as amended), to take all reasonable precautions to prevent or control the harmful effects of contaminated water to patients, visitors, staff and other persons working at or using its premises in line with the current version of the Water Safety Plan, Site-specific 'Written Schemes', and Water Safety Policy Appendices.

1.2 Extent of application:

This Water Safety Policy applies to all premises whether owned or occupied by the Organisation under lease or other Service Level Agreements (SLA) including:

i. All premises owned and occupied exclusively by the Organisation.
ii. All premises owned and occupied partly by the Organisation.
iii. All premises not owned by the Organisation but occupied exclusively by the Organisation on a permanent basis.
iv. All premises not owned by the Organisation but occupied partly by the Organisation on a permanent basis.
v. All premises not owned by the Organisation but occupied partly by the Organisation on a temporary or periodic basis.

1.3 General aim:

The aim of this Policy is to introduce all structured Management practices required to allow the Organisation to deliver suitable and sufficient *Legionella* and *Pseudomonas aeruginosa,* "safe" hot water, cold water, drinking water and ventilation systems Management and Control in compliance with current Guidelines (WHTM's, HGN's, Model Engineering Specifications and Approved Codes of Practice), Legislation and Water Supply Regulations. It is expected that this Water Safety Policy will be complied with by all the Organisation's employees and by all appointed contractors, in whatsoever capacity, with or without contractual agreements.

2. MANAGERIAL APPOINTMENTS

2.1 General requirements:

As required by the Health and Safety Commissions (2013) Approved Code of Practice (L8 - Fourth Edition), the Organisation will undertake to:

i. Identify and assess sources of risk;
ii. Prepare site specific 'Written Scheme' for preventing, reducing or controlling the risk;
iii. Implement and manage and monitor precautions;
iv. Keep records of the precautions implemented for each of the premises under the Organisation's control.
v. Appoint appropriate persons, at various positions, to be managerially responsible.

Group and individual responsibilities are described in Water Safety Policy Appendix 1 – Management Responsibilities.

2.2 Executive management at 'Trust Level':

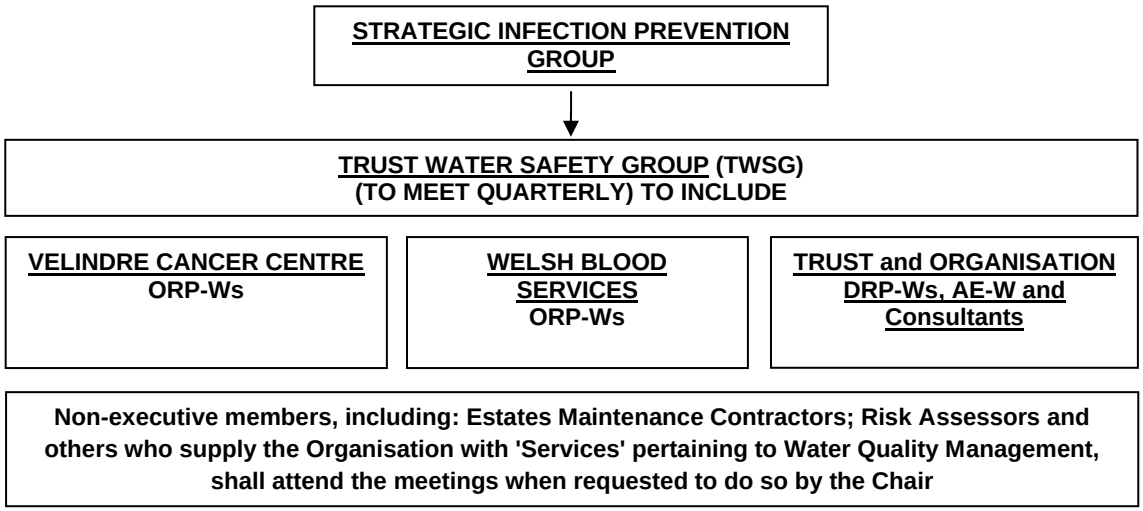
The Chief Executive shall appoint a Trust Water Safety Group (TWSG) Chair and Authorising Engineer-Water (AE-W), operating at Trust Wide Level.

The TWSG Chair shall propose Responsible Persons to the AE-W who shall assess their suitability for the position nominated, and advise the TWSG Chair upon their suitability for appointment. This shall include all TWSG members (Departmental Responsible Persons – Water and Organisation Responsible Persons - Water) Following assessment, these persons shall be appointed to accept the strategic implementation and internal auditing responsibility for the control of the 'Water Quality Management and Control' and to be legally accountable, on a joint and several liability basis, for assessing and controlling identified risks from Legionella, Pseudomonas aeruginosa and other water borne pathogens and hazards.

2.3 Management at 'Organisation Level':

Through the Trust WSG, suitable Organisation Responsible Persons - Water shall be nominated, assessed and then appointed for each Organisation within the scope of this Policy. These persons will be responsible for implementing the specific management

2.4 Water Quality Management and Control Programme Management Structure:



2.5 Measures to be taken to attain the Policy objectives include:

a) The appointment of a Trust Water Safety Group (TWSG) responsible for ensuring the suitable and sufficient implementation of Water Management and Control Programme on a Trust level.

b) The appointment of Organisation Water Safety Groups (OWSG) responsible for ensuring the suitable and sufficient implementation of Water Management and Control Programme on an Organisation level.

c) The appointment of suitably equipped, trained and financed Responsible Persons, on a Trust Wide and Organisation-specific level; capable of delivering the necessary Water Quality Management and Control Programme at the level appointed.

d) Regular monitoring of all implemented Management Systems, Training Programmes and procedures, to establish and ensure their continuing efficacy and legislation compliance.

e) The appropriate selection, design, installation and maintenance of plant.

f) Regular independent third-party Audits designed to allow for the status of the Water Quality Management and Control Programme across the Organisation to be reported.

g) Where in house (Trust) resource is not available, external resource may be appropriated to ensure the control schemes are implemented in line with the agreed requirements.

APPENDIX 1 MANAGEMENT RESPONSIBILITIES

All appointed Responsible Persons (members of TWSG and OWSG) shall, before being formally appointed in writing, be evaluated by the AE-W, using the 'Responsible Persons Evaluation Pro-forma' found in Appendix, for their suitability to the appointment. Upon approval by the AE-W, the Chair of the TWSG shall issue formal appointment instructions to each Responsible Person, using the 'Letter of Nomination - Responsible Person' found in Appendix.

1.1 Trust Water Safety Group (TWSG):

The Trust has set up this group as one element of its Water Quality Management and Control infrastructure, in order to achieve all Policy objectives. See TWSG Terms of Reference for remit, membership and responsibilities.

1.2 Organisation Water Safety Group (OWSG):

The Organisation has set up this group as one element of its Water Quality Management and Control Infrastructure, in order to achieve all Policy objectives.

The OWSG is a formal sub-group of the TWSG and shall formally report to this group through minutes of scheduled or extra-ordinary meetings. See OWSG Terms of Reference for remit, membership and responsibilities.

1.3 Trust Chief Executive (Duty Holder)

i. Has the Corporate Responsibility for all aspects of Water Quality within all properties occupied by the Trust.
ii. Shall nominate, in writing the TWSG Chair, and the Authorising Engineer-Water (AE-W).

1.4 TWSG Chair (Assistant Director of Estates, Environment and Capital Development):

i. Shall have responsibility for monitoring and reporting the performance of the Water Quality Management and Control Regimes throughout the Trust to Board Level, this shall fulfil the requirements of WHTM00 Designated Person (Water).
ii. Shall have responsibility for ensuring that all appointed Responsible Persons are suitably informed of current legal and guideline requirements pertaining to Water Quality Management & Control.
iii. Shall lead in the compilation of the WSP, WSPolicy and other pertinent management documentation.
iv. Shall control the distribution and dissemination of information from the WSP and WSPolicy
v. Shall facilitate the appropriate formalised suitability evaluation and appointment of all Responsible Persons.
vi. Shall lead in the roll-out of the WSP and ensure the adequate implementation of its requirements by commissioning periodic auditing of the status of

implementation of all requirements whether these are delivered by Organisation staff or by a third party (contractor).

vii. Shall facilitate suitable and sufficient training of all associated members of Organisation staff.

viii. In association with the TWSG and OWSG, shall prepare and issue any required tender documentation to manage all water system management, water dosing, Legionella and safe working water related contract in compliance with Organisation contract management procedures.

ix. Assist in the development of schemes for risk minimisation and control in order of priority giving consideration to cost, risk and difficulty.

1.5 TWSG Vice Chair (Senior Nurse Infection Prevention and Control):

i. Shall act as the TWSG Chair in their absence.

ii. Shall carry out local clinical risk assessment of 'users' to enable for suitable implementation of appropriate Water Quality Management processes and procedures, and provide these assessments to TWSG

iii. Provide advice the members of the TWSG and OWSGs in all matters relating to Legionella and *Pseudomonas aeruginosa* contamination and infection prevention and management.

iv. Shall review the status of all Pseudomonas aeruginosa risk assessments within their organisation, and where required supervise the completion of suitable and sufficient risk assessments on all areas assigned High or Urgent Risk.

iii. Shall assist in the compilation of the Organisation's Water Safety Plan (WSP).

iv. Shall undertake an annual review of the practical implementation of aspects of the policy for which they are responsible.

1.6 Consultant Microbiologist:

i. Shall assist with the interpretation of local clinical risk assessment of 'users' to enable for suitable implementation of appropriate Water Quality Management processes and procedures.

ii. Provide advice the members of the NWSG and OWSGs in all matters relating to Legionella and *Pseudomonas aeruginosa* contamination and infection prevention and management.

iii. Shall assist in the compilation of the Organisation's Water Safety Plan (WSP).

iv. Shall undertake an annual review of the practical implementation of aspects of the policy for which they are responsible.

1.7 Trust Capital Manager:

i. Shall have the responsibility for ensuring that all water systems are designed, modified, installed, tested and commissioned to the Guidance and standards referred to in this Policy and the WSP.

ii. Shall have responsibility for ensuring the completion of the 'Permit for Hand-over and Occupation' of new builds and major refurbishments.

iii. Shall ensure that, all new and altered water systems, including minor and major modifications/refurbishments, comply with the requirements of the Guidance and standards referred to in this Policy and the WSP. In this respect, at the design stage the consulting engineer shall liaise with Organisation's AE-W.

iv. Shall liaise with the members of the TWSG for the design, installation and commissioning of water systems equipment and provide these with a summary of the description and status of all current capital schemes.
v. Shall ensure that the specification, and the consulting engineer's competence and interpretation of the requirements are suitably assessed and confirmed and supervise all contracts under the control of the department.
vi. Shall ensure the Clerk of Works' competence and interpretation of the requirements.
vii. Shall notify the water undertaker of any proposed installation of water fittings and to have the water undertakers' consent before installation commences, as required by the Water Supply (Water Fittings) Regulations 1999.
viii. Shall, for all contracts under their control, provide as fitted and schematic diagrams of all modified or new water systems and equipment and to ensure that the OWSG are provided with copies.
ix. Shall provide copies of commissioning results, maintenance and test instructions and details of any specific hazards pertaining to the systems and equipment which will include the full requirements of the WSP, particularly all certificates and permits pertaining to design verification, installation, commissioning and hand-over of new and/or refurbished buildings/areas.
x. Shall ensure that operating and maintenance manuals are provided for all building services installation, including commissioning data, disinfection certificates and biological analysis results.
xi. Shall supervise the completion of suitable and sufficient risk assessments on all water systems and 'wet' air conditioning plant of new and/or refurbished systems/buildings. The risk assessment shall be reviewed a few weeks after complete occupation.
xii. Shall ensure that adequate spares are provided on initial handover.
xiii. Shall inform users of any planned interruptions to water systems and equipment.
xiv. Shall inform the TWSG of any forthcoming schemes.
xv. Shall ensure that only appropriately trained contractors with the respective accreditation are employed to undertake work for the Organisation.
xvi. Shall have the responsibility of periodically assessing the training requirements of all staff under their control who are associated with Legionella and *Pseudomonas aeruginosa* contamination management and arranging suitable training where required.
xvii. Shall assist in the compilation of the Water Safety Plan (WSP).

1.8 Organisation Responsible Person – Water (OWSG Chair):

i. Shall accept responsibility for the Organisational implementation of an Organisation specific Water Quality Management & Control Programme in accordance with the requirements of the WSP and other pertinent Water Quality Management & Control guidance documentation and instruction. In line with WHTM00, this shall fulfil the Position of Authorised Person (Water)
ii. Shall Chair the OWSG under their jurisdiction.
iii. Shall facilitate the development of Written Schemes for risk minimisation and control in order of priority giving consideration to cost, risk and difficulty.
iv. Shall have the responsibility of periodically assessing the training requirements of all staff and third-party organisations (contractors) under their control who are

associated with Water Quality Management and Control; arranging suitable training where required, and recording these assessments.

v. Shall assist in the compilation of the Water Safety Plan (WSP).
vi. Shall appoint a Deputy Organisation Responsible Person (Water) to act up in their absence, including Deputy Chair OWSG.
vii. Shall review the status of all risk assessments within their organisation, and where required supervise the completion of suitable and sufficient risk assessments on all water systems and 'wet' air conditioning plant within each site under their control.
viii. Shall consider the risk assessment findings and, together with the members of the OWSG, prioritise any remedial works.
ix. Shall instruct and supervise the completion of all prioritised remedial work highlighted during the risk assessment or the review.
x. Shall, where practicable, ensure record drawings of systems are available and kept updated.
xi. Shall be responsible for ensuring that all processes, procedures, Permits, and Certification detailed in the WSP are suitably executed and implemented.
xii. Shall keep maintenance and monitoring records and make available for inspection, all records to be kept for 5 years.

1.9 Departmental Responsible Person - Water:

i. Shall accept responsibility for the Organisational implementation of an Organisation specific Water Quality Management & Control Programme in accordance with the requirements of the WSP and other pertinent Water Quality Management & Control guidance documentation and instruction.
ii. Shall attend TWSG and/or OWSG under their jurisdiction
iii. Shall act as the contact point between their Department and the TWSG and/or OWSG and report to the performance of the Water Quality Management and Control Regime within their remit, and disseminate to their department the findings and requirements of the TWSG and/or OWSG.
iv. Shall assist in the compilation of the Water Safety Plan (WSP).
v. Shall appoint a Deputy Organisation Responsible Person (Water) to act up in their absence.

1.10 Competent Persons:

Competent Persons are Technicians, trades staff and contractors who have received approved training and have sufficient experience to service, maintain and clean water systems in a safe and effective manner.

i. Shall ensure that all procedures, safe working practices and permits to work are followed and that any personal protective equipment or clothing is used.
ii. Shall report to the Organisation Responsible Person (Water) of all defects, unusual occurrences and other anomalies, and record such defects in writing in the defects register before leaving site.
iii. Shall complete written records when required.

1.11 Authorising Engineer - Water (AE-W):

i. Shall act as an independent professional adviser to the Organisation. The AE-W shall be appointed by the TWSG Chair with a brief to provide services in accordance with Welsh Health Technical Memoranda guidance.
ii. Shall act as auditor and assessor and make recommendations for the appointment of members of the TWSG and OWSG, monitor the performance of the TWSG and OWSGs and provide an annual Governance Audit to the TWSG. To carry out this role effectively, particularly with regard to audit, the AE-W shall remain independent of the operational structure of the Organisation.
iii. Shall be a member of the TWSG and attend at the Group's meetings.
iv. Shall provide training, advice and assistance in all Legionella and *Pseudomonas aeruginosa* Management & Control and Safe Water Management matters, including the PPM Programme, Log-Book system and all relevant Management Manuals.
v. Shall sanction any interpretation of HTM 04-01 and any other relevant professional guidance, any local house rules and any derogation that may be necessary for their application.
vi. Shall ensure that any amendments or updates to WHTM 04-01 and associated documents, or any replacement guidance issued and any other relevant mandatory or statutory professional guidance is brought formally to the attention of the Organisation and are understood by all appropriate personnel by recording / documenting the process.
vii. Shall, on receipt of an “operational restriction" or "Estates Alert” related to water storage and distribution systems, ensure that all TWSG members are made aware and receive copies.
viii. Shall agree in writing any local deviation/derogation from HTM’s or other mandatory / statutory guidance that may be necessary for their application to a particular location.
ix. Shall, when required to do so, provide to the members of the TWSG ad-hoc general 'remote' verbal advice on matters pertaining to Legionella and *Pseudomonas aeruginosa* management and control and other Water Quality Management issues.
x. Shall, when required to do so, provide input advice to the design process in respect to the construction/installation phase and for the subsequent operational service thereafter.
xi. Shall, in conjunction with the appointed design engineer, contribute to the design process, to ensure all water and air systems, implicated within the design remit, comply with the requirements of the WSP.
xii. Shall, when required to do so, upon completion, provide a certificate of compliance for new water systems including major modifications/refurbishments.
xiii. Shall undertake an annual review of the practical implementation of aspects of the policy for which they are responsible.

1.12 Water Safety Consultant:

i. Shall be independent from all other contractors who provide the Organisation with services and/or products pertaining to Water Quality Management and Control.
ii. Shall be suitably trained and qualified to perform all auditing tasks described in the Water Safety Plan and be a member of the Legionella Control Association (LCA).
iii. Shall carry out a System and Process Audit, as instructed by the TWSG Chair and present findings to the TWSG and OWSG chairs.
iv. Shall provide input advice to the design process in respect to the construction / installation phase and for the subsequent operational service thereafter.
v. Shall, upon completion, provide a risk assessment for new water systems including major modifications / refurbishments.

1.13 Risk Assessor:

i. Shall be independent from all other contractors who provide the Organisation with services and/or products pertaining to Water Quality Management and Control.
ii. Shall be suitably trained and qualified to perform all risk assessment tasks described in the Water Safety Plan and be a member of the Legionella Control Association (LCA).
i. When commissioned to do so, shall carry out a suitable and sufficient Legionella risk assessment compliant with: a) HTM 04-01 Parts A, B and C; b) UKAS ISO/IEC 17020:2012; c) HSG274 Part 2 (2014) – 'The control of *Legionella* bacteria in hot and cold water systems'; d) BS 8580 – 'Water quality: risk assessments for *Legionella* control – Code of Practice'; e) BSRIA's (1999) FMS 4/99 – 'Guidance and the standard specification for water services risk assessment'; and f) BSRIA's (2015) BG 57/2015 – 'Legionnaires' disease.
iii. When commissioned to do so ensure that risk assessments are reviewed and/or updated when there are significant changes to statutory standards, operational requirements and when there are significant changes to a building's domestic water and wet air systems.
iv. When commissioned to do so, ensure that risk assessments are carried out on all process and equipment, such as medical equipment (where applicable).
v. Ensure that, for all buildings/areas assessed to be of Moderate Risk or higher, issue an 'Interim Problem Notification Pro-Forma' found in the WSP, detailing any necessary immediate corrective and remedial actions which need to be carried out. In addition, the 'Notification' shall indicate the Short/Medium-term and Long-term corrective and remedial actions that need to be carried out. The list of remedial actions shall be suitably divided and allocated to each organisation for completion. Each organisation must report to the OWSG on the status of completion of remedial works thus allocated.

1.14 Water Quality Management Contractors and Sub-contractors:

i. A contractor is the person or organisation commissioned, under contract, by the TWSG or the OWSG to be responsible for the maintenance, supply, installation, validation and verification of hot and cold water services and 'wet' air handling systems, and for the conduct of the installation checks and tests.
ii. All contractors involved in the Water Quality Management Programme, shall be suitably trained and qualified to perform tasks described in their contract and detailed in the Water Safety Plan and be a member of the Legionella Control Association (LCA). However, where a specialist contractor is required to carry out emergency remedial works and does not meet the membership criteria listed above, they may be employed by the discretion of the site TWSG or the appropriate OWSG.
iii. Shall issue all reports in a format agreed by the OWSG and as detailed in the Written Scheme.
iv. Shall work with members of the TWSG and OWSGs to identify hazards and reduce risks by following safe working practices.

APPENDIX 2. LEGISLATION STANDARDS AND GUIDANCE

1. The Construction (Design and Management) Regulations 2007 (CDM)
2. The Building Regulations 2010 (and associated amendments)
3. The Water Regulations Advisory Scheme's (WRAS) 'Water Regulations Guide', and any other requirements of the local water undertaker
4. The Water Supply (Water fittings) Regulations 1999
5. The Water Supply (Water Quality) Regulations 2016
6. CIBSE Guide G Public Health and Plumbing Engineering
7. BS 1710 – 1984 - Specification for identification of pipeline services
8. HSE Legionnaires' disease The control of legionella bacteria in water systems. Approved Code of Practice and guidance on regulations: L8 (Fourth edition) Published 2013
9. HSE Legionnaires' disease Part 2: The control of legionella bacteria in hot and cold water systems: HSG274 Part 2 Published 2014
10. HSE Legionnaires' disease: Technical guidance Part 3: The control of legionella bacteria in other risk systems: HSG274 Part 3 Published 2013
11. BS 1710 – 2014 - Specification for identification of pipeline services.
12. BS 8558:2015 provides complimentary guidance to BS EN 806. It is a guide to the design, installation, testing, operation and maintenance of services supplying water for domestic use within buildings and their curtilages.
13. BS EN 806-5:2012 Specification for installations inside buildings conveying water for human consumption - Operation and maintenance.
14. BS EN 806-1:2000 Specifications for installations inside buildings conveying water for human consumption -General.
15. BS EN 806-2:2005 Specifications for installations inside buildings conveying water for human consumption – Design.
16. BS EN 806-3:2006 Specifications for installations inside buildings conveying water for human consumption - Pipe sizing. Simplified method.
17. BS EN 806-4:2010 Specifications for installations inside buildings conveying water for human consumption – Installation.
18. BS 8551-2015 Provision and management of temporary water supplies and distribution networks
19. BSI PD 855468-2015 Guide to the flushing and disinfection of services supplying water
20. BS 8558-2015 Guide to the design, installation, testing and maintenance of services
21. BS EN ISO 5667-1 2006 Water Quality - Sampling
22. BS 8554 2015 - Code of practice for the sampling and monitoring of hot and cold water services in buildings
23. BS7592:2008 – Sampling for Legionella bacteria in water systems – Code of practice.

24. BS 8580:2010 – Water Quality – Risk assessments for Legionella Control – Code of Practice.
25. The Health and Social Care Act 2008 COP of Practice on the prevention and control of infections and related guidance
26. WHTM 00 Policies and Principles of Healthcare Engineering 2014
27. WHTM 04-01:2016 Safe Water in Healthcare Premises Parts A, B, C 2016 and Supplement 2017.
28. Heating and ventilation systems Welsh Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises.
29. Department of Health 'Performance requirements for building elements used in healthcare facilities Version:0.6:England'
30. Responding to the detection of legionella in healthcare premises Guidance for PHE health protection teams
31. HBN 00-10 Part C Sanitary assemblies 2013.
32. PWTAG Code of Practice - The Management and Treatment of Swimming Pool Water:2013
33. Model Engineering Specification C07 1997 rev 3.
34. PHE Hospital waters – how to ensure high quality microbiological testing:2014
35. Guidance on the Control and Prevention of Legionnaires' Disease in England Technical Paper 1 - Disease Surveillance: 2010
36. Public Health England (PHE) – Examining food, water and environmental samples from healthcare environments – Microbiological Guidelines: 2013.
37. World Health Organisation (WHO) – Water Safety in buildings: 2011.
38. DH - HBN 00-09: Infection control in the built environment: 2013.
39. DH (2006 - 05) Shower heads.
40. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe Care & Treatment. Providers must make sure that the premises and any equipment used is safe. See in particular Reg 12 (1) (s) (a) (b) (d) and (e).
41. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 15: Premises & Equipment. The premises where care and treatment are delivered must be clean, secure, suitable for the intended purpose, properly used, properly maintained and where required, appropriately located for the purposes for which they are being used. See in particular Reg 15(1) (c) and (e).

APPENDIX 3 – RESPONSIBLE PERSONS SUITABILITY ASSESSMENT PRO-FORMA

Proposed Responsible Persons Suitability Assessment

Department:								
Position nominated for:								
Name:								
Position (job title):			Management level:		Low	Middle	High	
Is nominee currently acting in this position?	Yes	No	If Yes; how long has nominee acted in this position:					
Has candidate held this position previously?	Yes	No	If Yes; when and for how long:					
Is nominee expected to take executive decisions:	Yes	No	If Yes; is nominee at an appropriate position to adequately complete this task?			Yes	No	
Is nominee expected to take financial decisions?	Yes	No	If Yes; is nominee at an appropriate position to adequately complete this task?			Yes	No	
Is nominee a member of the TWSG/OWSG?	Yes	No	If Yes; how long has nominee been a member?					
	If Yes; is nominee a regular attendee at the TWSG/OWSG meetings?					Yes	No	
Is nominee suitably trained?	Yes	No	If No; is nominee scheduled to attend training imminently?			Yes	No	
Is nominee aware of relevant guidance and legislation	Yes	No	If No; what level of knowledge is possessed by the nominee					
Is nominee aware of the remit of this nomination?	Yes	No	If No; has the nominee been provided with a remit description?			Yes	No	
Is nominee willing to accept the nomination?	Yes	No	If No; why not?					
Additional Information								
Is nominee approved?	Yes	No	If No; why not?					

Signed - AE-W: ..... Date: .....

APPENDIX 4 – COMPETENT PERSONS SUITABILITY ASSESSMENT AND APPOINTMENT PRO-FORMA

Proposed Competent Persons Suitability Assessment

Organisation:						
Name:						
Position (job title):						
Is the nominee a Contractor?	Yes	No	If a Contractor, have they provided suitable accreditation certification?		Yes	No
Is nominee currently acting in this position?	Yes	No	If Yes; how long has nominee acted in this position:			
Has candidate held this position previously?	Yes	No	If Yes; when and for how long:			
Tasks covered by this Assessment						
Has nominee been provided with relevant approved Trust Procedures for tasks and agrees to abide by their requirements?	Yes	No	If no Trust Procedures are available for the task, have Procedures been provided for ORP-W to approve?		Yes	No
Has nominee been provided with Policy and Written Scheme for relevant site and agrees to abide by their requirements?	Yes	No				
Is nominee suitably trained in Legislation and Guidance	Yes	No	If No; is nominee scheduled to attend training imminently?		Yes	No
Is nominee suitably trained in Tasks covered by this assessment?	Yes	No	If No; is nominee scheduled to attend training imminently?		Yes	No
Is nominee willing to accept the nomination?	Yes	No	If No; why not?			
Additional Information						
Is nominee approved?	Yes	No	If No; why not?			

Signed – ORP-W: ..... Date: .....

Signed – Nominee: ..... Date: .....

APPENDIX 5 – STANDARD LETTER OF APPOINTMENT

Ref: .....
Date: .....

FOR THE ATTENTION OF [NAME OF NOMINEE HERE]

Dear [name of nominee here]

Re: ***Yours nomination as Chair of the Trust Water Safety Group (TWSG)/Organisational Water Safety Group (OWSG)*** *delete as appropriate*

The TWSG/OWSG *delete as appropriate* is a multidisciplinary group formed to accept ownership of delivering the highest water quality across the Organisation by ensuring the correct management of water systems and other associated processes and practices, to reduce the risk of microbial growth including opportunistic pathogens such as *Legionella* and *P. aeruginosa* which is vital to user safety in line with current guidance including WHTM04-01 and ACoP (L8).

You shall be jointly legally accountable and responsible for ensuring that the TWSG/OWSG *delete as appropriate* identifies microbiological hazards, assesses risks, identifies, implements and monitors control measures, and develops incident protocols.

The TWSG/OWSG *delete as appropriate* Terms of Reference are attached for your consideration.

This section to be completed by nominee

I have read and understood the TWSG/OWSG *delete as appropriate* Terms of Reference and I accept my position as Chair of the TWSG/OWSG *delete as appropriate* as nominated.

[Name of nominee here] .....

Signature: .....

Date: .....

This section to be completed by Duty Holder and AE-W

I authorise the nomination of [Name of nominee here] as a Chair of TWSG/OWSG *delete as appropriate*

Duty Holder:		**AE-W**
Signature:	……..….....	……..….....
Name:	…….....	.....…..….....
Date:	…….....	..….....

Ref: **.....**

Date: **.....**

FOR THE ATTENTION OF [NAME OF NOMINEE HERE]

Dear [name of nominee here]

Re: ***Your nomination as a member of the Trust Water Safety Group (TWSG)/Organisational Water Safety Group (OWSG)*** ***delete as appropriate***

The TWSG/OWSG ***delete as appropriate*** is a multidisciplinary group formed to accept ownership of delivering the highest water quality across the Organisation by ensuring the correct management of water systems and other associated processes and practices, to reduce the risk of microbial growth including opportunistic pathogens such as *Legionella* and *P. aeruginosa* which is vital to user safety in line with current guidance including WHTM04-01 and ACoP (L8).

Irrespective of who chairs each group, you, as a nominated member shall be jointly legally accountable and responsible for ensuring that the TWSG/OWSG ***delete as appropriate*** identifies microbiological hazards, assesses risks, identifies, implements and monitors control measures, and develops incident protocols.

The TWSG/OWSG ***delete as appropriate*** Terms of Reference are attached for your consideration.

This section to be completed by nominee

I have read and understood the TWSG/OWSG ***delete as appropriate*** Terms of Reference and I accept my position in the TWSG/OWSG ***delete as appropriate*** as nominated.

[Name of nominee here] .....

Signature: .....

Date: .....

This section to be completed by TWSG Chair and AE-W

I authorise the nomination of [Name of nominee here] as a member of TWSG/OWSG ***delete as appropriate***

Signed for on behalf of the TWSG:

	TWSG Chair	**AE-W**
Signature:	……..….....	……..….....
Name:	…….....	.....…..….....
Date:	…….....	..….....

APPENDIX 6 – MANAGEMENT HIERARCHY

Trust Management Hierarchy		Appointment completed Y/N
Position	**Current named individual**	
Trust Chief Executive		
TWSG Chair		
TWSG Vice Chair		
Consultant Microbiologist		
OWSG Chair		
Trust Capital Manager		
Authorising Engineer - Water		
External Independent Water Safety Consultants/Risk Assessors		
Departmental Responsible Persons		

TRUST BOARD

Transforming Cancer Services
Communications and Engagement Update

DATE OF MEETING	24/11/2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	NON GWILYM, ASSISTANT DIRECTOR COMMUNICATIONS AND ENGAGEMENT
PRESENTED BY	NON GWILYM, ASSISTANT DIRECTOR COMMUNICATIONS AND ENGAGEMENT
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE
REPORT PURPOSE	FOR NOTING

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

COMMITTEE OR GROUP	DATE	OUTCOME

ACRONYMS

nVCC	New Velindre Cancer Centre

1. SITUATION AND BACKGROUND

This paper provides the Trust Board with an update on communications and engagement since the October meeting.

2. ASSESSMENT

2.1 Local Community Engagement Events

The events provided an opportunity for members of the local community, staff and patients to hear about our plans, see the model of the new cancer centre, meet both project and Acorn teams and “ask the experts” about issues of interest. We were very pleased that members of the community attended the events and we learned valuable lessons that will inform similar community events which we intend to run on a quarterly basis.

2.2 Public Communications

- **60:40 Ratio**
  Additional queries regarding the 60:40 ratio were raised at the initial Engagement Event and on social media. A clarification post was issued on October 18.

For the avoidance of doubt, the Design Brief, a key document that formed part of the public tender documentation associated with the competition to develop the new Velindre Cancer Centre in spring 2021, clearly states:

“In recognition of public concern, the majority of the site must remain green with the Velindre NHS Trust committed to retaining 60% of the development site as landscape, with a 40% built footprint.”

It was a key commitment from Velindre University NHS Trust and Acorn have delivered on it. Combined, the new cancer centre and its green roofs, the road, the proposed car park and the new Maggies centre form a 40% built footprint on the site.

We hope this clarifies the situation for everybody.

Er mwyn osgoi unrhyw amheuaeth, mae'r Briff Dylunio, dogfen allweddol a oedd yn rhan o'r dogfennau tendro cyhoeddus a oedd yn gysylltiedig â'r gystadleuaeth i ddatblygu'r Ganolfan Ganser Felindre newydd yng ngwanwyn 2021, yn nodi'n glir:

"I gydnabod pryder y cyhoedd, rhaid i fwyafrif y safle barhau'n wyrdd gydag Ymddiriedolaeth GIG Felindre wedi ymrwymo i gadw 60% o'r safle datblygu fel tirwedd, gydag ôl troed wedi'i adeiladu o 40%."

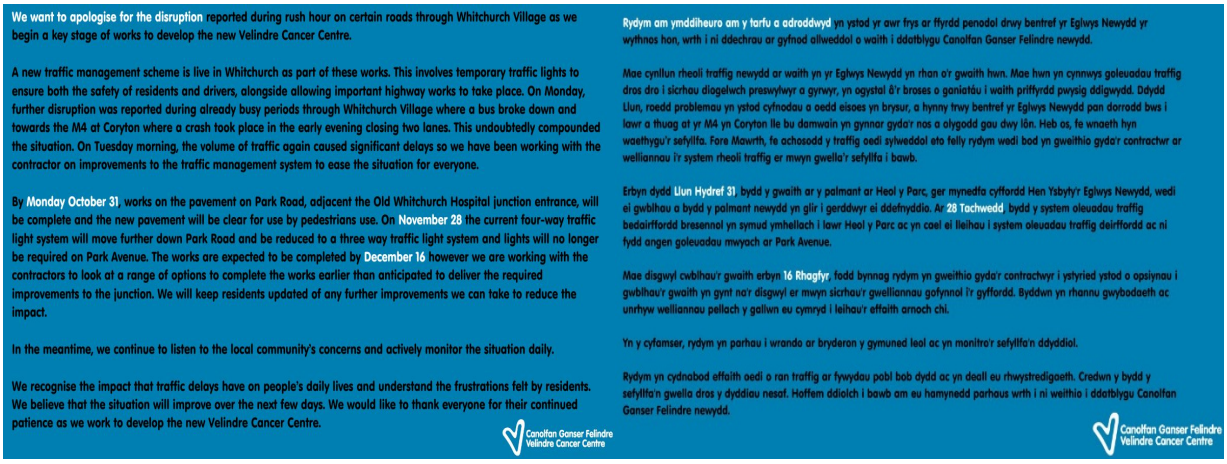
Roedd yn ymrwymiad allweddol gan Ymddiriedolaeth GIG Prifysgol Felindre ac mae Acorn wedi cyflawni hynny. Gyda'i gilydd, mae'r ganolfan ganser newydd a'r toeau gwyrdd, y ffordd, y maes parcio allanol arfaethedig a'r ganolfan Maggies newydd yn ffurfio ôl troed wedi'i adeiladu o 40% ar y safle.

Rydyn ni'n gobeithio bod hyn yn egluro'r sefyllfa i bawb.

- **Old railway cutting**
  A reminder that the PROW (Public Right of Way) of the Old Railway Cutting remains closed was published on social media on October 25. This was in response to some correspondence received suggesting that members of the public continue to use the cutting.

- **Traffic issues**
  Several residents sent correspondence following the implementation of the new traffic management scheme. An apology was issued on October 27 and distributed via social media channels explaining the importance of these works and what we had done to improve the situation.

  The apology was well-received and was included in a WalesOnline article published on October 28 (Velindre issue update after work on new cancer centre causes major disruption).


We want to apologise for the disruption reported during rush hour on certain roads through Whitchurch Village as we begin a key stage of works to develop the new Velindre Cancer Centre.

A new traffic management scheme is live in Whitchurch as part of these works. This involves temporary traffic lights to ensure both the safety of residents and drivers, alongside allowing important highway works to take place. On Monday, further disruption was reported during already busy periods through Whitchurch Village where a bus broke down and towards the M4 at Coryton where a crash took place in the early evening closing two lanes. This undoubtedly compounded the situation. On Tuesday morning, the volume of traffic again caused significant delays so we have been working with the contractor on improvements to the traffic management system to ease the situation for everyone.

By Monday October 31 works on the pavement on Park Road, adjacent the Old Whitchurch Hospital junction entrance, will be complete and the new pavement will be clear for use by pedestrians use. On November 28 the current four-way traffic light system will move further down Park Road and be reduced to a three way traffic light system and lights will no longer be required on Park Avenue. The works are expected to be completed by December 16 however we are working with the contractors to look at a range of options to complete the works earlier than anticipated to deliver the required improvements to the junction. We will keep residents updated of any further improvements we can take to reduce the impact.

In the meantime, we continue to listen to the local community's concerns and actively monitor the situation daily.

We recognise the impact that traffic delays have on people's daily lives and understand the frustrations felt by residents. We believe that the situation will improve over the next few days. We would like to thank everyone for their continued patience as we work to develop the new Velindre Cancer Centre.

Canolfan Ganser Felindre Velindre Cancer Centre

Rydym am ymddiheuro am y tarfu a adroddwyd yn ystod yr awr frys ar ffyrdd penodol drwy bentref yr Eglwys Newydd yr wythnos hon, wrth i ni ddechrau ar gyfnod allweddol o waith i ddatblygu Canolfan Ganser Felindre newydd.

Mae cynllun rheoli traffig newydd ar waith yn yr Eglwys Newydd yn rhan o'r gwaith hwn. Mae hwn yn cynnwys goleuadau traffig dros dro i sicrhau diogelwch preswylwyr a gyrwyr, yn ogystal â'r broses o ganiatáu i waith priffyrdd pwysig ddigwydd. Ddydd Llun, roedd problemau yn ystod cyfnodau a oedd eisoes yn brysur, a hynny trwy bentref yr Eglwys Newydd pan dorrodd bws i lawr a thuag at yr M4 yn Coryton lle bu damwain yn gynnar gyda'r nos a olygodd gau dwy lôn. Heb os, fe wnaeth hyn waethygu'r sefyllfa. Fore Mawrth, fe achosodd y traffig oedi sylweddol eto felly rydym wedi bod yn gweithio gyda'r contractwr ar welliannau i'r system rheoli traffig er mwyn gwella'r sefyllfa i bawb.

Erbyn dydd Llun Hydref 31 bydd y gwaith ar y palmant ar Heol y Parc, ger mynedfa cyffordd Hen Ysbyty'r Eglwys Newydd, wedi ei gwblhau a bydd y palmant newydd yn glir i gerddwyr ei ddefnyddio. Ar 28 Tachwedd, bydd y system oleuadau traffig bedairffordd bresennol yn symud ymhellach i lawr Heol y Parc ac yn cael ei lleihau i system oleuadau traffig deirffordd ac ni fydd angen goleuadau mwyach ar Park Avenue.

Mae disgwyl cwblhau'r gwaith erbyn 16 Rhagfyr fodd bynnag rydym yn gweithio gyda'r contractwyr i ystyried ystod o opsiynau i gwblhau'r gwaith yn gynt na'r disgwyl er mwyn sicrhau'r gwelliannau gofynnol i'r gyffordd. Byddwn yn rhannu gwybodaeth ac unrhyw welliannau pellach y gallwn eu cymryd i leihau'r effaith arnoch chi.

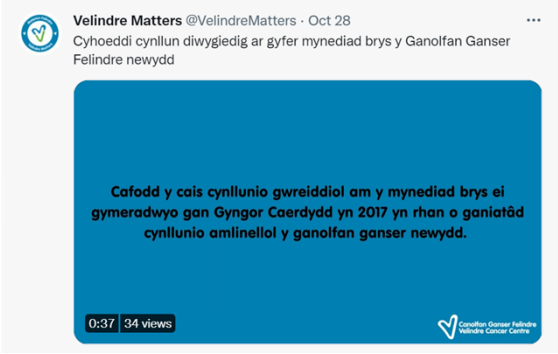
Yn y cyfamser, rydym yn parhau i wrando ar bryderon y gymuned leol ac yn monitro'r sefyllfa'n ddyddiol.

Rydym yn cydnabod effaith oedi o ran traffig ar fywydau pobl bob dydd ac yn deall eu rhwystredigaeth. Credwn y bydd y sefyllfa'n gwella dros y dyddiau nesaf. Hoffem ddiolch i bawb am eu hamynedd parhaus wrth i ni weithio i ddatblygu Canolfan Ganser Felindre newydd.

Canolfan Ganser Felindre Velindre Cancer Centre

2.3 Emergency access

The announcement of the revised emergency access plans was published on October 28. It was published on social media, the staff intranet, and the weekly VCC staff newsletter and was also included in the WalesOnline article above published on October 28.



2.4 WKSpace Workshops

A series of follow-up workshops were delivered during October for staff to receive feedback on both WKSpace workplace design surveys. Attendees were keen to share their thoughts and the lively discussion themes have populated a series of FAQs.

2.5 Responding to correspondence from a wide range of stakeholders.

The main themes of correspondence received during the reporting period include:

- Bees trapped in netting
- School embargo times
- Vibrations from works on site
- 60/40 commitment
- Cones and signage hit by lorry at Whitchurch Hospital entrance on 17/10
- Police being called to LCF on 3/10
- Traffic management on Park Road (twofold):
  - Safety
  - Disruption
- Construction noise
- Conduct of contractor staff

2.6 Political stakeholder meetings

During the reporting period, two meetings with the local MS/MPs have taken place. Another meeting is scheduled on December 2 to provide an overview of the Transforming Cancer Services Programme.

2.7 Media Queries

The Western Mail ran a story (2 November) on the cost of securing an injunction in support of the development of the new Velindre Cancer Centre. The story carried the full VUNHST response to the queries which was as follows:

> "The Velindre University NHS Trust spokesperson said: "Velindre University NHS Trust is committed to working closely with the local community throughout the process of developing the new Velindre Cancer Centre. This was most recently evidenced by three community engagement events held in Whitchurch during October where members of the public were invited to share their views on the development.
>
> "We recognise some do not support the plans for the site, and we are respectful of their opinions. We will continue to listen to, and work with all people, to deliver the best new Velindre Cancer site possible.
>
> "When preparatory works commenced at the site we were prepared for the prospect of some peaceful and legal protest. Unfortunately, while the majority of people engaged in peaceful protest, a small number of people took direct action. This significantly impeded our ability to carry out our lawful work in a safe and efficient manner. Following legal advice, the Trust obtained an injunction to enable it to continue the approved works to deliver the new Velindre Cancer Centre at the earliest opportunity in a safe manner. The injunction does not remove the right to peaceful protest.
>
> "Applying for the injunction was not a step we took lightly and the bar to secure it is extremely high; demonstrating our concerns about future disruption were very real and likely. We as a Trust are disappointed that we needed to take this course of action.
>
> "However, we believe that we had very little choice given our need to ensure the safety of the public and our staff working on the site and to be able to undertake the approved works in a timely manner. Following the court's award of the injunction, the planned work has proceeded efficiently, and this will support us in delivering the project successfully and supporting cancer care in Wales."

3. NEXT MONTH

For the next month, our priorities will be as follows:

- Refresh Communications and Engagement strategy in support of the Full Business Case process

- Development of Content strategy with an emphasis on audience segmentation, platforms and a process map to rationalise our content distribution and make it more efficient/effective.
- Working to develop a consistent three-week cycle of digital stories promoting the TCS Programme.
- Refresh of the TCS and Velindre Cancer Centre public website to provide an updated and improved experience including a new FAQ section and explainer on the clinical model.
- Confirming residents' meetings with HETRA and Clos Coed Hir.
- Developing the CIVICA Engage platform to support stakeholder management, Community Panel recruitment & staff awareness poll.
- Autumn Jamboree, to include autumnal-themed arts and crafts workshops for the local community, patients and their families.

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

The Trust Board are recommended to **NOTE** the paper.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	24th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Vice-Chair and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
EW	Enabling Works
WG	Welsh Government
nVCC	New Velindre Cancer Centre
FBC	Full Business Case
SACT	Systemic Anti-Cancer Therapy

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 22nd September 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board
ADVISE	There were no items identified to Advise the Trust Board
ASSURE	**TCS Programme Finance Report** The Sub-Committee received and noted the TCS Programme Finance Report and the following key points were noted: • Due to the delay in the project, £3.4M handed back to Welsh Government which will be re-provided in 2023/24. • Final capital funding position for the enabling works project to be reported to Welsh Government by the end of October. It was reported that funds due to be re-provided from the EW project (previously provided from the nVCC project in 21/22) are not sufficient to cover the increased costs of the project, therefore discussions with WG are currently underway with regards to obtaining the required financial support from the EW project which would be expected to be paid back once the nVCC FBC is approved. Clarity was sought with regards to the reference to low financial risk, although it was agreed that this was not a significant risk, would be managed effectively within the overall envelope. **Programme Director's Report** The Sub-Committee received the Programme Director's Report. It was noted that, although Delivery Confidence Assessment currently remains as amber, the stocktake, once complete, is expected to have a positive impact on this. The Sub-Committee received a positive update on the outcome of a Welsh Government Infrastructure Investment Board meeting at which both the

	Integrated Radiotherapy Solution and Radiotherapy Satellite Centre cases were heard, noting that the decision on both cases is expected towards the end of September/early October. It is understood that support from Health Boards needs to be established and written letters of commissioner support obtained. Clarity was sought on the relationship between the development of SACT Outreach centres and the opening of the new Velindre Cancer Centre. It was discussed that further precision around levels of care required in different locations and expected timelines should be included in the next iteration of the stocktake report.
INFORM	**Communications & Engagement** The Sub-Committee received an update, noting the potential opportunities surrounding the Acorn Community Benefits package. **Hefyd+** The Sub-Committee received an overview of the Hefyd programme and noted progress of work undertaken. The Sub-Committee received a presentation of the Sustainable Summer Jamboree, nothing that this had been an extremely successful event for staff, patients and their families and the local community.
APPENDICES	None.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	24th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Vice-Chair and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
WG	Welsh Government
LHB	Local Health Board
nVCC	New Velindre Cancer Centre
IRS	Integrated Radiotherapy Solution

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 18th October 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert/Escalation to the Trust Board.
ADVISE	There were no items identified to Advise the Trust Board.
ASSURE	The Sub-Committee **received** the TCS Programme Finance Report and the following key points were noted: • It is anticipated that of the £15m remaining in the capital budget, the full amount would be utilised in 2022/2023. • In response to questions, detailed clarifications were provided in respect of the formal delegation of budgets, apparent virements between programs and financial years, and any risks associated with slippage and underspends. • It was agreed that the report be updated to include the cashflow forecast for the next six months along with a simplified, easier to scrutinise format of the complex data contained within the report. The Sub-Committee **noted** the TCS Programme Finance Report. **Programme Director's Report** The Sub-Committee received the Programme Director's Report and noted the following key points: • IRS Contract Award – although this had not been achieved by the expected date it was understood that almost all conditions (delivery of an implementation plan, approval letters from four Local Health Boards) had been met. The Trust is awaiting approval from the Minister. • Risk Register - the persistent risks (272, 2408) were highlighted, and the Sub-Committee noted that these are expected to be reduced following

	discussions at the forthcoming Extraordinary Scrutiny Sub-Committee meeting. Clarification was sought on what effect waiting for the stocktake paper was having on the progress of these works. The Sub-Committee was assured that there would be no elevation to the risk as a result of the delay in receiving the paper. The Sub-Committee **noted** the Programme Director's Report.
INFORM	**Communications & Engagement** The Sub-Committee received an update and discussed the Community Engagement Events. The Chair extended his thanks to the team involved in what can sometimes become a challenging environment. The Sub-Committee **noted** the Communications and Engagement update. **RD&I Update** The Sub-Committee received and noted the RD&I update. Noted that as the appendices had been a late distribution members would not have had sufficient time to read through and were invited to submit questions or comments as appropriate.
APPENDICES	None.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	24th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Vice-Chair and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
LIMS	Laboratory Information Management System
WHAIS	Welsh Histocompatibility & Immunogenetics Service
IMTP	Integrated Medium Term Plan
WBMDR	Welsh Bone Marrow Donor Registry

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 13th October 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS)** The Committee received the LIMS/WHAIS Business Case and the following points were discussed: • Concern was raised regarding the support for the current platform and it was explained the previous mitigation had been to deliver the software solution known as Orpheus, but the new business case implementation would address these concerns. • The statement "…an interface between the WHAIS and WBMDR solutions will be required to enable transfer of information between the two systems" was highlighted, and it was queried whether this was included in the business case and where the responsibility for this would lie. It was confirmed that it was included and it was understood that it would be an in-house solution which would be supported by the planned implementation of Prometheus. The Committee **endorsed** the Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS) for Trust Board approval.
ASSURE	The Committee received the **Integrated Medium Term Plan (IMTP) 2023-26** and attention was drawn to the ministerial priorities (para 2.13) which it was noted are due to change, guidance for which is expected in November. It was highlighted that the scheduled date for Trust Board (31st January) is the last date for submission of the IMTP to Welsh Government and concern was raised regarding the potential pressure on Independent Members to approve the document given the limited timeframe. The Committee was assured that as the three-year plan is currently in place this essentially serves as a refresh,

	therefore, aside from a few key points which require further consideration, members will already be familiar with the general content. The Committee noted the IMTP 2023-26. **Trust Assurance Framework** The Trust Assurance Framework and the accompanying dashboard were received. Some arithmetic errors was highlighted and these were noted, although the Committee was assured that the colour-coded scores for inherent, residual and target were correct. The Committee **reviewed** and **discussed** the Trust Assurance Framework. **Research, Development & Innovation Sub-Committee Highlight Report** The Committee was advised that a very positive internal audit report on RD&I had been presented to the recent Audit Committee which provided substantial reassurance. An update was provided on what was considered an extremely positive meeting with the University Status Panel on 30th September, and it was noted that the Government continue to place emphasis on embedding University status within the organisation, particularly in terms of the IMTP.
INFORM	The Committee received the **Integrated Medium Term Plan Accountability Conditions** paper which was **noted.** The Committee received the **Welsh Blood Service Infrastructure – Business Case Update,** noting that initial plans for the refurbishment were centred around ensuring resilience of the building and support of the decarbonisation agenda. It was explained that subsequently, due to several changes to the overall programme (i.e. lab modernisation, strategic potential of plasma for fractionation), an opportunity to pause and review the scope of the Business Case had been created. Contingency plans should the Business Case not receive Welsh Government approval were queried and it was explained that the plan would continue as per the currently developed plan, although this would not be sufficient in the long-term interest of the organisation. The Committee **noted** the Welsh Blood Service Infrastructure Business Case Update.

	The Committee received an update on the **Hefyd+ Community, Staff and Patient Engagement Programme** and the forthcoming planned and proposed events, which were positively received. The Committee **noted** the Hefyd+ Community, Staff and Patient Engagement Programme.
APPENDICES	None.

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	24th November 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
REPORT PURPOSE	FOR NOTING

ACRONYMS	
nVCC	New Velindre Cancer Centre
PPE	Personal Protective Equipment

1. PURPOSE

This paper has been prepared 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 10th November 2022.

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 during

October 2022, the Committee continues to mature, actively seeking opportunities for continuous improvement together with the ongoing development of reporting formats, additional assurance mechanisms and discussions to facilitate ongoing streamlining and triangulation of information.

3. HIGHLIGHT REPORT: 10th November 2022

3.1 Committee Governance

Overall Committee Governance was a theme of the meeting with the Audit Wales Quality and Governance review report, effectiveness survey, revised Terms of Reference and Cycle of Business being received and discussed. Committee members concurred that although improvements in papers had been noted over the previous year, further work is required to ensure robust and succinct assurance focussed reporting and effective tracking of improvement actions. The establishment of the new operational Integrated Quality & safety Group and the work due to commence on the implementation of the 7 levels of assurance was identified as further vehicles that would improve future meeting effectiveness. It was proposed that a further effectiveness survey and terms of reference and cycle of business review would be undertaken in March 2023 so that further refinements could be made.

In addition, following the meeting, the Committee Chair, Executive Lead and Business Support Officer reviewed the highlight report to facilitate targeted, high level reporting of items for escalation, key risks and actions undertaken / required to the Board. For Board members, who are not members of the Committee who require further detail, the agenda and papers for the November Quality, Safety & Performance Committee can be accessed at: https://velindre.nhs.wales/about-us/quality-safety-performance/

3.2 Summary of Committee Highlights

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

ALERT / ESCALATE	There are no items to alert or escalate to the Board.
ADVISE	• **Quality & Safety Framework and Quality Priorities Update** The Committee received a report detailing the current position in relation to the implementation of the Trust's Quality & Safety Framework and Quality Priorities. The Committee were advised that some delays have occurred to the completion of some of the

framework requirements but all were on track to be delivered by March 2023. The proposed revised completion dates were provided.

The 2023/24 Quality Priorities are under consideration and will be brought to the March 2023 Committee for consideration.

- **Private Patient Improvement Plan**
  The Committee received a comprehensive Private Patient Improvement paper that included a highlight report from the Private Patient Improvement Group, and an amended Private Patient Improvement Plan. The Committee were advised that there was not currently full assurance that the delivery dates were achievable as awaiting feedback from the external expertise procured to support the delivery of this work. The Committee approved the revised improvement plan with the caveat that some delivery timescales may require amending.

- **Patient Safety Alerts**
  The Committee received the highlight report from the Trust Safety Alerts Management Group. The Committee were advised that there was one safety alert (safe storage of medicines) where the Trust currently remains non-compliant (original due date for compliance 30/09/2021).

  The Committee were advised that the majority of the alert requirements had been met with and there were four areas outstanding. The implementation requirements are currently being worked through and a risk / cost analysis being undertaken considering the new hospital build. This work will be completed by December 2022. The four specific areas of non-compliance were related to medicines storage were:

  - Further roll out of DigiTRAC.
  - Air conditioning.
  - Improved lighting.
  - Appropriate locks.

- **Trust Risk Report**
  The Committee received the current extract of risk registers, outlining the current risks scoring 15 and above. The Committee were advised that further work is being undertaken within Velindre Cancer Service in respect of its risk profile, ensuring clearer

	presentation of risks, actions, ownership, mitigations and risk reduction timescales. • **Financial Report** The Committee received the financial report, outlining the financial position for the period to the end of September 2022. The rapidly changing position in terms of finance risks was discussed. It was noted that despite a projected year-end position of break even, key risks remain in terms of costs of additional capacity required to meet planned services and COVID backlog, additional cleaning requirements and PPE costs. • **Audit Wales Review of Quality Governance Arrangements – Management Response** The Committee received the Audit Wales review of Quality Governance Arrangements that concluded in June 2022 and the management response.The Committee was advised that although significant progress has been made in relation to improvements to Trust Quality Governance arrangements further work was required as detailed in the recommendations. The Trust welcomed the review and its findings and had accepted all recommendations. A further review of the effectiveness of the new arrangements that are currently being put in place including the Quality Hubs and Integrated Quality & Safety Group will be undertaken in early 2023 / 24 by Internal Audit.
ASSURE	• **Donor Story** The Committee received an uplifting donor story by means of a video relating to the re-commencement of blood collections within a secondary school as such collections had ceased during the pandemic: (https://youtu.be/ojSy_0WZgXw) The Committee commended the passion and commitment of the team in relation to the rollout of the schools' education programmes and identifying methods of wider recruitment of bone marrow donors during difficult times. The Welsh Blood Service is now undertaking further work in relation to how the service can better reach out to ethnic minorities and hard to reach communities.

	• **Trust Estates Assurance Report** The Committee RECEIVED the Estates Assurance report which included the Annual Fire report which succinctly provided assurance to the Committee in relation to assurance mechanisms and outcomes in relation to required standards and regulations.
INFORM	• **Duties of Quality and Candour Report** The Duties of Quality & Candour report provided the Committee with an overview of the development of the national statutory guidance and regulations, the outcome of a gap analysis in respect of the Duty of Candour regulations and a draft implementation plan, that includes the establishment of a Trust implementation Group. As the Duty of Quality statutory guidance consultation document had only recently been published, the gap analysis against this will be provided at the next Committee. It was noted that both a Regulatory and an Equality Impact Assessment are required for both Duties prior to implementation. This is currently being undertaken at a National level, and this will support the local Trust assessments. **Additional items discussed at the November Committee:** • IMTP Quarterly Actions Progress. • Workforce & Organisational Development Performance Report / Financial Report. • TCS Programme Finance Report. • Workforce Report. • Welsh Blood Service Quality, Safety & Performance Divisional Report. • Velindre Cancer Service Performance Report. • Putting Things Right Report – Quarter 2. • Annual Estates Report. • Health Inspectorate Wales Inspection Report and Improvement Plans. • Highlight Report from the Safeguarding & Vulnerable Adults Group. • Highlight Report from the Medicines Management Group. • Quality Safety & Performance Committee Policy Compliance Report. The agenda and papers for the November Quality, Safety & Performance Committee (including minutes from the September Committee), once available, can be accessed at: https://velindre.nhs.wales/about-us/quality-safety-performance/

APPENDICES	N/A

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 10th November 2022.

TRUST BOARD

AUDIT COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Gareth Jones, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
~	~

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 04 October 2022.

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 meeting of the Audit Committee held on the 04 October 2022:

ALERT / ESCALATE	There was nothing to be escalated.
ADVISE	**GOVERNANCE OF THE TRACKER** **Full Audit Action Tracker Review of Recommendations from Internal & External Audit** The AUDIT Committee **NOTED**: • Twice a year the Audit Committee will be reviewing not just Green and Red status actions but also Yellow and Orange status actions. **Internal Audit Reports**: • Since July 2022 further Internal Audit Reports added to tracker, consisting of 12 recommendations, 5 high, 4 medium 3 low, resulting in 12 actions. • Since July 21 Green, 15 Red, 17 Amber and 11 Yellow status actions. • 64 actions remain outstanding. **External Audit Reports:** • 17 further actions completed since July 2022 Committee. • 29 outstanding actions. • 3 reports added since July 2022 Committee, 2 of which are not new reports and ones that weren't sighted in the tracker, now added for completeness. **The AUDIT Committee:** • **NOTED** the contents of the report and the assurance it provides regarding the activities undertaken to address audit report recommendations and associated risks. • **APPROVED** the 21 Internal Audit report actions and 17 External Audit report actions since the July 2022 Audit Committee that have been completed (Green Status). The Committee also APPROVED those recommendations that could be formally Closed (Blue Status). • Was not prepared to approve extensions on the actions that have passed their agreed implementation date (Red Status), until more specific dates and formal requests for extension are provided for consideration. • Decided it was not the role of the Audit Committee to decide what action should be taken for actions not on target for completion (Orange Status) as this was an operational matter for Executives. Requested realistic extension dates for these actions be provided for consideration out of Committee. • **NOTED** the actions that are on target for completion (Yellow Status). **AUDIT POSITION UPDATE** Audit Wales confirmed the Audit of the Charity Accounts will commence the beginning of December 2022.
ASSURE	**TRUST RISK REGISTER** The Audit Committee **NOTED**: • The paper has been scrutinised in Quality, Safety and Performance Committee around Digital Health and Care Record Risks.

	Framework Development – • The various framework documents, the procedure, the risk appetite strategy, and the Trust Assurance Framework which has been circulated to members, considered and approved by the Trust Board September 2022 and that it is being published on the Intranet. • Level 3 training for Leadership is complete and Level 2 doing final mop up sessions for those who haven't had this training yet and the ESR module is due to roll out as soon as the Level 2 training is complete. • Welsh Blood Service have completed all migration onto Datix 14 of their Board level reportable risks and are now going through a phased transition of the remainder and all new risks are being loaded on to Datix 14. • The ongoing development of the Trust's risk framework.
INFORM	**INTERNAL AUDIT REPORTS** The Committee received the following internal audit reports: • Staff Wellbeing (Advisory) • Financial & Service Sustainability • Research & Development • Enabling Works Integrated Audit Plan 2021/22 ○ New Velindre Cancer Centre Enabling Works – Final Report **OTHER BUSINESS:** The Committee also received written or verbal reports under the following agenda items: • 2022/23 Internal Audit Progress Update Report • Public Sector Readiness for Net Zero Carbon by 2030 • Public Sector Readiness for Net Zero Carbon by 2030: Evidence Report • Counter Fraud Progress Report Quarter 2 • Procurement Compliance Report • Private Patient Service Debt Position • Losses and Special Payments Report
APPENDICES	**NONE**

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE Private Remuneration Committee

DATE OF MEETING	24th November 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Carol Meredith, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE
EXECUTIVE SPONSOR APPROVED	Professor Donna Mead OBE
REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Private Remuneration Committee on 22nd September 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to note
ADVISE	Nothing to note
ASSURE	Nothing to note
INFORM	**National Pay Awards** Details of National Pay Awards to be applied to staff paid under Agenda for Change, Doctors and Dentists and Executive and Senior Managers terms and conditions were received. **Salary Changes within NWSSP** Details of changes to salaries paid within NWSSP were noted. **Anonymous Communications** The Committee received details of an anonymous communication that had been received by the Trust and resulting management action.
APPENDICES	None

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE Private Remuneration Committee

DATE OF MEETING	24th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carol Meredith, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE
EXECUTIVE SPONSOR APPROVED	Professor Donna Mead OBE

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Private Remuneration Committee on 25th October 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to Alert/Escalate
ADVISE	Nothing to Advise
ASSURE	Nothing to Assure
INFORM	**Anonymous Communications** Anonymous Communication was noted by the Committee and has been dealt with. **Settlement Agreement** A proposed Settlement Agreement was APPROVED by the Committee.
APPENDICES	None

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 8 NOVEMBER 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 8 November 2022. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings
The minutes of the meeting held on the 6 September 2022 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising
Members **noted** the progress on the actions outlined on the action log.

3. Draft Integrated Commissioning Plan (ICP) 2023-2026
Members received an informative presentation on the draft Integrated Commissioning Plan (ICP) 2023-2026.

Members discussed the financial elements of the plan and noted the constrained economic environment, recovery challenges and the volatile inflationary pressures. Members noted that the draft ICP was brought to Joint Committee early on in the planning process in order to support Health Boards (HBs) in developing their own Integrated Medium Term Plans (IMTPs), and that WHSSC will work closely with HBs to develop the ICP in line with HB expectations.

Members **noted** the presentation and that the final plan will be considered at the next meeting 17 January 2023.

4. Recovery Update (incl Progress with Paediatric Surgery)
Members received a presentation providing an update on recovery trajectories since the workshops held with the Joint Committee on the 12 July and 6 September 2022.

Member noted updates on recovery trajectories for paediatric surgery recovery and recovery in key speciality areas including for the six accountability conditions specialities – cardiac, neurosurgery, paediatric surgery, bariatrics, thoracics and plastics.

Members **noted** the presentation and that a further recovery update will be provided at the next meeting 17 January 2023.

5. Chair's Report

Members received the Chair's Report and **noted**:

- The recommendation to appoint two new WHSSC Independent Members (IMs) following a fair and open selection process,
- The recommendation to extend the tenure of the of the Interim Chair of the All Wales Individual Patient Funding Request (IPFR) Panel until 31 March 2023,
- Attendance at the Integrated Governance Committee 11 October 2022; and
- Key meetings attended.

Members (1) **Noted** the report, (2) **Approved** the recommendations to appoint two new WHSSC Independent Members (IMs) from 1 December 2022 for a period of 2 years; and (3) **Approved** the recommendation to extend the tenure of the Interim Chair for the Individual Patient Funding Request (IPFR) panel until 31 March 2023.

6. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates on:

- **Paediatric Radiology Consultant Recruitment** - units in NHS England (NHSE) had agreed to host NHS Wales funded paediatric radiology training posts for trainees on the Wales Radiology Training Programme. HEIW are taking this forward,
- **Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service** – **Engagement Process Update** – Further to the HBs agreeing the approach for engagement at their Board meetings in September 2022, it was planned that the engagement process would commence on 24 October 2022, however this had unfortunately been delayed and the engagement will now commence in November,
- **Evaluation of 4th Thoracic Surgeon activity -** WHSSC supporting the appointment of a 4th consultant surgeon post in CVUHB to provide continued support for the Major Trauma Centre (MTC) and to support the future needs of the service; and
- **Briefing Duty of Candour and Duty of Quality –** WHSSC received a briefing from Welsh Government (WG) on the Health & Social Care (Quality & Engagement) (Wales) Act 2022 with a specific focus on the consultation process for the duty of candour and the soon to be launched consultation process on the duty of quality.

Members **noted** the report.

7. Delivering Thrombectomy Capacity in South Wales

Members received a report outlining WHSSC's position on the commissioning of Mechanical Thrombectomy for the population of Wales.

Members noted the proposed plan for a Mechanical Thrombectomy service at the Neurosciences centre, CVUHB and that WHSSC continued to work with CVUHB to progress the Business Case to develop a Mechanical Thrombectomy centre in south Wales and the financial model had been shared and was being worked through. It was proposed that the service would be implemented in a phased approach over a number of years.

Members (1) **Noted** the report, (2) **Noted** the WHSSC Position Statement on the Commissioning of Mechanical Thrombectomy and **requested** that a revised report be brought back to the Joint Committee to include additional detail on the networked approach, interdependencies around the network approach and to include additional elements concerning the stroke pathway, (3) **Noted** the associated risks with the current delivery model for Welsh stroke patients requiring access to tertiary Thrombectomy centres; and (4) **Noted** the NHS Wales Health Collaborative (NWHC) proposal to strengthen and improve regional clinical stroke pathways in Wales to support the Mechanical Thrombectomy pathway to ensure that patients receive this time-critical procedure in a timely manner.

8. Mental Health Strategy Development

Members received a report advising the Joint Committee of the stakeholder feedback received from the engagement exercise for the Specialised Services Strategy for Mental Health and outline the next steps and proposals to move into implementation of the strategy from April 2023.

Members discussed the need for the demand and capacity work to inform the final version of the strategy and to ensure that it is focussed on delivering sustainable services which offer value for money.

Members (1) **Noted** the stakeholder feedback received from the 12-week engagement exercise on the draft Specialist Mental Health Strategy; and (2) **Agreed** the proposals to:

- Undertake an 8 week consultation process using the draft consultation document,
- Commission demand and capacity modelling with immediate effect; and
- Develop a programme approach to implementation of the Strategy following the consultation exercise; and

(3) **Noted** that the final version of the strategy and the timescales for implementation will need to take into account the demand and capacity modelling.

9. Single Commissioner for Secure Mental Health Services Proposal

Members received a report presenting the options for a single national organisation to commission integrated secure mental health services for Wales for HBs to consider. The report had been prepared following a request received from WG for the WHSSC Joint Committee to provide the mechanism for the recommendation from the "Making Days Count" review to be considered, and for the Joint Committee to make a recommendation to WG on the preferred option.

Members discussed the report and agreed to share the report with HB colleagues and for a response to the options appraisal to be sent to WHSSC by the end of December 2022 in readiness for the Joint Committee meeting 17 January 2023.

Members (1) **Noted** the report, (2) **Considered** the options for a single national organisation to commission integrated Secure Mental Health Services for Wales; and (3) **Agreed** to share the report with HB colleagues and for a response to the options appraisal to be sent to WHSSC by the end of December 2022; and (4) **Noted** that the proposal will return to the Joint Committee for decision on 17 January 2023.

10. Gender Identity Development Service (GIDS)

Members received a report updating members about the Gender Identity Development Service (GIDS) for Children and Young People including what the changes mean for children and young people in Wales and next steps.

Members (1) **Noted** the information presented within the report; and (2) **Noted** the information presented at Appendix 1 regarding the decommissioning of the Tavistock and Portman NHS Foundation Trust (TPNFT) and the NHS England (NHSE) transformation programme.

11. Individual Patient Funding Requests (IPFR) Engagement Update

Members received a report seeking support for the proposed engagement process for the WHSSC Individual Patient Funding Request (IPFR) panel Terms of Reference (ToR) and the specific and limited review of the all Wales IPFR policy.

Members noted that the engagement process would commence on the 10 November 2022 for a 6 week period with key stakeholders, including the All Wales Therapeutics and Toxicology Centre (AWTTC), the IPFR Quality Assurance Advisory Group (QAG), the Medical Directors and the Board Secretaries of each of the HBs and Velindre University NHS Trust (VUNT).

Members noted that the process adhered to the specific request from WG for the engagement for the IPFR panel ToR and the specific and limited review of the All Wales IPFR Policy.

Members (1) **Noted** the report; and (2) **Supported** the proposed process for engagement for the WHSSC Individual Patient Funding Request (IPFR) panel Terms of Reference (ToR) and the specific and limited review of the all Wales IPFR policy.

12. COVID-19 Period Activity Report for Month 5 2022-2023 COVID-19 Period

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity.

Members **noted** the report.

13. Financial Performance Report – Month 6 2022-2023

Members received the financial performance report setting out the financial position for WHSSC for month 6 2022-2023. The financial position was reported against the 2022-2023 baselines following approval of the 202-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The financial position reported at Month 6 for WHSSC is a year-end outturn forecast under spend of £13,711k.

Members **noted** the current financial position and forecast year-end position.

14. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

15. Other reports

Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Management Group (MG),
- Quality & Patient Safety Committee (QPSC),
- Integrated Governance Committee (IGC),
- All Wales Individual Patient Funding Request (IPFR) Panel

16. Any Other Business

- **Skin Camouflage Pilot Service** – members noted that on 28 October 2022 WHSSC received a formal request from WG following agreement at the NHS Wales Leadership Board (NWLB) for WHSSC to commission the national skin camouflage pilot service. This service will support the national commitment to "Pledge to be Seen". A further formal update will be provide at the next meeting,
- **CMTUHB Audit Lead Independent Member (IM)** – on behalf of the Joint Committee the Chair formally thanked Ian Wells, IM

CTMUHB for all of his support since he was appointed as CTMUHB audit lead for WHSSC eighteen months ago. The Chair advised that he had been an invaluable member of the team and that WHSSC were extremely grateful to him for his commitment of time and effort, which was especially notable given his normal HB responsibilities; and

- **Retirement of CEO BCUHB** – The Chair acknowledged what would have been Joe Whitehead's last meeting with the Joint Committee, and on behalf of the Joint Committee offered thanks for her time and commitment to the Joint Committee's business and wished her well in her retirement.

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	22 September 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising – Recruitment

G Hardacre, Director of People, Organisational Development and Employment Services, gave a verbal update on the position with the pre-employment checks software system.

The Home Office have announced that from 1st October 2022 organisations will be able to use a certified Identification Document Verification Technology service provider to carry out digital identity checks on their behalf for those appointees who have an in-date UK or Irish Passport or Share Code. Those who do not meet these criteria will still require a face-to-face pre-employment check from 1st October 2022. Without this system, all appointees would require a face-to-face pre-employment check meeting.

NWSSP Recruitment Services have procured a service provider to enable digital identity checks for NHS Wales as part of the Recruitment Modernisation Programme, which will be implemented on 28th September 2022. This will improve the experience for appointees and also provide process efficiencies for NWSSP Recruitment Service and internal Health Board/Trust recruitment services such as Medical and Bank Recruitment, as most appointees will be able to complete their pre-employment checks via this route. NWSSP have agreed to fund this software for the first year for all organisations due to the benefits this will bring to NHS Wales.

The Committee **NOTED** the update.

Matters Arising – Programme Management Office Highlight Report (Student Awards).

G Hardacre provided members with an update on the replacement of the Student Awards system which had been noted at the May Committee as a red risk within the Programme Management Office Report. He reported that good progress was

now being made with the new system having received confirmation of funding from Welsh Government and the conclusion of the procurement process he now expected the new system to be in place and fully operational by April 2023.

The Committee **NOTED** the update.

Deep Dive – Energy Price Risk Management Group

Eifion Williams (EW), Chair of the Energy Price Risk Management Group (EPRMG), introduced a deep dive into the work of the Group, particularly focusing on recent weeks and months, due to the significant increase in energy prices.

EW has chaired the EPRMG since it was set up in 2005. Prior to that electricity and gas was purchased on behalf of NHS Wales by an individual Procurement Officer who would purchase for the year ahead with little strategic input. The Group was established with representation from all NHS Wales organisations together with a British Gas market specialist who provides an overview of the energy market at each meeting. Based on this, the Group considers its pricing strategy. Currently British Gas provide both electricity and gas to NHS Wales and there is an ability to purchase energy on a monthly or quarterly basis. The Group currently meets on a weekly basis to consider its purchasing strategy but in times of extreme volatility (e.g. when Russia first invaded Ukraine) it has met three times a week. Prices are monitored daily which enables tranches of volumes of energy to be secured when appropriate.

EW demonstrated the current volatility in the market through a comparison of prices in the month of August for the last five years. Between 2018 and 2021 inclusive, the price being paid for gas by NHS Wales in each August was in the range of 39p to 44p a therm. In August 2022, the price per therm was 281p. The same comparison for electricity saw a range of £40 to £47 per megawatt hour between 2018 and 2021 and the price in August 2022 was £218. The price had been falling prior to the Ukraine conflict, and is also affected by the weather, the world economy outlook, and the price of oil. Although the price of energy is totally unpredictable, the forward purchasing strategy adopted by the EPRMG delivered savings of £33.8m for NHS Wales against the actual average daily cost of gas and electricity in 2021/22. It is also important to note that the prices quoted are the global prices on the energy markets which all suppliers use.

The current contracts with British Gas are due to end in March 2025 for electricity and March 2027 for gas. British Gas has given notice that it will not seek new Commercial energy contracts but will fully support existing contracts. Whilst the EPRMG has served NHS Wales well, there was a need to consider whether the current approach remains the best option for NHS Wales given the volatility in the energy market. Liaison is currently taking place with Crown Commercial Services to assess the options that they have available. It was agreed that EW would come back to the Committee later in the year to provide an update on progress.

The Committee **NOTED** the presentation.

Chair's Report

The main update was on the planned IMTP / Committee development sessions, where invites have been issued for Friday 11th November. The Chair stressed the importance of attending and that if members cannot make this date that they nominate another Executive Director to attend in their place.

The NWSSP Senior Leadership Group held a number of internal workshops to provide some initial reflections and ideas for the sessions. The indicative agenda will focus on where NWSSP will be in 2033, assessing where we feel NWSSP is now, identifying opportunities to improve and develop further, and taking a fresh look at our strategic objectives and overarching goals/outcomes. There will also be some discussion on our appetite for risk as a Committee.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The CEO NHS Wales / DG Health and Social Care Group WG wrote in July confirming acceptance of NWSSP IMTP recognising the continued development and maturing of integrated planning across NWSSP and demonstrating the positive position that the organisation is in as we move from the pandemic towards recovery. The letter highlights the continued role of the Committee to scrutinise and monitor progress against the plan throughout the year;
- As part of the decarbonisation work the NWSSP Head of Operations – Procurement Services, is currently working with Health Boards, Trusts, and Special Health Authorities, in reviewing fleet management arrangements with the purpose of defining a common set of data standards and management information to support the decarbonisation agenda. Specialist Estates Service is also supporting Health Boards in establishing a national infrastructure plan for electric vehicle charging. Health Boards have been approached to nominate representatives to sit on the various decarbonisation sub-groups that support the above agendas;
- The Payroll team within Employment Services are currently experiencing an exceptionally busy period responding to the implications of the recent pay rise and processing of pay arrears. This is in addition to implementing the changes to the pension tiers.
- The NWSSP Medical Director, has been asked to work with health organisations to review how the Single Lead Employer rotational and recruitment processes can be further streamlined to improve overall experiences for the trainees; and
- In terms of major projects, the Laundry and TrAMs projects are continuing but in the context of extreme limitations on available capital funding. In particular NWSSP were waiting for formal feedback from WG on the laundry OBC scrutiny panel.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Chair's Appraisal Process

G Hardacre, NWSSP Director of People, Organisational Development and Employment Services introduced a report setting out a proposed revised formal framework process for the appraisal of the Chair.

Following discussion, the Committee **APPROVED** the revised framework which will be implemented during the next few months and **AGREED** to increase the Chair's time commitment given the requirements of the role. Committee members asked to review the various time commitments of the other Chairs at other NHS organisations at the next November meeting.

Procurement SLA

The Chair reminded Committee members that the Service Level Agreements for 2022/23 had already been agreed at the May meeting. However, it was previously agreed that the Procurement element of the SLA would be brought back for approval as it was important to reflect the recent changes which were as a direct result of implementation of the new procurement Operating Model.

The Committee **APPROVED** the Procurement SLA element.

Provision of Digital Patient Pathways and Remote Advice and Guidance

A Butler, Director of Finance & Corporate Services introduced a number of reports which outlined the procurement for two separate contracts for which funding had already been secured and agreed by Welsh Government. Given the nature of the clinical digital elements of the contracts it was felt important to ensure that DHCW were clear on how they linked into the current strategy and processes.

Following discussion the Committee **NOTED** the reports and **ENDORSED** both contracts. Further discussions would be needed with DHCW to ensure the digital elements were aligned to the national strategies.

Welsh Risk Pool – Risk Sharing Agreement

The Committee received a paper setting out the risk sharing details for the current financial year. Committee members were informed that the proposal within the paper had been endorsed at the Welsh Risk Pool Committee on the 21st September 2022.

The Welsh Risk Pool receives an annual funding stream to meet in-year costs associated with settled claims, the Departmental Expenditure Limit (DEL). When expenditure rises above the DEL allocation, the excess is recouped from Health Boards and Trusts via a Risk Sharing Agreement approved by the Shared Services Partnership Committee. The core DEL allocation is currently £109.435M per

annum for Clinical Negligence, Personal Injury and Redress claims. The 2022/23 IMTP DEL forecast is £134.780M and therefore the estimated Risk Share charge for 2022/23 is £25.345M. In 2021/22 this figure was £16.495m.

The current Risk Share methodology was approved by the Welsh Risk Pool Committee and Directors of Finance in March 2017. The overarching principles are set out below:

- a risk-based contribution, based on size and activity levels;
- a contribution based on paid claims experience over five years; and
- a contribution based on known outstanding claims.

These principles have been translated into five specific measures and a weighting applied to each. This results in those organisations that can demonstrate learning and who have implemented strategies to lower risk weightings benefitting as their share of the overall total should be lower.

Applying these measures to the forecast risk share for the current year has meant that although some Health Boards percentage share has reduced compared to last year, the expected 2022/23 monetary charge has increased for all, due to the substantial overall increase in the total charge to be apportioned.

The Committee **NOTED** the report and **APPROVED** the updated Risk Share charges to NHS Wales for 2022/23.

Items for Noting

All-Wales Agency Audit

The Committee received a paper on audit arrangements for agencies supplying nursing staff.

The Temporary Staffing Group is a workstream which reports directly to the National Nursing Workforce Group (NNWG). The Temporary Staffing Group is responsible for the award and monitoring of contracts for agency workers throughout Wales. The contract was awarded in March 2021 for a period of three years with an option to extend for a further year to February 2025. There are 146 agencies on contract and each agency is aware that failure to abide by the contract specification would result in their removal from the framework.

Implementing appropriate audit measures is essential to ensure that all contracted agencies supplying nurses and health care support staff to NHS Wales uphold the conditions of the contract. Agency audits have typically been undertaken internally on an ad-hoc basis when issues arose rather than via a proactive approach linked to a planned audit programme. Following discussions at the Temporary Staffing Group it was agreed that a robust audit programme should be put in place and that various options to achieve this should be explored, including the use of external audit firms and the potential use of NWSSP Audit & Assurance Services.

The Committee **NOTED** the Report and **AGREED** for NWSSP's Audit and Assurance team to carry out the necessary audits providing an audit specification (All-Wales Agency Audit Checklist) was developed and utilised. A risk-based programme of audits will be undertaken focussing initially on the highest spend and highest usage providers. Usage data will be used to agree a priority list of agencies to be audited. It is anticipated that:

- 30 audits will be carried out per year;
- Audit plans will be annually set out based on provider usage and spend; and
- The audit plan will be discussed and created annually by the Temporary Staffing Group led by procurement.

Based on 30 audits in the first year (2022/23), the total auditor time required would be 60 days at a cost of £19,870. This amounts to less than £3k per Health Board.

Finance, Performance, People, Programme and Governance Updates

Finance – A Butler, NWSSP Director of Finance and Corporate Services reported a balance position at Month 5. The year-to-date position includes a number of non-recurrent savings that will not continue at the same level during the remaining months of the financial year. Divisions are currently reviewing budgets with a view to accelerating initiatives to generate further benefits to NHS Wales and a potential increase in the distribution. The forecast outturn remains at break-even with the assumption of £4.985m of exceptional pressures funding being allocated from Welsh Government.

The current Capital Expenditure Limit for 2022/23 is £1.947m. Funding for the Welsh Healthcare Student Hub (Student Bursary and Streamlining) was approved in early September. Capital expenditure to Month 5 is £0.366m and plans are in place to fully utilise all available capital funding. A priority list of capital projects is being finalised in case additional funding becomes available later in the year. Since the transfer of the All-Wales Laundry Service in 2021/22 there is increased pressure on the discretionary capital allocation as this was not increased following the transfer of the new Service.

The Committee **NOTED** the Report.

Performance – The Committee Members reviewed the KPIs and felt that this was a positive position with only six KPIs not meeting target. These in the main related to the recruitment position and call handling within the Payroll Helpdesk. Committee members were asked to advise their organisations that prior notice of local recruitment plans is very helpful in that it enables NWSSP to adapt demand and capacity within teams to meet those peaks in demand. There was also a short-term issue with Payroll call handling in August because of increases in activity driven by the new Doctor intake and rotation, and this was not helped by the loss of the phone system for a few hours. Peaks in demand are also anticipated in September because of the payment of pay award arrears and again

in October because of the pension changes. The Quarter Two individual Performance Reports will be issued at the end of October.

The Committee **NOTED** the Report.

Project Management Office Update – The Committee Members noted the report and in particular the ongoing supplier dispute with regard to the Legal & Risk Case Management system replacement which had temporarily halted the implementation. Contingency arrangements have been put in place to ensure that there is no risk to the continuity of services. A question was raised as to whether projects not covered by the PMO (e.g. the Once for Wales Concerns Management System) should be included in the report. This will be included going forward. It was also suggested that a separate and more detailed briefing on the TrAMs programme would be helpful – this will be issued in December.

The Committee **NOTED** the Report.

People & OD Update – The Committee **NOTED** the Report.

Corporate Risk Register – The Committee **NOTED** the Report. In particular members discussed the risk relating to the threat of industrial action had been added to the register.

Papers for Information

The following items were provided for information only:

- Disposal of Surplus Beds to Moldova;
- Audit Committee Assurance Report;
- Welsh Risk Pool Annual Report 2021/22
- Finance Monitoring Returns (Months 4 and 5)

AOB

N/a

Matters requiring Board/Committee level consideration and/or approval

- The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.

Matters referred to other Committees

N/A

Date of next meeting	19 January 2023

TRUST BOARD

COVID 19 INQUIRY (PREP GROUP)

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Modupe Akinrinade, Executive Support Administrator
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THE MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26.10.2022	Noted
Quality, Safety & Performance Committee	10.11.2022	Noted

PURPOSE

This paper has been prepared to provide the Quality, Safety and Performance Committee with details of the key discussions held and issues considered by the COVID 19 Inquiry Preparation Group during their meeting held on 21st October 2022.

BACKGROUND

The Trust's COVID 19 Inquiry Preparation Group is chaired by the Director of Corporate Governance and Chief of Staff and is attended by key personnel from Corporate and both Divisions. The Group has been established to support the preparation of the Trust to respond to the Inquiry once it is established. The Group reports to the Executive Management Board.

The Group has now been formally established and meets monthly, the frequency of which will be reviewed as matters progress with the Inquiry.

The following are the highlights from the COVID 19 Preparation Group meeting held on 21st October 2022.

ALERT/ESCALATE	No items to escalate
ADVISE	**Terms of Reference** The Group has updated the Terms of Reference in line with the developments in the Inquiry – Attached. **Core Participant Status** There will be a decision before end of calendar year on the Trust's position on whether to apply for Core Participant Status of Module 3 of the Inquiry. It has been agreed with the Chair and Acting CEO that this will be a Trust Board decision. **Leavers** It has been established that in some cases, staff leaving the organization may take information with them to their new organisation within NHS Wales. The DHCW is developing some measures to ensure the protection of the integrity of all data, to ensure that all NHS organisations will have access to their own data should there be any request for it
ASSURE	**Legal and Risk** Solicitors from Legal and Risk are represented in the group providing guidance and legal support. Counsel has also been instructed
INFORM	**Archivist** An Archivist has been appointed and is working with the Head of Information Governance and this Group to progress the workplan of the Records Management and the Timeline workstream. **Staff Communication** The activities of the Group will be updated in the Trust Newsletter. The Group agreed key messages.

APPENDICES	Appendix 1: UK COVID-19 Inquiry Prep Group Terms of Reference

RECOMMENDATIONS

The Trust Board is asked to **NOTE** the key deliberations and highlights from the meeting of the COVID 19 Prep Inquiry Group meeting.

Covid-19 Inquiry Preparation Group

Terms of Reference

1. Framework

The Covid-19 Public Inquiry will operate under the Inquires Act 2005. Key aspects of the Inquires Act include:

- The aim is to help restore public confidence in systems or services by investigating the facts and making recommendations to prevent recurrence.
- Can compel evidence to be provided, both documents and witnesses.
- No power to determine civil or criminal liability.
- Inquiries' findings do not have legal effect.
- However responsibility may be inferred from a determination of a fact

2. Principles

The Group will coordinate the Trust Board engagement in, and possible refreshed commitment, in this context (previously signing up to in relation to Infected Blood Inquiry in 2018) the Charter for Families Bereaved through Public Tragedy.

The Group will have an approach based on empathy for all those involved and will strive to ensure positive actions as a result of this preparation work at all times, whether in learning from any lessons or supporting ensuring the continuation of improved ways of working for our staff, patients, donors and all other stakeholders.

3. Objectives

The Group's objectives are aligned to two core initial workstreams: 1. Record Retention and 2. Timeline. The objectives are aligned to All Wales guidance documents provided by NWSSP Legal and Risk team.

1. Record Retention Workstream

- To ensure a strategic oversight of the archiving, cataloguing and records management process across the Trust as a whole, in order to:
  - Prepare the necessary evidence for a future Public Inquiry in relation to the Covid-19 pandemic
  - Preserve relevant information
  - Ensure there is a robust, secure document management system with adequate storage
  - Archive documents, evidence, complaints, decisions and testimonies in an orderly format that is easy to search, locate and export, including recordings, digital and paper evidence

- Provide a systematic audit trail of the pandemic response

- To consider and recommend the necessary archiving during the recovery phase of the pandemic; immediate, medium and long term recovery

- To review and agree appropriate retention periods for documents, in line with Trust Policy

2. Timeline Workstream

- To prepare organograms of organisational changes and Trust Policies in place at the time, as well as relevant interaction with third parties

- To identify partner bodies and organisations which impacted on the Trust's pandemic response and to liaise with these to ensure joint documents are archived and catalogued

- To identify groups set up with partner bodies and organisations, membership of those groups and, to prepare charts setting out the organisations the groups reported to and which reported into them

- To coordinate decision making and effective use of resources in terms of Public Inquiry readiness

3. Other Objectives

- To identify senior members of staff who can provide evidence in respect of decisions made, if gaps are identified in the documentary evidence

- To provide guidance to staff on the ongoing process for managing information in relation to the pandemic

- To seek legal and other independent guidance, as necessary, during the preparatory stages

- To consider expenditure requirements

- To engage with other NHS bodies on an All Wales basis to share practices and learning

- To consider the identifying, obtaining and provision of additional support, if required, such as for staff members who may be required to provide witness evidence

4. Scope

From an initial review of the possible areas that may be covered as part of the Inquiry's terms of reference, those relevant to the Trust are:

- Pandemic preparation
- Clinical decision making – including immediate and longer term impacts – at patient/donor and system level
- PPE provision – staff, patients, donors
- Interaction with other public section bodies
- Discharge to other healthcare settings
- Disproportionate impact on Black and ethnic minority communities
- Nosocomial infections
- Testing processes
- Care provided to patients with Covid-19 in hospital
- Stepping down and up of other healthcare services
- Vaccination roll out
- Support given to staff
- Staff management – including Covid-19 status of staff/ families/ contacts
- How Government Directives and guidance was implemented
- Key specific accountabilities – e.g. convalescent plasma trial

5. Membership

- Lauren Fear, Director Corporate Governance & Chief of Staff – Chair
- Lisa Miller, Head of Operational Services and Delivery VCC
- Sarah Richards, General Services Manager WBS
- Nigel Downes, Deputy Director of Nursing, Quality and Patient Experience
- Annie Evans, Clinical Transformation Lead
- Helen Jones, Health & Safety Manager
- Susan Thomas, Deputy Director Workforce and Organisational Development
- David Mason-Hawes, Head of Digital Services
- David Osborne, Head of Business Partnering

- Laurie Thomas - Trust business continuity lead
- Ian Bevan – Head of Information Governance
- Covid-19 Inquiry Archivist
- Caldicott Guardian and Divisional Leads, as required (standing meeting invite)
- NWSSP Legal and Risk Legal Support Leads, as required (standing meeting invite)
- Modupe Akinrinade - Executive Support Administrator

6. Decision Making

The Group does not have a formal delegation of decision making authority and any formal decision making will be managed through the Business Continity, Divisional and Executive level governance arrangements as appropriate.

7. Reporting Arrangements

- The Group will report a highlight report into:
    - Executive Management Board
    - Trust Business Continuity Group.
- In addition, there will be reporting into Divisional SLT/SMT.
- Divisional level coordination will be via Divisional Leads.

8. Meeting Arrangements

The Group will meet monthly initially and frequency will be adapted accordinaing the the stage of the inquiry process.

9. Appendicies

APPENDIX 1 - CHARTER FOR FAMILIES BEREAVED THROUGH PUBLIC TRAGEDY *(Below)*

APPENDIX 2 – COVID-19 INQUIRY TERMS OF REFERENCE *(Attached)*

APPENDIX 1

CHARTER FOR FAMILIES BEREAVED THROUGH PUBLIC TRAGEDY

1. In the event of a public tragedy, activate its emergency plan and deploy its resources to rescue victims, to support the bereaved and to protect the vulnerable.

2. Place the public interest above our own reputation.

3. Approach forms of public scrutiny – including public inquiries and inquests – with candour, in an open, honest and transparent way, making full disclosure of relevant documents, material and facts. Our objective is to assist the search for the truth. We accept that we should learn from the findings of external scrutiny and from past mistakes.

4. Avoid seeking to defend the indefensible or to dismiss or disparage those who may have suffered where we have fallen short.

5. Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely.

6. Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media.

Covid-19 Inquiry Terms of Reference

The Inquiry will examine, consider and report on preparations and the response to the pandemic in England, Wales, Scotland and Northern Ireland, up to and including the Inquiry's formal setting-up date, 28 June 2022.

In carrying out its work, the Inquiry will consider reserved and devolved matters across the United Kingdom, as necessary, but will seek to minimise duplication of investigation, evidence gathering and reporting with any other public inquiry established by the devolved governments. To achieve this, the Inquiry will set out publicly how it intends to minimise duplication, and will liaise with any such inquiry before it investigates any matter which is also within that inquiry's scope.

In meeting its aims, the Inquiry will:

a) consider any disparities evident in the impact of the pandemic on different categories of people, including, but not limited to, those relating to protected characteristics under the Equality Act 2010 and equality categories under the Northern Ireland Act 1998;

b) listen to and consider carefully the experiences of bereaved families and others who have suffered hardship or loss as a result of the pandemic. Although the Inquiry will not consider in detail individual cases of harm or death, listening to these accounts will inform its understanding of the impact of the pandemic and the response, and of the lessons to be learned;

c) highlight where lessons identified from preparedness and the response to the pandemic may be applicable to other civil emergencies;

d) have reasonable regard to relevant international comparisons; and

e) produce its reports (including interim reports) and any recommendations in a timely manner.

The aims of the Inquiry are to:

1. Examine the COVID-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland, and produce a factual narrative account, including:

a) The public health response across the whole of the UK, including

   i) preparedness and resilience;

   ii) how decisions were made, communicated, recorded, and implemented;

   iii) decision-making between the governments of the UK;

   iv) the roles of, and collaboration between, central government, devolved administrations, regional and local authorities, and the voluntary and community sector;

v) the availability and use of data, research and expert evidence;

vi) legislative and regulatory control and enforcement;

vii) shielding and the protection of the clinically vulnerable;

viii) the use of lockdowns and other 'non-pharmaceutical' interventions such as social distancing and the use of face coverings;

ix) testing and contact tracing, and isolation;

x) the impact on the mental health and wellbeing of the population, including but not limited to those who were harmed significantly by the pandemic;

xi) the impact on the mental health and wellbeing of the bereaved, including post-bereavement support;

xii) the impact on health and care sector workers and other key workers;

xiii) the impact on children and young people, including health, wellbeing and social care;

xiv) education and early years provision;

xv) the closure and reopening of the hospitality, retail, sport and leisure, and travel and tourism sectors, places of worship, and cultural institutions;

xvi) housing and homelessness;

xvii) safeguarding and support for victims of domestic abuse;

xviii) prisons and other places of detention;

xix) the justice system;

xx) immigration and asylum;

xxi) travel and borders; and

xxii) the safeguarding of public funds and management of financial risk.

b) The response of the health and care sector across the UK, including:

i) preparedness, initial capacity and the ability to increase capacity, and resilience;

ii) initial contact with official healthcare advice services such as 111 and 999;

iii) the role of primary care settings such as General Practice;

iv) the management of the pandemic in hospitals, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels;

v) the management of the pandemic in care homes and other care settings, including infection prevention and control, the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, workforce testing and changes to inspections;

vi) care in the home, including by unpaid carers;

vii) antenatal and postnatal care;

viii) the procurement and distribution of key equipment and supplies, including PPE and ventilators;

ix) the development, delivery and impact of therapeutics and vaccines;

x) the consequences of the pandemic on provision for non-COVID related conditions and needs; and

xi) provision for those experiencing long-COVID.

c) The economic response to the pandemic and its impact, including governmental interventions by way of:

i) support for businesses, jobs and the self-employed, including the Coronavirus Job Retention Scheme, the Self-Employment Income Support Scheme, loans schemes, business rates relief and grants;

ii) additional funding for relevant public services;

iii) additional funding for the voluntary and community sector; and

iv) benefits and sick pay, and support for vulnerable people.

2. Identify the lessons to be learned from the above, to inform preparations for future pandemics across the UK.

Trust Board

CHAIR REPORT

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lenisha Wright, Business Support Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff
REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
N/A		

ACRONYMS	

1. SITUATION/BACKGROUND

This report provides information to the Board from the Chair on a number of matters. A summary of activities and engagements is included to advise of areas of focus since the last Trust Board meeting held in September 2022.

Matters addressed in this report cover the following:

- Board Development Session
- Risk and Assurance Board Development Session
- new Velindre Cancer Centre (nVCC) Community Drop-in sessions
- Pop-up Gift Shop
- Velindre University Designation Panel
- The National Service of Remembrance

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

A summary of priorities, activities, engagements and matters of interest is provided by the Chair below.

2.1. Board Development Session

A Board Development session was held on 27th October 2022 with discussions on a number of items, including: PREVENT/Contest Training; Infection Prevention and Control Showcase; Performance Management Framework and Equality, Diversity & Inclusion.

2.1. Risk and Assurance Board Development Session

A Risk and Assurance Board Development session was held on 8th November 2022. This forms part of the next phase in the development of the Risk and Assurance Frameworks. A targeted focussed workshop was held on key items including the refresh of Board Risk

Appetite and the Trust Assurance Framework Strategic Risks. These initial shaping discussions will form part of the formal governance routes over coming months.

2.2. new Velindre Cancer Centre (nVCC) Community Drop-in sessions

The Trust and Acorn are working in partnership to develop the new Velindre Cancer Centre. As part of this partnership work, a number of Community drop in sessions were arranged through October, with the Chair attending on 14th October. At these drops in sessions, information was shared on the plans for the nVCC and opportunity given for answering of any questions. The community were able to see the beautiful, elegant and sustainable new cancer centre using computer generated images of the designs and gain insight into our sustainability commitment with benefit to patients, staff and the wider community.

2.3. Pop-up Gift Shop

The pop-up gift shop located at the Velindre Cancer Centre closed on 7th October. The Chair would like to share the unwavering efforts of Ambassador Beverley Parry and her team of Velindre Crafter volunteers who have excelled in running this temporary shop. During the six weeks of running the Velindre Crafters Charity gift shop a staggering £10,000 was raised. The Chair extends a huge thank you for the generosity of all supporters and visitors. The Chair would like to share a personal note from ambassador Beverley Parry:

"Thank you from the bottom of my heart to Velindre crafters, staff and patients for all the fabulous donations and purchases to enable us to raise these funds. It has been wonderful to speak with many patients each day, hear their stories and connect through our mutual passion for wanting to give back to Velindre. I will miss your company."

2.4. Velindre University Designation Panel

The Velindre University Designation Panel was held on 30th September 2022. There was discussion and introspection into the following:

- How University Status can be embedded through our strategies and plans.

- How the culture of learning can be embedded through learning, research and innovation through our structures and ways of working.

Progress and highlights regarding the Research Hub and Cancer Research Ambition 2021-2031 was also discussed.

2.5. The National Service of Remembrance

The Chair would like to share with the Board her attendance to Cardiff Remembrance Sunday held 13th November, a day we remember the Armed Forces and their families, as well as the vital role played by the emergency services and those who have lost their lives as a result of conflict or terrorism. On the day, there was observance of two minute silence and the laying of wreaths.

2.6. Remembrance Day at VCC

On Friday 11th November, a small service was held at the Velindre Cancer Centre to mark Remembrance Day. The Service was led by Col Simon Lawrence, Commanding Officer of 203 Wales Field Hospital and Radiographer at the Velindre Cancer Centre. We are very grateful every year for the support we receive from 203 Wales field hospital The order of service included a message from the Chair, and observation of two minutes silence. Wreaths were laid and both the last post and reveille were played by Alexandria James who is part of the fundraising team. Wreaths were laid and poppies and hot drinks distributed by the estates and facilities teams.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

The Board is asked to **NOTE** the contents of this update report from the Trust Chair.

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
HIW	Healthcare Inspectorate Wales

1. SITUATION/BACKGROUND

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

Matters addressed in this report cover the following:

- Health Inspectorate Wales Feedback
- COVID-19 Update
- Flu Vaccination
- Welsh Language Commission Investigation
- Digital Health Care Record
- Teams Wales event

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Health Inspectorate Wales Feedback

The Healthcare Inspectorate Wales (HIW), an independent inspectorate of the NHS and regulator of independent healthcare, recently published its Annual Report 2021-2022. Aiming to encourage improvement and influence standards, HIW places patients at the heart of its work to check that people in Wales receive good quality healthcare.

The Annual Report said: *"We saw evidence of Velindre University NHS Trust working very hard to maintain the services they provide through specialist cancer inpatient and outpatient services, and also across Wales through the Welsh Blood Service. We have seen transparent and constructive challenge taking place by independent members on all aspects of the Trust at committee meetings. Engagement between HIW and the executive team for the Trust remains positive and constructive, with a welcome for the scrutiny we are able to provide"*.

The Chief Executive noted to the Board the strength and resilience shown by staff at all levels of the organisation to deliver safe healthcare in the midst of substantial challenge during 2021-22. The positive comments in the report by HIW are testament to this.

2.2 COVID-19 Update

With us going into the winter season, there have been COVID-19 outbreaks on the first floor ward at the Velindre Cancer Centre. With a robust patient management process in place with admissions into a single room and Infection Prevention and Control measures, the situation was managed well and contained quickly. As a result, there was no impact to patient admissions, with clear and transparent communication with patients.

2.3 Flu Vaccination

As flu poses a significant threat in Wales this winter, the Chief Executive together with members in our Executive Team rolled up their sleeves to get their flu vaccines! Staff were encouraged to book their appointment for the flu vaccination with arrangements made to ensure critical services were not affected.

Public Health Wales advise that flu vaccination is important because, while flu is unpleasant for most people, it can be dangerous and even life threatening for some people, particularly those with certain health conditions.

2.4 Welsh Language Commission Investigation

The Acting Chief Executive would like to inform the Board that the Trust received its first formal Welsh Language investigation on 12/10/2022. The focus of this investigation is to ascertain the Trust's compliance with nine specific Welsh language standards. Including front line communication, especially answering of the telephone, recruitment and Welsh language skills.

The Welsh language Manager has responded to the initial Terms of reference. The Trust is awaiting a response to a number of questions relating to the investigation and will then formally draft an official response to questions raised.

2.5 Digital Health & Care Record

With the demand for healthcare rising, there is an increase in the need for digital health. Digital solutions support the Trust in delivering care in a different way. Acting Chief Executive noted to the Board that the new Digital Health & Care Record (DHCR) solution to replace Canisc goes live at Velindre Cancer Centre in November 2022. This will ensure a standardised approach to digital systems, providing enhanced use of data. On behalf of the whole Board, the Acting Chief Executive would like to thank the teams involved for their professionalism, expertise and effort over many years in achieving this significant milestone for our patients.

2.6 Team Wales Event

The Executive Team attended the Team Wales event which brings together the Executive Teams of all NHS Wales organisations and the Welsh Government. The programme for the day focused on the strategic opportunities for the healthcare system over the coming years and how we could work in partnership with a wide number of partners to develop the quality of services locally, regionally and nationally. This aligns with the Trusts' 'Destination 2032' strategy and will be a feature of the Integrated Medium Term Plan 2023 – 2026.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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

TRUST BOARD

WALES INFECTED BLOOD SUPPORT SCHEME (WIBSS) ANNUAL REPORT 2021-22

DATE OF MEETING	24.11.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mary Swiffen-Walker, Service Manager, WIBSS
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	26.10.2022	NOTED
QUALITY, SAFETY & PERFORMANCE COMMITTEE	10.11.2022	ENDORSED

ACRONYMS	

1. SITUATION/BACKGROUND

Established in October 2017, the Wales Infected Blood Support Scheme (WIBSS) aims to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

WIBSS supports 217 beneficiaries, including bereaved spouses and partners. However, the welfare and psychological support is also provided to wider family members of the beneficiaries.

The Governance Group monitors the operational management of WIBSS and provides governance, leadership and accountability for the scheme, on behalf of Welsh Government through Velindre University NHS Trust. The membership of the Group is:

- Director of Corporate Governance, Velindre University NHS Trust (Chair)
- Director of Operations, Velindre Cancer Centre
- Director of Planning, Performance and Informatics, NWSSP
- WIBSS Service Manager
- Welsh Government Finance Representative
- Welsh Government Policy Representative
- Senior Welfare Rights Manager
- Consultant Psychologist

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The report provides: an update on the finance and support services during 2021-22 as part of the WIBSS; detail on the proactive work carried out by WIBSS during 2021-22; and a to look ahead to WIBSS priorities relating to 2022-23.

One of the matters arising in the report relates to the Compensation Framework. In May 2021, it was announced that Sir Robert Francis QC had been appointed to consider a compensation framework for those people infected and affected by infected blood. Sir Robert Francis submitted his report to UK Government in March 2022 for consideration. He also appeared in front of the Infected Blood Inquiry to discuss the report in July. On 29 July 2022, it was announced that interim payments of £100,000 would be made to all who were currently registered with one of the UK Infected Blood Support Schemes by October 2022. These payments were all processed by the WIBSS team w/c 23rd October 2022.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Infected Blood Inquiry - Safety
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Across WIBSS scope
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Infected Blood Inquiry
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Trust processing of compensation framework payments

4. RECOMMENDATION

Trust Board is asked to **APPROVE** the Annual Report.

Cynllun Cynorthwyo Gwaed wedi'i haentio Cymru

Wales Infected Blood Support Scheme

ANNUAL REPORT 2021/2022

WALES INFECTED BLOOD SUPPORT SCHEME (WIBSS)

VELINDRE UNIVERSITY NHS TRUST

THROUGH

NHS WALES SHARED SERVICE PARTNERSHIP (NWSSP)
AND
VELINDRE CANCER CENTRE (VCC)

ANNUAL REPORT 2021/2022

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Introduction

Established in October 2017, the Wales Infected Blood Support Scheme (WIBSS) aims to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

Taking over from the existing UK schemes (Eileen Trust, Macfarlane Trust, MFET Ltd, Skipton Fund and Caxton Foundation), now referred to as the Alliance House Organisations (AHOs), WIBSS aims to provide both a streamlined financial payment service and personalised support for Welsh beneficiaries. WIBSS also offers a dedicated Welfare Rights Service and a Psychology and Well-being Service.

WIBSS supports 217 beneficiaries, including bereaved spouses and partners. However, the welfare and psychological support is also provided to wider family members of our beneficiaries.

Purpose of Report

The purpose of this report is:

- **to provide an update on the finance and support services during 2021-22 as part of the Wales Infected Blood Support Scheme;**

- **to detail the proactive work carried out by WIBSS during 2021-22;**

  and

- **to look ahead to WIBSS priorities relating to 2022-23.**

Matters arising during 2021-2022

COVID-19 – The Pandemic

In March 2020 the UK entered its first lockdown, because of the global COVID-19 pandemic. Everybody who could work at home, was told to work at home, this included the staff at WIBSS. We successfully made this transition and operated on a “business as usual” basis throughout 2021-22.

We continued to make all regular payments and to offer help and support to all our beneficiaries, many of whom were shielding because of their condition. We provided updates and advice on our website and were available throughout, to help with any queries, provide benefit checks etc. Whilst we did need to stop home visits, to comply with Government guidance, we adapted to offer the well-being and counselling services remotely, over the telephone, on Microsoft Teams or via skype calls.

Public Inquiry – The Infected Blood Inquiry

This is an independent public statutory inquiry established to examine the circumstances in which men, women and children treated by the National Health Service in the United Kingdom were given infected blood and infected blood products, since 1970.

In 2021-2022 we responded to four Rule 9 requests from the Infected Blood Inquiry. The requests were seeking clarification of information contained in the witness statement previously provided by Alison Ramsey, Director of Planning, Performance, and Informatics at NWSSP, prior to her appearance before the inquiry in May 2021.

https://www.infectedbloodinquiry.org.uk/evidence/transcript-london-thursday-20-may-2021-vaughan-gething-and-alison-ramsey, and following her appearance.

In providing evidence to the Inquiry, the WIBSS team committed to take stock, and review all our procedures, documentation, communication channels e.g., our website and newsletters etc. This review identified a few areas where we needed to update our advice and guidance to reflect changes since the service was first established. This included updating a few our application forms and improving the guidance to completing some of those forms. The website and documentation have now been refreshed to provide an accurate reflection of how the service is provided.

Matters arising during 2021-2022

Parity across the four UK nations

When the four devolved infected blood schemes were established in 2017, three of the four operated largely on similar terms and payment rates. Scotland adopted a slightly different model. WIBSS introduced a welfare rights service, which the other schemes did not have, but the payment rates were initially comparable to those in England and Northern Ireland.

With effect from 1 April 2019, the UK Government directed EIBSS to significantly increase the payment rates for their beneficiaries, leading to disparity between the schemes. This subsequently then triggered a series of meetings between government officials across all four nations with the aim to reach an agreement on parity across the four schemes.

The WIBSS finance team worked closely with UK government colleagues to model the estimated costings, including back dated elements and an estimate for future years.

On 25th March 2021 the then Welsh Minister for Health and Social Care announced agreement on parity had been reached and payments would be made by the end of the calendar year (December 2021).

https://gov.wales/written-statement-infected-blood-update-financial-parity
Under the parity model, provided by Welsh Government in March 2021, the overall additional funding required, totalled £13.1m in 2021/22. This also included some backdated elements relating to 2019/20 and 2020/21.

Following the announcement, WIBSS staff worked closely with Welsh Government to clarify the likely detail of the agreement, and then calculate the individual payments to be made to each beneficiary on the WIBSS.

This was complex work, requiring attention to detail to ensure that accurate payments could be made promptly to the WIBSS beneficiaries.

Welsh Government issued the final directions on 13 August 2021 and the payments were made on 20 August 2021. During the latter half of 2021-22, two further parity adjustments were made:

- Co-infected HIV and Hep C Stage 1 widows were
- paid the additional £30,000 lump sum payment.
- Widows received the winter fuel payments.

Matters issues arising during 2021-2022

Compensation Framework

In May 2021, it was announced that Sir Robert Francis QC had been appointed to consider a compensation framework for those people infected and affected by the infected blood scandal.

The Terms of Reference of the Framework were:

- Give independent advice to the Government regarding the design of a workable and fair framework for compensation for individuals infected and affected across the UK to achieve parity between those eligible for compensation regardless of where in the UK the relevant treatment occurred or place of residence. While the Study is to take into account differences in current practice and/or law in the devolved nations, it is not asked to consider whether delivery of that framework should be managed centrally or individually by the devolved administrations.

- To Submit to the Government its report and recommendations as quickly as possible and no later than the end of February 2022 [amended to 14 March 2022], to provide the Government with advice on potential options for compensation framework design.

In January 2022, the WIBSS Manager, together with the policy manager from Welsh Government, met with Sir Robert and his staff to discuss the operation of WIBSS and what the beneficiaries wanted from the framework.

The WIBSS Manager explained the operation of the scheme and highlighted the fact that WIBSS operates a “wraparound” holistic service, providing, not only financial support, but also welfare rights support and a bespoke psychology and wellbeing service, staffed by people who have a good knowledge of the subject area, who can empathise and understand the issues our beneficiaries are facing on a daily basis.

Whilst we felt that the financial support was important, many of our beneficiaries have commented how they value the face-to-face support, the personal interactions with them and the fact that the service is easily accessible. They would not want to lose that, in any revised service that was proposed.

Sir Robert Francis submitted his report to UK Government in March 2022 for consideration. He also appeared in front of the Infected Blood Inquiry to discuss the report in July.

On 29 July 2022, it was announced that interim payments of £100,000 would be made to all who were currently registered with one of the 2 UK Infected Blood Support Schemes by October 2022. The schemes all wrote to their beneficiaries notifying them of this fact.

As a result of the announcement, WIBSS received an increased number of enquiries about how to register with the scheme.

Governance Group

The Governance Group monitors the operational management of WIBSS and provides governance, leadership and accountability for the scheme, on behalf of Welsh Government (WG) through Velindre University NHS Trust.

The WIBSS Governance Group (VCC and NWSSP) is authorised to:

- Investigate or have investigated any activity within its Terms of Reference, and in performing these duties, shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust, relevant to the Governance Teams remit, subject to any restrictions imposed by General Data Protection Regulations (GDPR). It can seek any relevant information it requires from any employee, and all employees are directed to co-operate with any reasonable request made by the Board.

It is empowered with the responsibility for:

- Reviewing and advising on the management of the WIBSS budgets, including running costs, the annual beneficiaries budgets and provisions

- Advising Welsh Government on rate changes and the potential financial and service implications of policy changes, both within Wales and other areas within the UK

- Implementation of Welsh Government policy

- Ongoing negotiation and partnership with Welsh Government to ensure the smooth running of the service.

Governance Group

The membership of the WIBSS Governance Group is as follows:-

- Director of Corporate Governance, Velindre University NHS Trust (Chair)
- Director of Operations, VCC
- Director of Planning, Performance and Informatics, NWSSP
- WIBSS Service Manager
- Welsh Government Finance Representative
- Welsh Government Policy Representative
- Senior Welfare Rights Manager
- Consultant Psychologist

In 2021-22 the Governance Group met on 21st July and 14th December and 29th March 2022, postponed to 5th April 2022.

Financial Support

The scheme recognises that individuals living with hepatitis C and/or HIV face extra costs for things like insurance, travel insurance, care costs and travel costs to attend hospital appointments etc. Financial support is available for:

- New Applicants to the scheme
- Members of previous legacy schemes

There are varying levels of financial support available to beneficiaries of the scheme. These were set out in our 2020-2021 Annual Report and are on the WIBSS website Home - WIBSS (wales.nhs.uk).

Appeals Process

If an application to join the scheme is unsuccessful, an applicant can appeal if they disagree with the outcome of their application. Appeals are heard by a panel of independent medical experts with relevant clinical or similar experience in the field.

An appeal will not be considered in cases where it is acknowledged that the applicant is not eligible under the current eligibility criteria, but the applicant disagrees with those criteria (in such cases, the application could only be reconsidered if the Welsh Government agreed to amend the eligibility criteria).

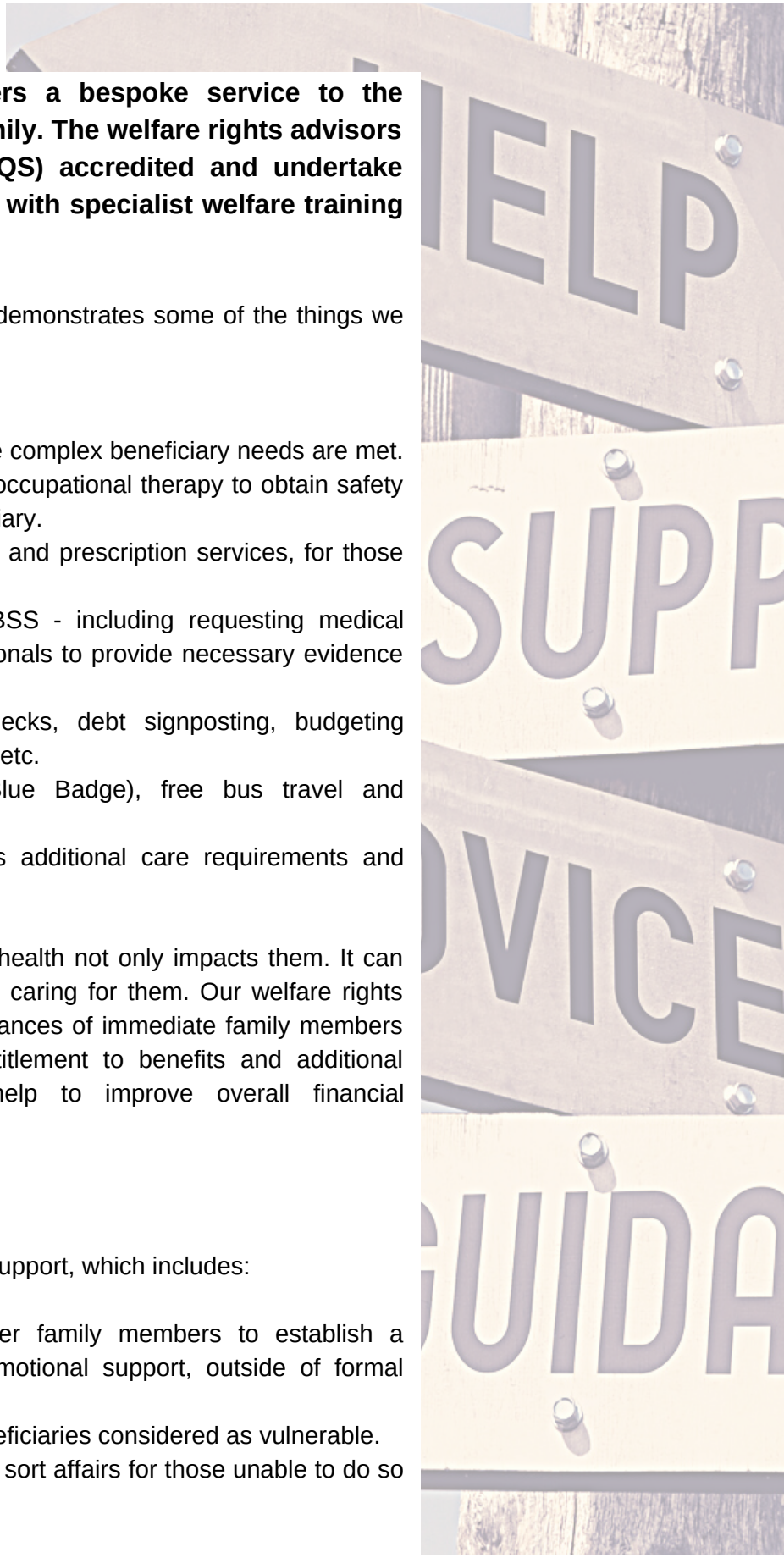
During 2021-22, two appeals were submitted, and an appeals panel was convened in March 2022. One appellant decided to postpone her appeal, prior to the Appeal Panel considering it. The Panel considered the remaining appeal.

The panel considered all the documentation received by WIBSS and detailing the decision-making process of WIBSS. The appellant also appeared in front of the panel to present their case. The panel then considered all the evidence, and upheld the original decision made by WIBSS to reject the application and the appellant was notified of the panel's decision.

The appeals panel process does not cover appeals regarding the Discretionary Small Grants process. At the inception of WIBSS we did not think a formal appeals process was proportionate given the value of these grants. To date we have not declined any small grant applications, however, as this was queried during WIBSS appearance at the Inquiry, we considered the issue and have introduced a less formal system of reconsideration for any applications for small grants that may be declined in the future.

The approach allows an applicant, unhappy with the outcome of their grant application, to resubmit it to WIBSS for reconsideration. The WIBSS Manager will arrange for the decision to be considered by somebody independent of the original decision-making process. As part of our overall review of our documentation and guidance, we have amended the small grants section to reflect these changes.

Welfare Rights Service



The Welfare Rights Service offers a bespoke service to the individual beneficiary and their family. The welfare rights advisors are Advice Quality Standards (AQS) accredited and undertake continuing professional education with specialist welfare training providers.

Although not exhaustive, the list below demonstrates some of the things we may be able to assist with:

- liaising with social services to ensure complex beneficiary needs are met. i.e. support from a social worker or occupational therapy to obtain safety adaptions to the home of the beneficiary.
- signposting to free NHS dental care and prescription services, for those eligible.
- assisting with applying to join WIBSS - including requesting medical records or chasing medical professionals to provide necessary evidence to support an application.
- undertake benefit and welfare checks, debt signposting, budgeting advice, navigating financial products etc.
- applying for a parking badge (Blue Badge), free bus travel and concessions.
- accessing health services, such as additional care requirements and health care transportation.

WIBSS also recognises a beneficiary's health not only impacts them. It can also have a significant impact on those caring for them. Our welfare rights advisors can also consider the circumstances of immediate family members and carers. They can check their entitlement to benefits and additional support requirements, which may help to improve overall financial circumstances.

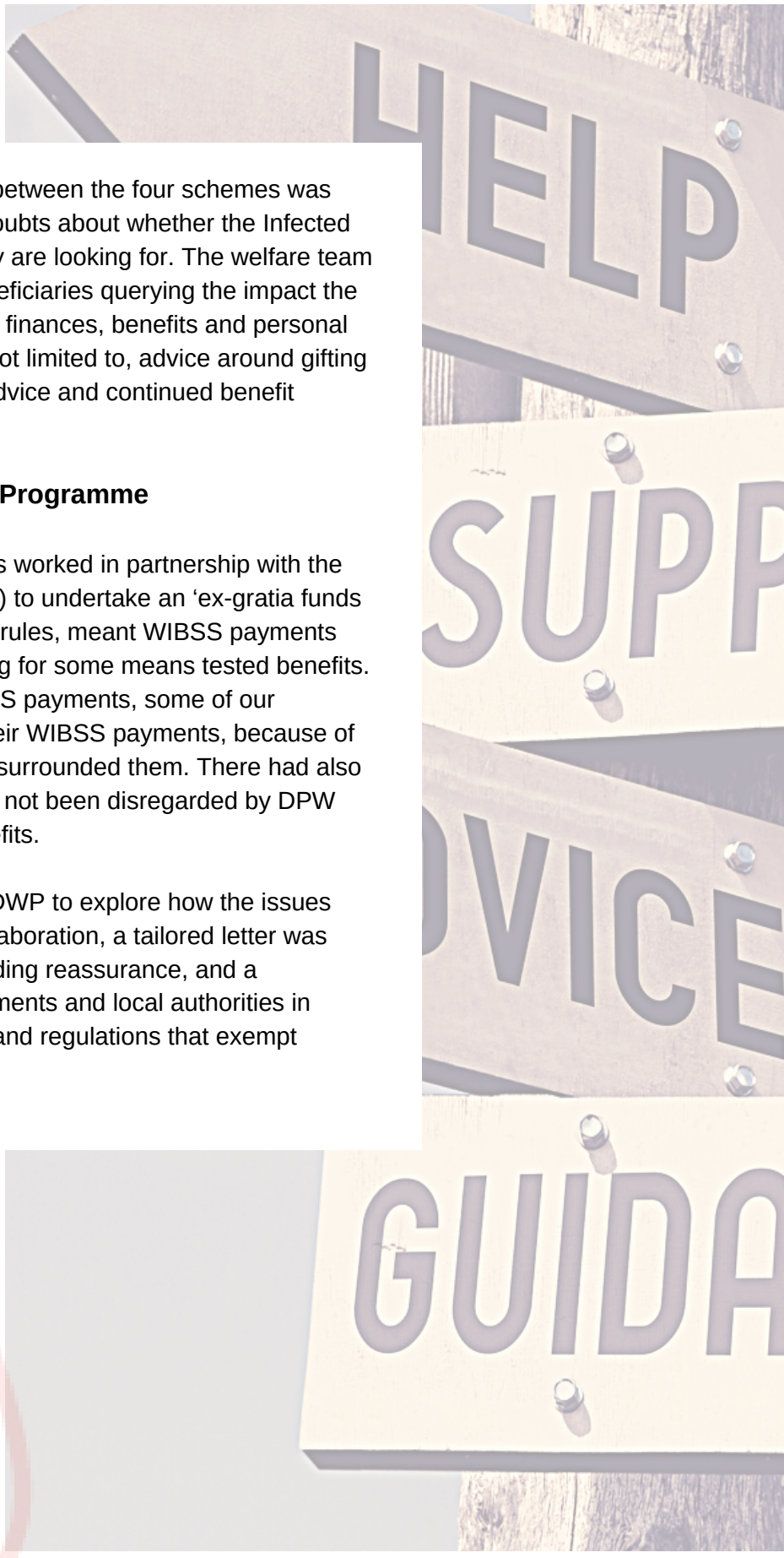
Key worker support

Another service provided is key worker support, which includes:

- liaising with beneficiaries and wider family members to establish a trusting relationship and provide emotional support, outside of formal psychology and well-being referrals.
- regular outbound check-ins with beneficiaries considered as vulnerable.
- completion of paperwork and help to sort affairs for those unable to do so themselves.

The welfare rights service is often the first point of contact for updates and reassurance on issues impacting WIBSS.

Welfare Rights Service



The lack of parity in the payment values between the four schemes was provoking feelings of anger, along with doubts about whether the Infected Blood Inquiry would find the answers they are looking for. The welfare team provided reassurance and advice for beneficiaries querying the impact the back payments would have on their other finances, benefits and personal circumstances. These included, but are not limited to, advice around gifting money to family and friends, budgeting advice and continued benefit entitlement.

DWP 'Ex-gratia Funds Declaration' Programme

In March 2022, the welfare rights advisors worked in partnership with the Department of Work and Pensions (DWP) to undertake an 'ex-gratia funds declaration' programme. A change in the rules, meant WIBSS payments now needed to be declared when applying for some means tested benefits. However, due to the sensitivities of WIBSS payments, some of our beneficiaries were reluctant to declare their WIBSS payments, because of the perceived stigma that has previously surrounded them. There had also been cases where WIBSS payments had not been disregarded by DPW staff, when assessing entitlement to benefits.

The WIBSS welfare team contacted the DWP to explore how the issues could be alleviated. As a result of the collaboration, a tailored letter was issued to beneficiaries by the DWP providing reassurance, and a memorandum was sent to benefit departments and local authorities in Wales, reiterating to staff the disregards and regulations that exempt WIBSS payments.

Welfare Rights Service

Case Study

To provide an equitable service to our beneficiaries, our welfare rights advisors travel throughout the UK to provide assistance.

Case study A involved a 455-mile round trip, as the beneficiary had requested a home visit. Although, we continued to provide our services remotely during the pandemic, as soon as COVID restrictions were lifted, we arranged to visit this beneficiary. They had been reluctant to receive support remotely, due to their nervousness and limited knowledge of technology.

The benefit check undertaken resulted in the following eligibility:

- a full claim for Universal Credit, including housing costs to help towards rent,
- a review of PIP entitlements due to deterioration of health,
- a claim for free NHS prescriptions in England
- a full reduction of Council Tax payable that year.

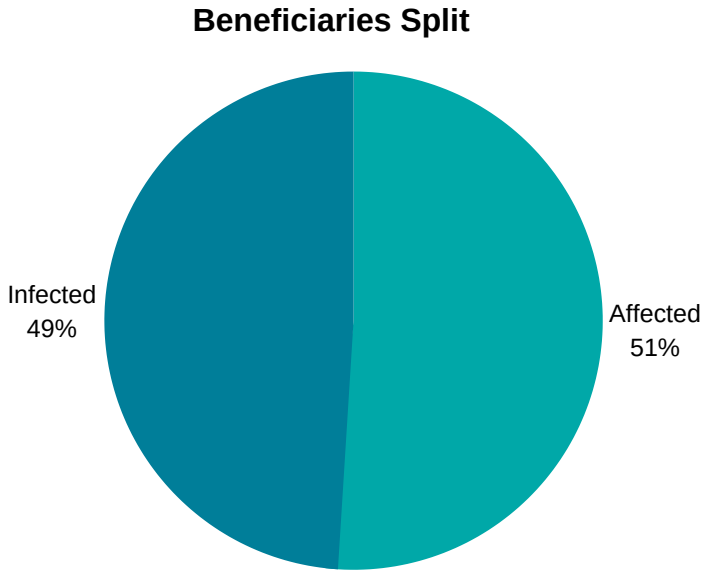
Prior to the visit, the beneficiary's household had been living solely on WIBSS funds. With the cost of living rising, the additional benefits identified by the welfare rights advisor, has provided our beneficiary with financial peace of mind. This, in turn, has eased their physical and mental health pressures.

Psychology and Emotional Well-being Service

Operation and Delivery

The Wellbeing and Psychology Service continues to provide specialist one to one psychological support to those infected and affected.

The split between those infected and affected who have accessed the service is shown in the chart below 49% (infected):51% (affected).



To date, over 80 people have accessed the service. The current caseload is 34.

For most of 2021/2022, therapy was delivered virtually or via telephone, due to COVID restrictions. As soon as the COVID restrictions were eased, face-to-face appointments were reintroduced. Where possible, upon request, the team also provide home visits for those with mobility issues and/or chronic co-morbidities commonly related to Hep C, HIV/AIDS or the treatment received, such as Interferon.

Therapy is heavily focussed on developing the therapeutic relationship with the client. It strives to deliver consistency and to promote trust and reliability, in a support service that is allied with the NHS system that provided the infected blood and blood products that have had such a devastating effect on their lives.

Feedback from those accessing the service would suggest that this approach is successful.

Psychology and Emotional Well-being Service

The team have been able to offer effective therapeutic interventions around a raft of themes including trauma (panic attacks and flashbacks), hypervigilance, loss and bereavement, stigma (secrecy), fear and isolation, misplaced guilt and responsibility, living with related life-limiting health issues, anger, mistrust, distress caused by a lack of understanding expressed by NHS staff as to the causes of chronic health conditions (e.g. the assumption that someone with Hep C is an alcoholic and the implication that they are lying about the causal factor of a cirrhosis diagnosis), carrier status, imposed infertility (the fear of passing on HIV or Hep C), relationship difficulties, anxiety and depression.

The ongoing proceedings of the Infected Blood Inquiry, the contentious evidence presented by some of those who have participated, and the creation and dissemination of the Compensation Framework have complicated the trauma responses of many. It has caused secondary and continued psychological trauma, resulting in many being stuck within a loop of psychological distress and reliving painful and traumatic events of the past.

Subsequently, therapy is having to address the immediate psychological and emotional responses to minimise further psychological harm, in the first instance, whilst addressing historic trauma is a secondary task in some cases.

The team feel that meaningful resolution-focussed therapy, to address historic trauma, might be more effective once the Inquiry is concluded and Compensation Framework has been agreed. In addition, preparatory therapy is underway around people's expectation of the Inquiry's findings and outcome (realistic vs unrealistic, what would justice look like? etc) to minimise further psychological harm in the future.

Developments

The team hosted an online focus group event earlier this year. It was held via Zoom, due to Covid restrictions. All WIBSS members were invited, and a small but lively group attended.

Attendees were asked for their ideas to help develop the Psychology and Wellbeing Service now that the specialist one to one support had been firmly established. WIBSS believe it is important the service users have a say in shaping the service to meet their needs.

There was a consensus around creating peer support opportunities and bringing together people as a community through shared experience. As a result, it was agreed the following ideas should be presented to the wider WIBSS community for their input and opinion:

1) Regular Zoom and/or face to face regional meetings to allow people to come together and discuss common themes and topics around wellbeing and share individual experiences.

2) A group regional and/or All-Wales social event to bring together all those infected and affected with the aim of creating a common community. The event could potentially encompass workshops with psychoeducational opportunities, links to promote peer support and guest speakers.

Psychology and Emotional Well-being Service

3) The creation of a ‘buddy’ system where people can register their interest in being paired with others within their community (small groups or one-to-one) to reduce isolation and create links with others through shared experience and friendship.

All WIBSS members have been asked for their expressions of interest in relation to these ideas, which the team intend to implement later this year, based on feedback.

In addition, the team have established the Infected Blood Psychology Network with colleagues from the Irish and Scottish psychology services. The group meet bi-monthly to share ideas, information, best practice, common themes and potential opportunities for research and cross-border work.

The network has also been consulted by colleagues from NHS England to help shape the English Infected Blood Support Scheme (EIBSS) psychology service, with emphasis on the importance of delivering a specialist service.

The Network are also examining and discussing published research around the cognitive impact of Hep C with the aim of creating a common assessment framework across the network to assess those members who present with cognitive impairment. The framework could also be applied to those with HIV.

Testimonials

Feedback was requested from those who has accessed the service, and they have given consent for their testimony to be shared.

Testimonial 1

A friend suggested that I contact WIBSS, as he was aware that attending the public inquiry in Cardiff had affected my health. I had tried counselling, via my workplace, but found that it was time restrictive i.e., six sessions, and was not that helpful. Eventually I couldn't cope with my emotions, so I contacted WIBSS, and am so glad I did. I now have help and support from my counsellor, who not only has great insight of the Infected Blood issue, but also appreciates that our suffering has been endured for a considerably long time, and so it will take time to be able to overcome the difficulties.

This counselling is tailored to suit my needs and I don't feel pressured to make a fast recovery. I have made progressive steps and also taken retrograde steps, but I know that no matter what I have the full support and encouragement of my counsellor which gives me strength to keep going. Every session leaves me feeling more able to cope with my issues. COVID 19 has impacted on my mental health, however, once again the counselling has been tailored to suit my current needs. I would advise anyone who is thinking about seeking counselling to approach WIBSS. This counselling is so different. It is helpful, supportive and adapts to the individual.

Psychology and Emotional Well-being Service

Testimonial 2

I'm a normal person, I live a normal life, but I sometimes find myself crying myself to sleep and I hide it. I'm in the car, and the tears just come from nowhere. Why do I feel so so sad and alone when I have so many people around me, friends and family?

It hasn't always been easy, not just the bad blood and everything that brings with it, but many other things that a person shouldn't cope with endure or experience, but I'm a strong person and I can cope, I'm the one everyone needs to help them, and then one day I can't anymore, and I need someone.

It's not easy to get help, it's not easy to ask.

WIBSS is there. I just filled out a form a couple of years ago, to say how I felt, and they came to help me. Just having someone to talk to about something or nothing is a safety net, I don't know why but it is. I look forward to the calls, it helps me. It could help you too.

Testimonial 3

The treatment I received for Hepatitis C had a devastating effect on my life. I found that talking to the WIBSS Wellbeing Service was reassuring and helped me understand some of the emotional and psychological issues that I have been dealing with. In particular, talking about some problems I have had with my relationships, with my family and friends, has enabled me to put things into context and enabled me to improve things. Talking to someone outside my circle has been very helpful.

In addition, some mindfulness exercises that she introduced me to have helped me with my sleeping difficulties.

Testimonial 4

The service has been helping our son, who has been struggling with issues relating to his dad's health, giving him ways to help cope with this and other anxiety and problems he is facing. He is finding the sessions really helpful.

Psychology and Emotional Well-being Service

Testimonial 5

I first decided to utilise The Wellbeing Service at WIBSS about a year ago. I have benefited enormously and have welcomed the support and reassurance that I have experienced during the last twelve months.

It has been a difficult year for all of us, especially so if you have been feeling isolated in your own home. Added to this, has been The Infected Blood Inquiry hearings, which may have transported many of us back to very traumatic and heart-breaking times, recreating difficult memories.

The Wellbeing service has provided me with a crutch to lean on and a safety net, giving me the support that I have needed for a very long time. I wish that this service had been available thirty years ago when I lost my Husband to AIDS.

I would encourage anyone to use this service which is confidential. Use it and don't suffer alone help is available to you.

Further testimonials are available on the WIBSS website.

Beneficiaries activity 2021-2022

There are 217 beneficiaries & bereaved partners registered for support through the scheme. This is broken down into the following groups. (Valid as at 31 March 2022).

Beneficiary Group	Number of registered Beneficiaries
Hepatitis C Stage 1	40
Hepatitis C Enhanced Stage 1+	77
Hepatitis C Stage 2	41*
HIV	2
HIV & Hep C Stage 1 (Co-infected)	3
HIV & Enhanced Stage 1+ (Co-infected)	11
HIV & Hep C Stage 2	2
Bereaved spouse/partner	41*

*2 beneficiaries are classified as both existing beneficiaries and as bereaved spouse/partners.
**2 beneficiaries and 1 bereaved spouse passed away during Q4 2021/22. However, they are still included in the above numbers they continue to receive payments until the end of the quarter in which they pass away i.e., the 31st March 2022.

Payments Rates 2021-2022

The levels of payments available to beneficiaries in 2021/2022 are set out in the table below.

Beneficiary Group	Annual Payments
Hepatitis C Stage 1	£18,912
Hepatitis C Enhanced Stage 1+	£28,680
Hepatitis C Stage 2	£28,680
HIV	£28,680
HIV & Hep C Stage 1 (Co-infected)	£38,928
HIV & Enhanced Stage 1+ (Co-infected)	£45,072
HIV & Hep C Stage 2 (Co-infected)	£45,072

WIBSS pay annual payments monthly or quarterly, depending on beneficiary preference. Payments are made on the 20th of the month. Where the 20th falls on a bank holiday or weekend, payment will be the nearest working day prior to the 20th.

One-off non-discretionary lump sum payments are also paid to successful new applicants to the scheme. Under Parity, a new applicant who is Hep C Stage 1 would be entitled to a £50,000 lump sum payment.

A beneficiary who moves from Hep C Stage1 to Hep C Stage 2 would receive an additional £20,000 lump sum payment.

A new applicant who has already developed to Hepatitis C Stage 2 would receive a £70,000.

A new applicant who has HIV would be entitled to a lump sum payment of £80,500. If they were co-infected HIV and Hep C Stage 1, the lump sum would be £80,500 + £50,000 = £130,500 and Stage 2 would be £80,500 + £70,000 = £150,500.

A one-off non-discretionary lump sum payment of £10,000 is also paid to the bereaved spouse/partner/dependant relative or estate of a deceased infected beneficiary to assist with funeral costs.

WIBSS also make regular payments to bereaved spouses/partners/dependant relatives, of an infected beneficiary who has passed away. These payments are equal to 100% of the rate the deceased beneficiary was on at time of death for one year and 75% of the rate thereafter.

WIBSS Structure

The main WIBSS team consists of eight members of staff, led by the WIBSS Manager.

Alison Ramsey
Director of Planning,
Performance and Informatics
NWSSP

Lisa Miller
Head of Operational Service and
Delivery
Velindre Cancer Centre

Mary Swiffen-Walker
WIBSS Manager

Psychology and Well-being

Caroline Coffey
Clinical Psychologist

Julie Armytage
Counsellor

Finance

Stefan Dakovic
Finance Officer

Welfare

Hayley Price
Welfare Rights Manager,
Deputy WIBSS Manager

Rebecca O'Callaghan
Welfare Rights Advisor

Sarah Ferrier
Welfare Rights Advisor

Admin Support

Ryan Clappe
Support Officer

Finance Report

The table below summarises the claims expenditure for 2021-22, which includes full year payments paid at parity rates, and includes £9m of backdated payments, relating to 2019/20 and 2020/21 that were paid in 2021/22 as a result of the parity agreement. Announced in March 2021 and actioned in August 2021. These costs include ad-hoc, widows and small grants payments.

WIBSS Claims Expenditure	2021-22	2020-21 Comparative
No. of Beneficiaries	217*	176
Regular Payments	£7,294,727	£3,382,927
Backdated Parity Payments	£0	£8,996,254
Total Payments to Beneficiaries	£7,294,727	£12,379,181

**Please note the 2021-22 No of Beneficiaries difference of 41 relates to the on-going payments to bereaved spouses/partners as result of Parity.*

Please note the figures above have been subject to in year movements i.e. new applications, deaths in year, moves from one stage to another, ad hoc requests etc.

NWSSP provide the NHS Wales Finance Team within Welsh Government with regular updates on forecasts throughout the year. The administration of the scheme is cost neutral to both NWSSP and Velindre Cancer Centre, with Welsh Government funding the scheme in full.

Running costs for 2021/22

A summary of the running costs for 2021-22 is set out below with a 2020-21 comparative:

WIBSS Running Costs	2021-22	2020-21 Comparative
Pay	£215,298*	£218,749
Expenditure	£11,328	£10,372
Total	£226,626	£229,121

**Note the 2021-22 running cost spend is not a full comparative to 2020-21, the reduction in pay is due to the impact of maternity leave within the team during the year.*

Performance Report

WIBSS performance against Key Performance Indicators is set out below.

Description of key performance indicator	20/21 Target	Status
Responding to correspondence within set time limits	Within 4 working days	100%
Responding to Freedom of Information requests within required deadlines	In line with Trust policy	100%
Dealing with applications within required timescales	Within 28 days from receipt of complete information	100%
Dealing with applications within required timescales	100% 2 appeals were lodged, but one was withdrawn by the appellant prior to the panel taking place, as they were unable to obtain the evidence they required. The other appeal was heard within the required timescale. However, we acknowledge that this appeal was postponed and needed to be re-arranged due to COVID-19 related pressures faced by clinicians on the panel.	100%
Payments made on a timely basis	100% of payments to be made 0-2 days before the due date	100%
Advising WG on CPIH Uplifts and the cost implications for the next financial year	In February each year	100%

Performance Report

Description of key welfare rights indicators	Status
Total Welfare Rights cases opened in previous 12 months	62
No of Key Worker Advice Only	34
No of welfare rights casework	28
Income Generated for beneficiaries (1 Apr 2021 - 31March 2022)	£45,928.62
Outstanding outcomes March 2022	1 PIP review 1 PIP claim 1 Pension Credit claim 1 ESA claim

New Applications for Financial Support

WIBSS received 9 applications in 2021-22.

Application Type	Applications received	Outcome
Hepatitis C Stage 1	5	1 Accepted, 4 Declined
HIV	1	Accepted
Widows' application	3	Accepted
Total	9	5 Accepted, 4 Declined

Where an application is declined, it will be because it does not meet the criteria set in Wales Infected Blood Support Scheme Directions, or insufficient evidence has been provided to support the application.

Support and Assistance Grants Scheme

In 2021-22 we received 12 applications for a support Grant. This is an increase a 50% increase from 2020-21. We believe this increase is as a result of promoting the support and assistance grants in a WIBSS Newsletter issued to all beneficiaries.

Forward Look 2022 -2023

The workplan for 2022-2023 will include the following –

- Progress the work started by the Psychology and wellbeing team around focus groups etc.
- Launch an outbound campaign, aimed at assisting beneficiaries during the cost-of-living crisis i.e., identify schemes to provide new boilers, reduce heating costs etc.
- Respond promptly to any future and additional directions of Ministers in their response to the Inquiry recommendations.
- Process interim compensation payments, as directed to do so by Welsh Government
- Respond to the Rule 9 request received in July 2022 and any subsequent Rule 9 requests received.
- On the 29 July the Chair of the Inquiry also published an interim report, with a recommendation to make interim payments, but at the time of writing this report, no decision has been taken by UK or Welsh Ministers. Respond to any action required as a result of response.

TRUST BOARD

SEPTEMBER 2022 Performance Management Framework COVER PAPER

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jeff O'Sullivan, Planning and Performance Manager Alan Prosser, Director WBS Amanda Jenkins, Head of WOD
PRESENTED BY	Cath O'Brien, Chief Operating Officer Sarah Morley, Director WOD
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT MEETING	12.10.22	Reviewed and Noted
VCC SLT	19.10.22	Reviewed and Noted
WBS PERFORMANCE REVIEW	19.10.22	Reviewed and Noted
VCC PERFORMANCE REVIEW	20.10.22	Reviewed and Noted
EMB RUN	26.10.22	Reviewed and Noted

QUALITY, SAFETY & PERFORMANCE COMMITTEE	10.11.22	Reviewed and Noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
UHB	University Health Board
VCC SLT	Velindre Cancer Centre Senior Leadership Team
WBS SMT	Welsh Blood Service Senior Management Team
QSP	Quality, Safety & Performance Committee
RCR	Royal College of Radiologists
JCCO	Joint Council for Clinical Oncology
PADR	Performance Appraisal and Development Review
KPIs	Key Performance Indicators
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board
COSC	Clinical Oncology Sub-Committee
IPC	Infection Prevention Control
RCC	Rutherford Cancer Centre

1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports provide an update to QSP with respect to Trust-wide performance against key performance metrics through to the end of September 2022 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The reports set-out performance at Velindre Cancer Centre **(*appendix 1*),** the Welsh Blood Service **(*appendix 2*)** and the Workforce **(*appendix 3).*** Each report is prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance. A number of areas from the reports are highlighted below.

2.1 Velindre Cancer Centre:

VCC continues to experience challenge in providing capacity to meet the overall demand for services within SACT and Radiotherapy, with referrals increasing and varying as health boards undertake additional activity to address their longest waiting patients.

Regular operational meetings continue to take place between VCC and the local Health Boards, which help to provide a more detailed picture of the expected number of referrals to VCC from Health boards and changes to specialist teams and practice that are likely to impact on demand for services from VCC

Alongside better intelligence on demand to support planning, there is a comprehensive programme of work underway supported by activity plans to maximise efficiency and productivity to demonstrate the most effective use of resources.

A number of immediate actions have been implemented as part of the ongoing capacity task force groups established in Radiotherapy and SACT. This includes incremental release of capacity through changes in practice and identifying options for increasing planning capacity. These are being reviewed on a weekly basis by the SLT in VCC and by the Executive team.

As a result of patient delays over the last few months, a process has been developed to assess whether any patients have come to harm. This process has been developed in other centres. A draft has been circulated widely for comment and it is being finalized by the Quality lead at the cancer centre for implementation.

Below we outline the details of the factors influencing performance in September 2022.

Radiotherapy Waiting Times

Overall referrals to radiotherapy for September (364) were above than those received in August (322).

There are also significant challenges associated with the fragility of the equipment due to its age of the equipment and the risk of potential breakdown, especially as we increase usage. The replacement programme that has commenced in October is essential in addressing this risk.

We have observed higher than planned referrals for breast cancer patients as health boards are commencing a range of activity to target the increasing patient referrals for diagnosis for patients with suspected breast cancer and increase activity in the initial parts of their treatment pathway. Variation in referral patterns occurring is also a challenge as health board undertake focused activity within specific specialist areas.

Capacity to treat breast patients has been compounded due to the configuration of the linear accelerator (LINAC) fleet at VCC, which means specific tumour sites such as breast, cannot be treated on all machines. This is being addressed through configuration changes to all LINAC to facilitate additional capacity during September which will impact on capacity in October.

Challenges also remain in relation to provision of specific Brachytherapy capacity and Medical Physics capacity. This is being addressed through the commissioning of additional service capacity, delivery of which is being planned and is reliant on

A gradual increase in LINAC capacity by 8% is underway, increasing from 73.5 planned hours in June to 76.5 hours in September and 79.5 planned in October. This is being supported through a temporary increase in staffing hours and reallocation of roles, whilst we continue to induct the recruited staff that started in recent months. This staff group will be fully operational in January.

Patient receiving radical radiotherapy within 28 day

There are a number of steps in the process to radiotherapy treatment after the patient has entered the radiotherapy waiting list. These include medical outlining, medical physics planning, scanning and scheduling and booking treatment. Delays can occur at any of these points in the patient pathway.

Of the 214 patients who were referred for treatment with radical intent. 27 did not begin treatment within 28-days (performance rate of 87%). The target is 98%. This is a 50% reduction from the breach number in August (55). Further improvement is reported for the end of October with 91% performance and a reduction from 27 to 12 breaches.

We have analysed the breach data at an individual patient level to determine why this occurred. 24 of the 27 of breaches in September were attributed to a lack of sufficient linac capacity for patients referred with breast cancers. Previously defined operational plans to secure sufficient breast treatment capacity in anticipation of the final decommissioning of one of two linear accelerators, relied on capacity from the Rutherford Cancer Centre (RCC). The closure of the RCC has presented capacity challenges which have been further compounded by the upturn in referrals noted above. As identified above, the radiotherapy service is delivering a plan which will introduce a

greater degree of flexibility, extending and improving the capability of the various LINAC, ensuring that more patients with breast cancers can undergo treatment on more machines than has been the case in the past. The actions above has resulted in zero breaches for Breast patients in October.

SACT Waiting Times

The patient pathway for SACT treatment is limited to scheduling and booking treatment and therefore any breach reasons are primarily limited to capacity.

Performance against the non-emergency time-to-treatment target has continued to improve, and has risen to 89% from 77% last month. Breach numbers have also reduced from 92 in August to 36 in September. Further improvement is reported for the end of October with 96% performance and a reduction from 36 to 14 breaches.

A taskforce is in place to identify short to medium term options to address shortfall in capacity and to deliver productivity and efficiency gains alongside additional resources being deployed. This work is ongoing but has already resulted in the highest ever recorded SACT delivery figures for August (2501) and September (2544).

A redistribution of patient treatments to outpatient, ambulatory care and clinical trial areas has supported an increase in activity. Additional weekend clinics established from August for a three-month period to expand capacity have now ceased, coinciding with the reopening of SACT chairs in the Prince Charles hospital setting commencing in October. Internal support is being provided from nursing within other departments as required to maintain activity.

Therapies

A number of our therapy teams are having recruitment and retention challenges and this has resulted in a small number of waiting times breaches (3), particularly where there is specialist provision or low resilience through small or single handed services and teams. This has also been compounded by levels of maternity absence which cannot always be covered. All actions that can be taken to support service delivery are being undertaken.

Other areas

Falls

During September 2022, there were 3 Velindre falls affecting 3 patients on first floor ward. 2 were deemed unavoidable by the Scrutiny Panel and all learning and actions to reduce the risk of pressure ulcers occurring was undertaken.

Pressure Ulcers

During September 2022, there were 4 Velindre acquired pressure ulcers affecting 3 patients on first floor ward. All were deemed unavoidable by the Scrutiny Panel and all learning and actions to reduce the risk of pressure ulcers occurring was undertaken.

Healthcare Acquired Infections

No Healthcare Acquired Infections (HAIs) were reported in September 2022.

SEPSIS bundle NEWS score

13 patients met the criteria for response to sepsis and all 13 received antibiotics within 1 hour where appropriate = 100% compliance.

9 of the 13 patients went on to receive a diagnosis of sepsis and all 9 patients received all 6 elements of the SEPSIS bundle within 1 hour = 100% compliance.

Delayed Transfers of Care (DTOC's)

There was no Delayed Transfers of Care reported in September 2022.

Further detailed performance data is provided in Appendix 1

2.2 Welsh Blood Service

All clinical demand was met in September without the need for mutual aid support and the service is in a good and stable position, with healthy stock levels across all priority groups, which is testament to a concerted effort by all staff working in the supply chain operation.

This has enabled the service to provide 20 O negative units to support the Northern Ireland Blood Transfusion Service on 26/09/2022 as part of mutual aid support. This is quite an achievement for the Welsh Blood Service as the rest of the UK supply chain remains extremely fragile and further support from WBS is anticipated.

2.2.1 Quality

At 98%, Quality Incident Records closed within 30 days continues to exceed target (90%) for September. There were no adverse event reports submitted to the MHRA and no adverse event reports were submitted to the HTA. In addition, no SHOT incidents were reported during the month. No formal concerns were received during September 2022, with over 7,481 donors registered at donation clinics.

All 6 informal concerns received were managed within 2 working days as required by Putting Things Right (PTR) regulations. At 96.5% donor satisfaction continues to remain above target.

2.2.2 Recruitment of new Bone Marrow Volunteers

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) is below target (151 against a target of 333). Recent performance is mainly attributed to the collection model used throughout COVID, which considerably reduced donor sessions at venues in educational and business settings, where we typically recruit donors eligible for bone marrow volunteer recruitment (resulting in a drop of 44.44% in eligible donors).

A Recovery Plan has been developed to explore new ways to increase recruitment of bone marrow volunteers, avoiding dependence on recruiting at donation sessions. A Project Group has been established to implement the recovery plan, which is expected to start to deliver results in Quarter 1 2023.

2.2.3 Reference Serology

In September, Reference Serology 'turnaround' performance improved to 73% against a target of 80%. Continued staff absence and continued high levels of testing requests and planned leave have contributed to this performance.

A Business Case is to be submitted to Welsh Health Specialist Services Committee (WHSSC) to support the appointment of an additional Band 6 Specialist Biomedical Scientist resource to increase complex testing capacity to drive an improvement in performance against this metric.

2.2.4 Time Expired Platelets

Time expired platelets did not meet target in September. The most significant expiry occurred during the 1st week of the month, following the bank holiday which accounted for almost half the expiry for September.

Given the variability of expired platelets over the past 12 months, the service has carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups are being established in November to implement the recommendations.

2.2.5 Manufacturing Efficiency

Manufacturing efficiency was just below target at 357.40 against a target of 392. Recent performance is due, in part, to manufacturing staff continuing to prioritise production of Fresh Frozen Plasma and Cryoprecipitate to support the swap out of products within the heath boards provision of Hepatitis B core tested blood components for the patients of Wales.

This target is based on the Pre COVID operating model and is due to be reviewed as part of the ongoing development of the performance management reporting framework.

2.2.5 New Blood & Apheresis Donors (Quarterly Reporting)

Performance did not meet the quarterly target (1544 against a target of 2750). Throughout July and August, WBS were in Blood Shortage Blue Alert and unable to sustain growth in O type blood supplies.

A measured approach to growing O type blood stocks was taken that involved using as many available existing donors as possible to ensure donors could be selected by their blood type. The high use of existing donors, as a mitigation to the national blood shortage position led to a significant reduction in available appointments for new donors.

As the service starts to stabilise collections and returns to the pre covid operating model it is hoped this target will improve.

3 WORKFORCE

3.1 PADR

Trust Wide 71.24%, increase on previous month (Target 85%)
WBS 79.27%, increased compared to last month
VCC 71.50%, increased compared to last month

3.2 Sickness Absence

Trust wide 6.31%, sickness rates decreased compared to last month. (Target 3.54%)
WBS 7.22%, sickness rates decreased compared to last month
VCC 6.26%, sickness decreased compared to last month.

3.3 Statutory & Mandatory Compliance

Trust Wide 85.49%, above target (Target 85%)
WBS 91.33%, above target but decrease on previous month
VCC 85.01% above target and increase on previous month.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust.

4 RECOMMENDATION

4.1 Board members are asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC September PMF Report
2. WBS September PMF Report
3. Workforce Monthly September PMF Report

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (September 2022)

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			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page xx)	Actual	97%	96%	92%	78%	92%	92%	92%	87%	92%	83%	72%	77%	87%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page xx)	Actual	82%	82%	74%	84%	90%	90%	81%	79%	81%	83%	83%	85%	85%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page xx)	Actual	97%	100%	85%	89%	100%	93%	88%	84%	88%	100%	100%	94%	93%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page xx)	Actual	98%	99%	99%	99%	94%	91%	71%	69%	61%	58%	66%	77%	89%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page xx)	Actual	100%	100%	86%	100%	100%	100%	83%	100%	100%	86%	100%	100%	100%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page xx)	Actual	53%	65%	65%	Data Collection (Paused)	Data Collection (Paused)	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)	70%	47%	57%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

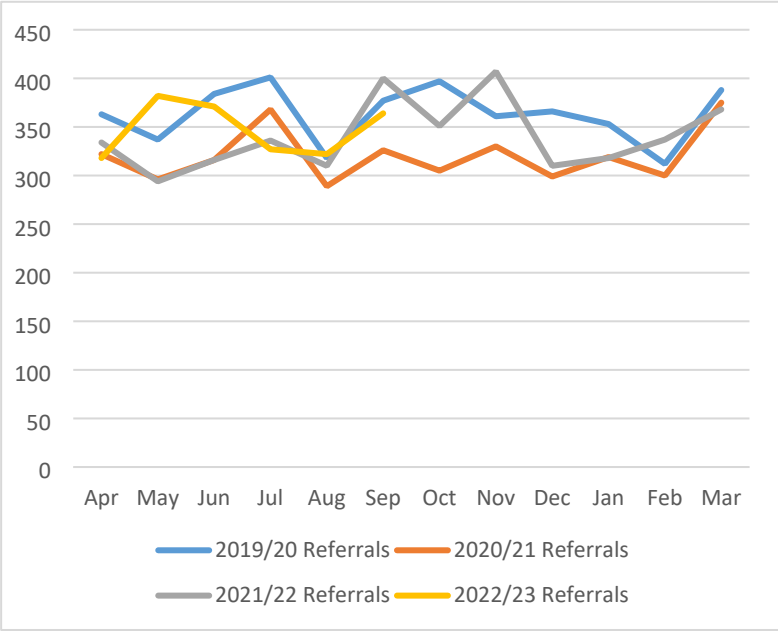
			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
	Did Not Attend (DNA) Rates	Actual	5%	5%	5%	3%	3%	3%	3%	3%	3%	3%	5%	5%	5%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	95%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page xx)	Actual (Dietetics)	98%	97%	100%	95%	98%	100%	98%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
	Routine Therapies Outpatients Seen Within 6 Weeks (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%	100%	100%	78%
		Actual (Occupational Therapy)	33%	78%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%
		Actual (Speech and Language Therapy)	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Pressure Ulcers (page xx)	Actual	1	1	0	1	0	1	1	0	0	1	0	0	4
		Unavoidable	1	1	0	1	0	1	1	0	0	1	0	0	4
		Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page xx)	Actual (Total)	2	3	1	4	3	2	9	4	1	1	2	1	3
		Unavoidable	1	3	1	4	2	2	9	3	0	1	2	1	2

			Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
	Number of VCC Inpatient Falls (page xx)	Avoidable	1	0	0	0	1	0	0	1	1	0	0	0	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	4	0	0	1	4	1	1	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Potentially Avoidable Hospital Acquired Thromboses (HAT)	Actual	0	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater than or Equal to Three Who Receive all 6 Elements in Required Timeframe	Actual	75%	100%	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections	Actual	0	0	0	0	1 (*C.diff*)	0	0	0	0	0	1 (E.Coli bacteremia)	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date		Actual	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above. Red - Target not achieved

Radiotherapy Referral Trends – Overall

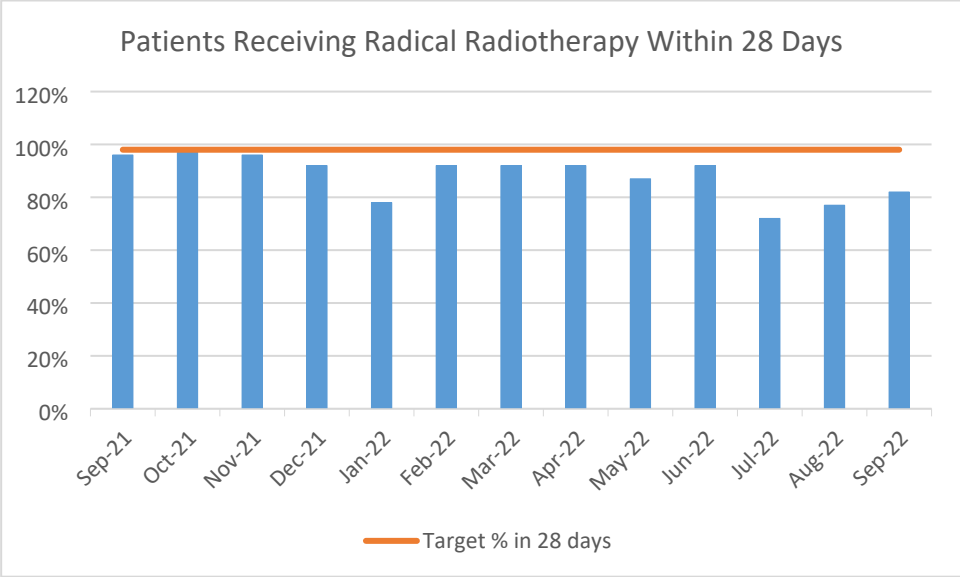


All Radiotherapy Referrals

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Referrals	363	337	384	401	318	377	397	361	366	353	312	388
2020/21 Referrals	322	296	316	368	289	326	305	330	299	319	300	375
2021/22 Referrals	334	294	316	336	310	400	351	407	310	318	337	368
2022/23 Referrals	318	382	371	327	322	364						

There was an increase in referrals in September, however this is in line with typical seasonal variation seen in previous years for the same period.

Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



Assessment of current performance - key points:
Demand for radiotherapy services has increased from August's referral number of 324 with 364 new patient referrals received in September. 214 patients were referred for treatment with radical intent. 27 did not begin treatment within 28-days (performance rate of 87%).

- 24 as a result of Linac capacity (breast)(all patients prioritised to minimise clinical significance)
- 2 required a rescan
- 1 as a result of the requirement for further diagnostic investigations prior to plan

Treatment Intent	29- 35 days	36- 40 days	41- 45 days	46- 50 days	51 days +
Radical (28-day target)	14	10	0	1	2

The three patients waiting over 46 days were all Breast patients who were clinically prioritised due to capacity constraints in Breast Linacs:

The longest wait was 62 days.

Initial plans for accommodating Breast patients included Rutherford Cancer Centre. this was not available as planned. Significant work has since taken place to realign the LINAC fleet to allow breast patients to be treated on multiple machines.

We have seen a major reduction in breach numbers for September and a significant improvement in the average waiting time for Breast patients from the very challenging July-Sep when we had to manage the repatriated patients from RCC: We are now seeing average waits lower than when we were using RCC.

Average wait in Days Breast Patients:

June	July	Aug	Sep	Oct
25.7	32	29.8	26.9	23.6

We are also managing a backlog of Basal Cell Carcinoma (BCC) skin patients, which has occurred due to single handed consultant and availability of DXR scanner capacity. Plans to address this include the ongoing increase to the number of additional ad hoc slots for patient treatments. From November, consultant sessions dedicated to management of these patients will increase from 3 to 4 weekly sessions to provide some sustainable capacity. All BCC patients are clinically prioritised. These patients are not reported under cancer waiting time standards.

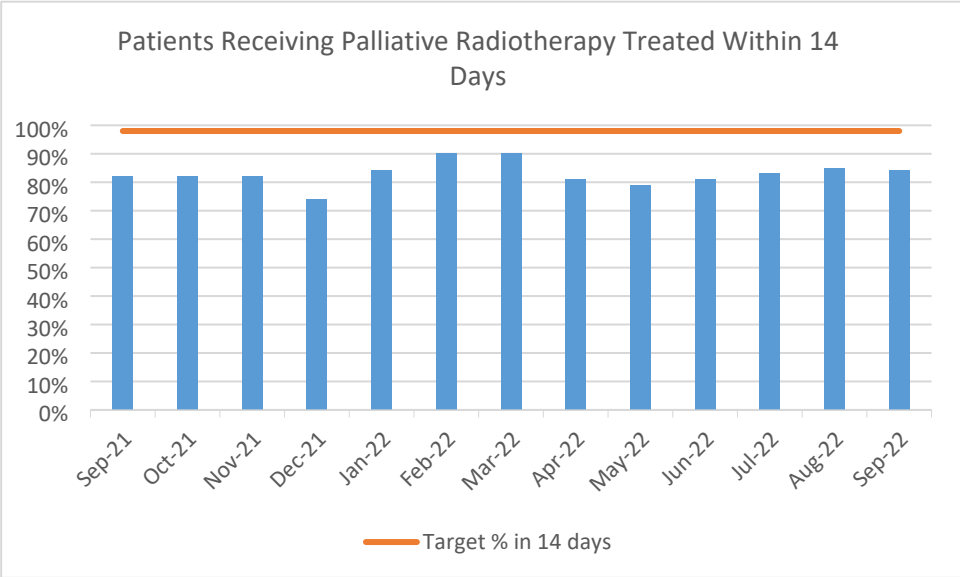
Fragility of the LINACs due to aged and associated potential for break down remains a significant risk to maintaining activity.

Key actions:

Plan in place for phased increase in LINAC capacity commenced July. This has been supported by extended working days and reallocation of resources. Three radiographers have been appointed and started in

	October. Further expansion is reliant on recruitment of additional staff and training. Advertisements are currently out to advert. Detailed work is taking place within the clinical teams to understand the trends associated with breaches. This will support a focused piece of work to address the areas of concern e.g. requests for re-scans and re-plans Escalation processes continue to monitor predicted breaches and prevent breaches where possible through weekly capacity meetings. Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group for action as required.

Patients Receiving Palliative Radiotherapy Within 14-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



105 patients were referred for treatment with palliative intent. 16 did not begin treatment within 14-days (performance rate of 85%)

- 11 as a result of requiring a complex 3D plan all were treated within the locally agreed timeframe in compliance with the Wales time to radiotherapy metrics. This aligns with the anticipated COSC standards.
- 1 was as a result of change of treatment plan
- 1 was as a result of change of treatment modality
- 1 was as a result of treatment capacity on DXR,
- 2 were as a result of process failure,

Treatment Intent	15- 20 days	21-25 days	26- 30 days
Palliative (14-day target)	13	3	0

The 3 longest waiting patients were treated as follows:
21 days due to consultant requesting further review with patient prior to treatment, delayed treatment by 1 week.
22 days due to orthovoltage capacity.
23 days due to change in patient priority on day of treatment from radical to palliative. Patient would have been treated within the original radical target.

Key Actions

Key actions are as outlined in the 28-day section

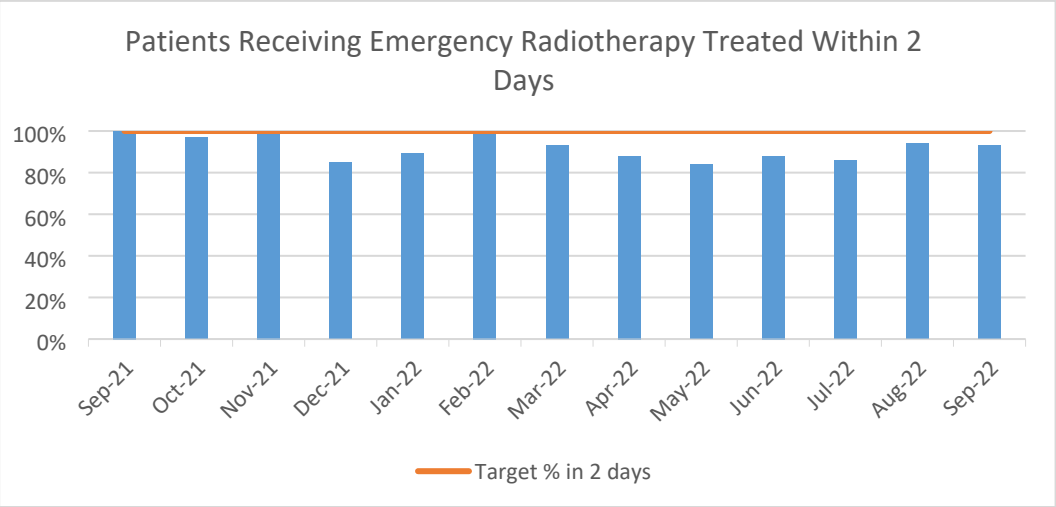
In relation to 3D planning: A proposal is being developed following review COSC implications and an improvement programme to support delivery of the revised targets will need to be agreed as a priority (Quality Performance indicators QPIs)

Patients Receiving Emergency Radiotherapy Within 2-Days

Target: 98%

SLT Lead: Radiotherapy Services Manager

Trend



Current Performance

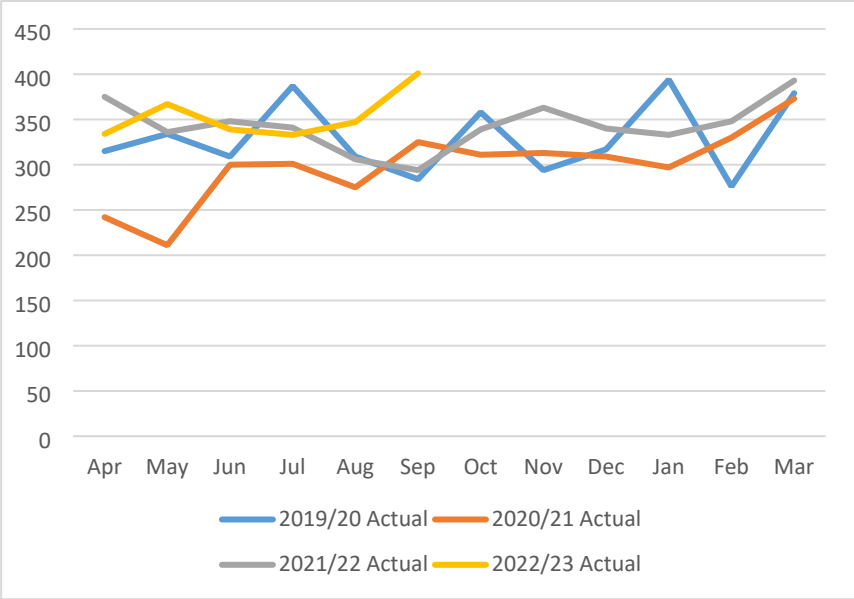
The number of patients scheduled to begin emergency radiotherapy treatment in September 2022 (28) was greater than the number scheduled to begin treatment in the previous month (17).

Treatment Intent	3-5 days	6-10 days
Emergency (2-day target)	2	0

28 patients were referred for emergency treatment. 2 did not receive treatment within 2-days of referral for emergency radiotherapy treatment (performance 93%).

Of these patients:
2 patients were treated within 3 days. This delay was as a result of Consultant request in relation to pathway management.

SACT Referral Trends – Overall

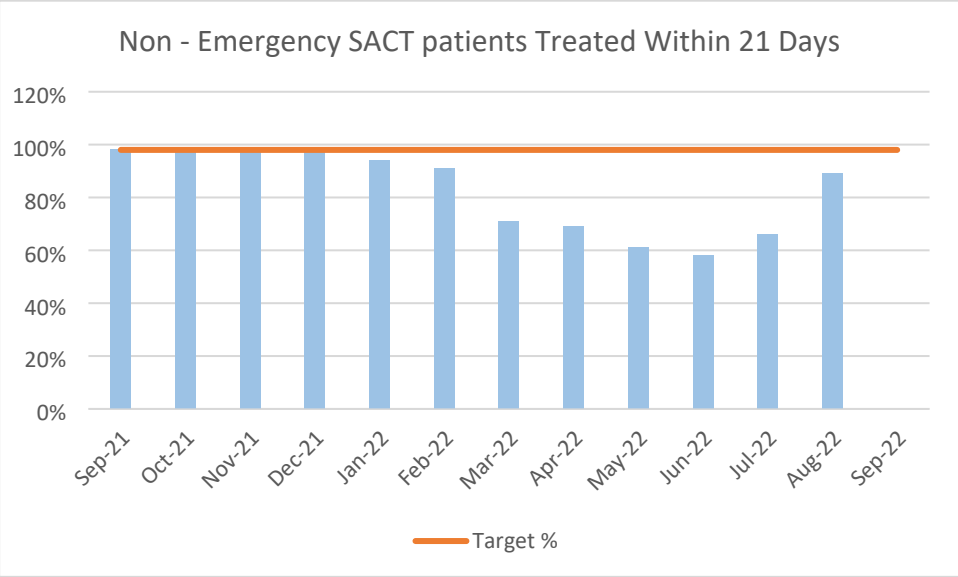


All SACT Referrals

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Referrals	315	334	309	387	309	284	358	294	317	394	276	379
2020/21 Referrals	242	211	300	301	275	325	311	313	309	297	330	373
2021/22 Referrals	375	336	348	341	306	294	339	363	340	333	348	393
2022/23 Referrals	334	367	339	333	347	401						

Referrals to SACT continue to increase, with referrals in September being the highest number in single month in the last 4 years.

Non-Emergency SACT Patients Treated Within 21-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend



Of 334 patients treated, 36 patients waited over 21 days = performance of 89%.

Intent / Days -	22-28	29-35	36-42	42+
Non-emergency (21-day target)	20	8	7	1

The longest waiting patient was 101 days. The patient had received previous SACT but have had a gap in treatment and was allocated to restart SACT. The functionality in Chemocare allows the Prescriber to incorrectly select as a repeat cycle. The patient does not then flag as a new referral and was originally delayed as a result. This has been investigated as a clinical incident.

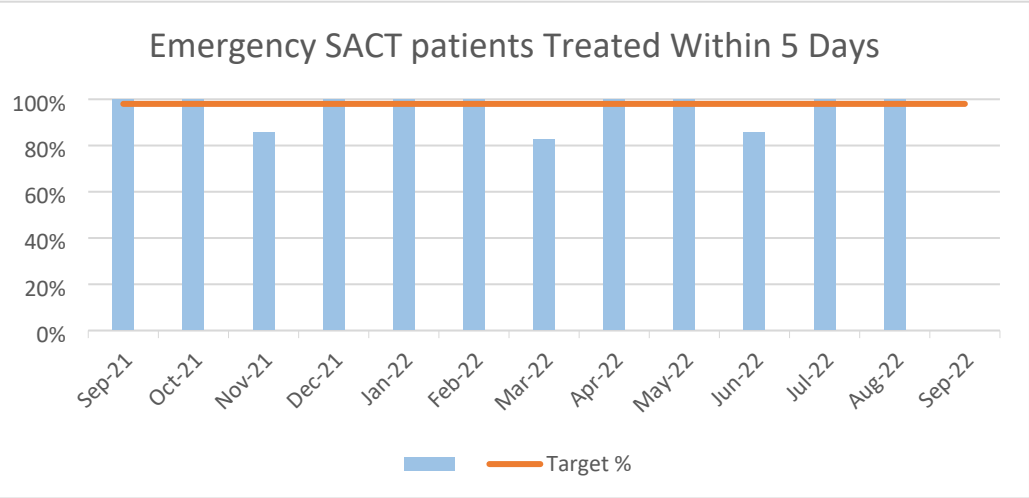
Performance has continued to improve, with breach numbers continuing to reduce from 92 in August to 36 in September.

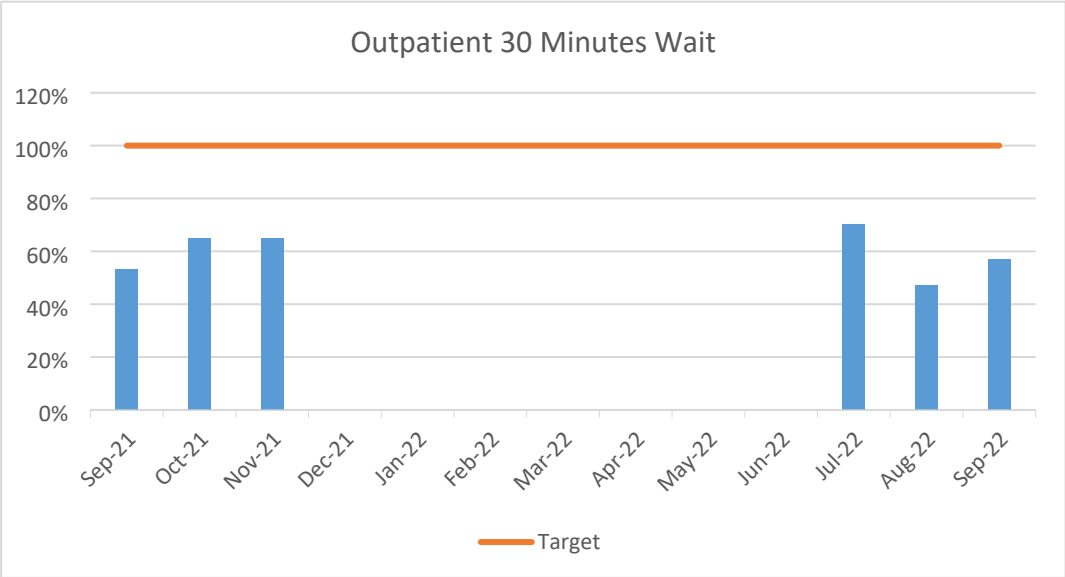
The attendance record was broken again in September with 2544 SACT attendances, up from last month's high of 2501. The average for the April to July period was 2300.

Breaches within SACT are as a result of demand outstripping available capacity as the pathway from entering the waiting list is straight to treatment.

All new patients and urgent patients are prioritised using Welsh Cancer Network guidance and available clinical information. Daily escalation

	meetings continue and capacity needs are continually reviewed and change frequently throughout the day. The clinical priority process commenced on 20th December 2021. All patients within a Clinical Trial are booked within the trial timeframes. A review of the process for measuring and managing potential harm to patients as a result of longer waiting times has commenced, along with an audit of the application of the clinical prioritisation process to ensure patients at most risk are managed appropriately.
	Key Actions
	• Week commencing 10th October additional chairs to be supported in Prince Charles Hospital resulting in sustainable increase in activity. • Additional capacity continues to be provided from RD&I, and first floor ward. • Incremental gains in pharmacy capacity are being delivered through reviews of working practices and the focus on maximising SACT provision. • Treatment regimens which can be delivered in other clinical areas have been actioned and further are being explored to release capacity in the SACT clinic area. • Proposal has been developed to support re-introduction of activity within Neville Hall Hospital as part of an interim solution pending the work of the Outreach Project. • Process to monitor the weekly activity data to ensure activity levels continue to be maintained across all delivery points

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend
	9 patients were treated in September who were referred for emergency SACT. All 9 patients were treated in target. Therefore 100% compliance with target. **Key Actions** • Continue to balance demand and ring fencing with capacity.

Outpatient 30 minute wait	
Target: 100%	**SLT Lead: Outpatient Manager**
Current Performance	Trend
 Performance reported for Sep 2022 was 57%.	Monitoring of indicator reinstated but remains limited as only a snapshot of clinics at particular times. The performance on patient waiting times has multiple influencing factors. This includes the delivery of "on the day" phlebotomy, variation in clinic management practice between clinical teams and increases in the number of patients requiring complex care. The Out Patient Programme is collating a wide range of actions to enable incremental improvements across the function. Currently the focus is on the implementation of DHCR. We are working with the Wales Cancer Network to scope pathway improvements. Actions Focus Groups to be established with patient involvement to define performance measures reflecting the entire patient experience at outpatients as part of the Trust wide PMF review. Delivery of the Out Patient Programme.

Equitable and Timely Access to Services - Therapies	
Target: 100%	**SLT Lead: Head of Nursing**
Current Performance	

Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	95%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

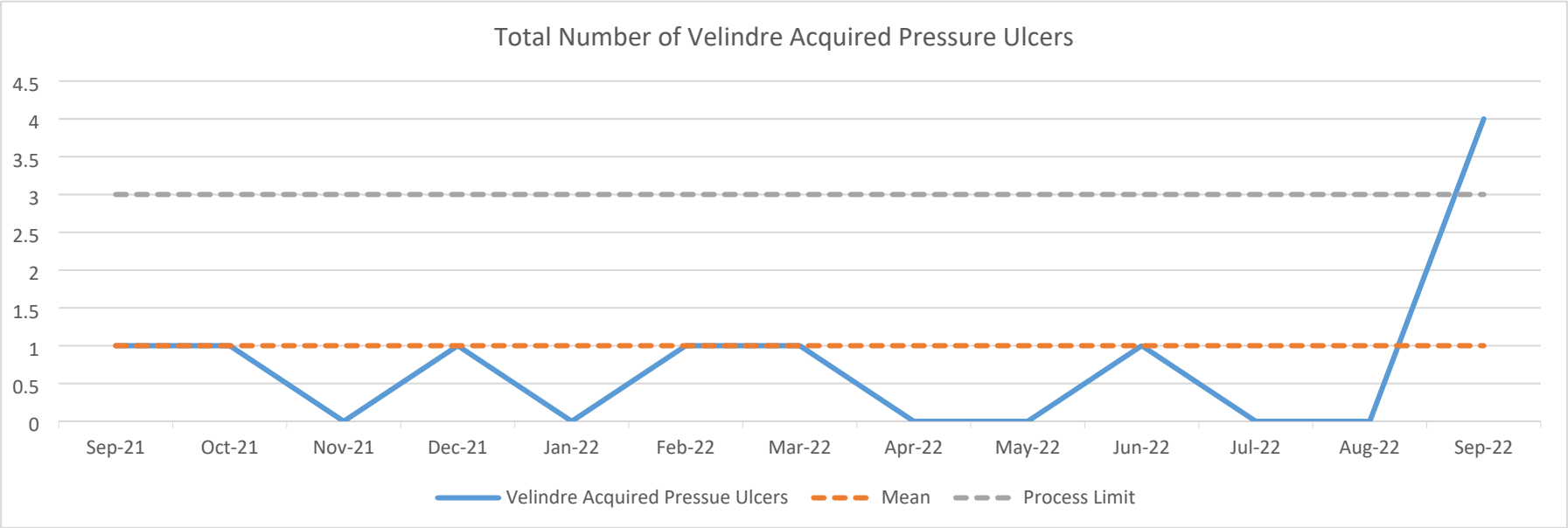
	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Dietetics	98%	97%	100%	95%	98%	100%	98%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	86%	100%	100%	100%	100%	100%	100%	100%	78%
OT	33%	78%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%
SLT	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%

Therapies had the following breaches: **IP's:** Dietetics = 1 breach for Dietetics (95%) - Workforce issues due to a new band 5 induction for inpatients. **OP's** (routine) Physiotherapy = 78% = 2 breaches, Locum is covering outpatients and had 2 weeks annual leave during this period. **OP's** (urgent) Speech and Language Therapy = 50% 1 breach due to workforce issues. Risk already raised due to recruitment problems and maternity leave x2	Actions: Departmental Leads continue to review recruitment and retention strategies and the use and cost of short term cover options.

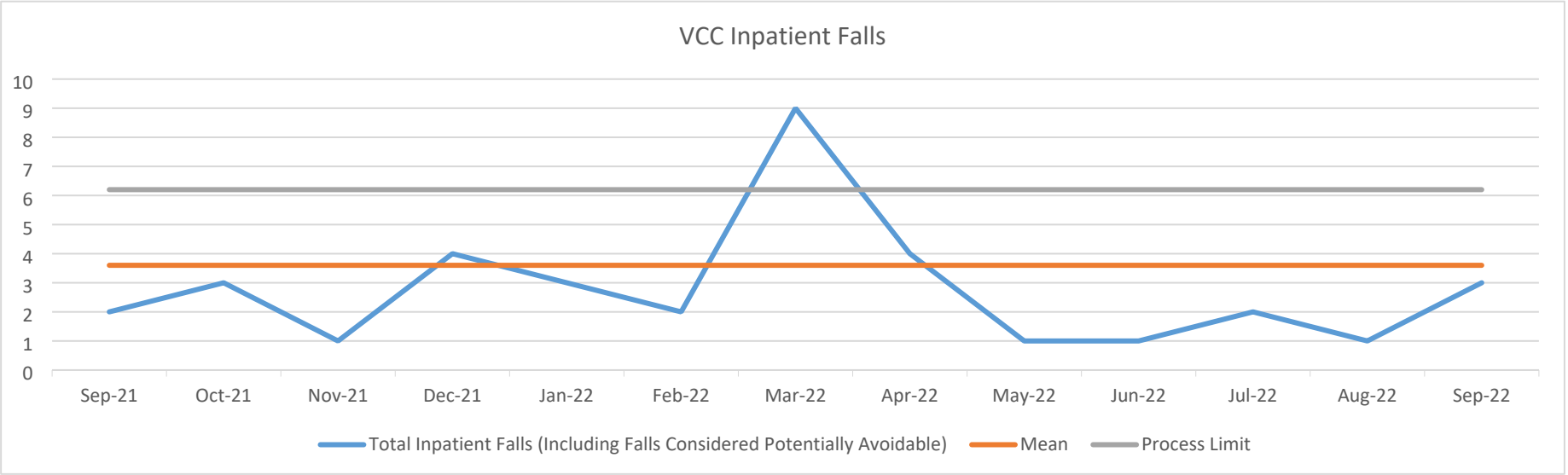
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Velindre Acquired Pressure Ulcers (Total)	2	1	1	0	1	0	1	1	0	1	0	0	4
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	0	0	0	0	1	0	0	1	0	0	0

Trend	Action
In September 2022 there were 4 Velindre acquired pressure ulcers affecting 3 patients on first floor ward. All three patients have been discussed at Scrutiny panel and all identified as unavoidable, however one case has been referred back to scrutiny as there were breaches in standards identified. The following themes were identified: firstly (2 out of 3 patients) where the timescale for the initial PU risk assessment being undertaken was delayed, and secondly 2 of the 3 patients were having to be nursed on their backs flat. ***Patient 1*** - (suspected deep tissues injury & grade 2) had all appropriate assessments and care, had capacity and was declining frequent turns and care on occasions despite risk based discussions. Patient, due to condition had to be nursed supine with neck brace on – pressure ulcers developed on heel and neck. ***Patient 2*** – (grade 2) slight delay in admission pressure ulcer risk assessment being undertaken (7 hours 45 mins after admission rather than within 6 hours) – deemed not to be contributory factors. All preventative measures in place and followed. Following identification of skin damage mattress changed to a new trial mattress and PU healed quickly. ***Patient 3***- (grade 2) – risk assessment 4 hours late in being undertaken due to care needs being prioritised. Patients' condition was generally poor. Patient had to be nursed flat. There were delays in repositioning and on occasions re positioning was declined. Following review at EMB this case has been referred back to Scrutiny panel as this may have been preventable given breach in standards.	Further review of patient 3, referred back to scrutiny panel. A full review of the reasons behind both the delays in undertaking PU risk assessments and in the moving of patient 3 within identified timeframe is being undertaken by VCS.

Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	

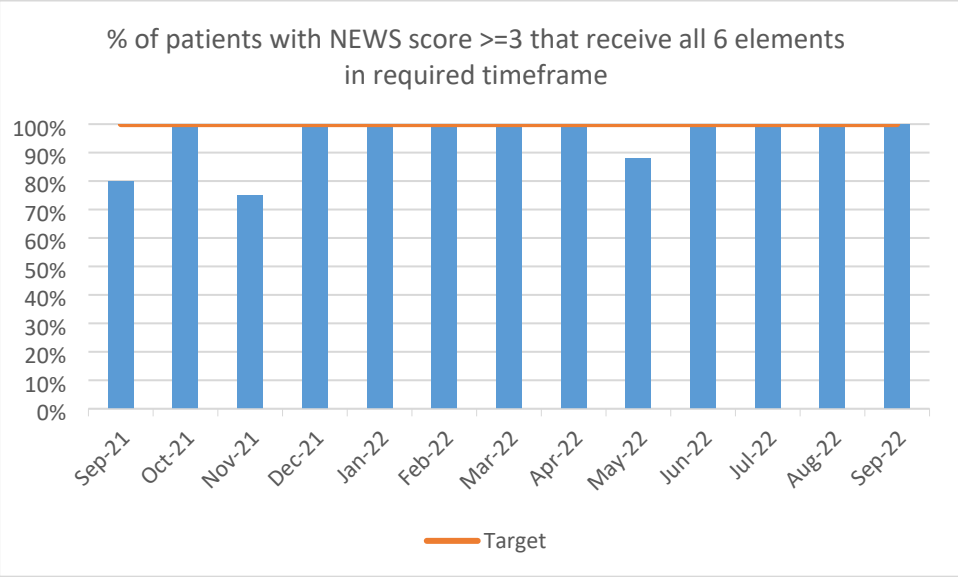


	Jul-21	Aug-21	Sep-21	Oct-21	Nov - 21	Dec - 21	Jan - 22	Feb - 22	Mar - 22	Apr - 22	May - 22	Jun - 22	Jul - 22	Aug-22	Sep-22
Total Inpatient Falls	3	4	2	3	1	4	3	2	9	4	1	1	2	1	3
Potentially Avoidable Inpatient Falls	0	0	1	0	0	0	1	0	0	1	1	0	2	0	1

Trend	Action
Patient 1 Patient was admitted to first floor ward The required admission assessments were complete the patient was not identified as risk of falls. The patient pressed the call buzzer, nurse attended and found patient on her knees at the edge of the bed. Post falls care plan was followed and the patient was assisted back to bed. No obvious injuries. **Outcome: UNAVOIDABLE** because the patient was not identified as at risk of falls and had no cognitive impairment but didn't use call bell. **Patient 2** Patient was admitted to first floor ward and was generally unwell and for consideration of Radiotherapy. All required admission assessments completed and falls reduction plan in place, patient was identified as risk of falls as unsteady on feet. Witnessed fall, patient reports attempting to stand to use zimmer frame and legs folded beneath him, patients legs leaking serous fluid and slipped on the wet floor. Falls care plans updated following the fall and Neurological observations completed as per falls policy. Referral made to Physiotherapist. **Outcome: UNAVOIDABLE** due to risk factors.	**Actions and Learning:**

Patient 3 Patient was identified as risk of falls and confusion. Patient admitted to ward late in the evening awaiting move to HB and only on the ward for a few hours overnight therefore, a physio assessment was not done. The patient could not be moved closer to the nursing station due to the ward acuity so the staff observed the patient within the ward. **Scrutiny Panel Outcome: AVOIDABLE -** Patient based on ward for short period awaiting ambulance transport, not obviously confused and not highlighted in handover from HB staff, on reflection enhanced supervision should have been provided and was provided post fall.	Feedback to staff on patient scenario and learning

Delayed Transfer of Care	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	
There were 0 DToC in September 2022	

Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe	
Target: 100%	**SMT Lead: Clinical Director**
Current Performance	Trend
	Measure 23 % of patients who receive antimicrobial within 1 hour • 13 patients met criteria for response to sepsis - 13 received antibiotics within 1 hour where appropriate = 100% Measure 24 % of patients who receive diagnosis of sepsis & all 6 elements within 1 hour • 9 patient received diagnosis of sepsis - 9 received all 6 elements within 1 hour = 100% % of patients who receive antimicrobial within VCC clinical guidelines = 100% % of patients who receive correct investigations in accordance to VCC guidelines = 100%
	Actions
	Although not impacting in delivery of the bundle there is some improvement regarding completion of bundle paperwork required - this has been added to the department's safety huddles and local sepsis champions identified to assist with cascade of information.

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**

Current Performance

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
C.diff	0	0	0	0	1	0	1	0	0	0	0	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0
E.coli bacteremia	0	0	0	0	0	0	0	0	0	0	1	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0	0

Trend	Action
No cases reported for September	No specific action required.

Welsh Blood Service Monthly Report
September 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

All clinical demand was met in September without the need for mutual aid support and the service is in a good and stable position, with healthy stock levels across all priority groups, which is testament to a concerted effort by all staff working in the supply chain operation. This has enabled the service to provide 20 O negative units to support the Northern Ireland Blood Transfusion Service on 26/09/2022 as part of mutual aid support. This is quite an achievement for the Welsh Blood Service as the rest of the UK supply chain remains extremely fragile and further support from WBS is anticipated.

At 98%, Quality Incident Records closed within 30 days continues to exceed target (90%) for September. There were no adverse event reports submitted to the MHRA and no adverse event reports were submitted to the HTA. In addition, no SHOT incidents were reported during the month. No formal concerns were received during September 2022, with over 7,481 donors registered at donation clinics. All 6 informal concerns received were managed within 2 working days as required by Putting Things Right (PTR) regulations. At 96.5% donor satisfaction continues to remain above target.

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) is still below target (151 against a target of 333). Recent performance is mainly attributed to the collection model used throughout COVID, which considerably reduced donor sessions at venues in educational and business settings, where we typically recruit donors eligible for bone marrow volunteer recruitment (resulting in a drop of 44.44% of eligible donors). A Recovery Plan has been developed to explore new ways to increase recruitment of bone marrow volunteers, avoiding dependence on recruiting at donation sessions. A Project Group has been established to implement the recovery plan, which is expected to start to deliver results in Quarter 1 2023.

2 stem cells were collected out of the 5 planned (2 collections were cancelled by the Transplant Centre and 1 donor failed medical evaluation). The pandemic has impacted on unrelated donor stem cell transplants globally, reducing the number of stem cell collection requests received. A review, re-appraising the existing collection model and its ambition, will culminate in the development of the WBMDR 5 year strategy outlining a structured recruitment strategy enhancing the collection of stem cells.

In September, Reference Serology 'turnaround' performance improved to 73% against a target of 80%. Continued staff absence and continued high levels of testing requests and planned leave have contributed to this performance. A Business Case is to be submitted to Welsh Health Specialist Services Committee (WHSSC) to support the appointment of an additional Band 6 Specialist Biomedical Scientist resource to increase complex testing capacity to drive an improvement in performance against this metric. Compatibility testing (47% of referrals) continues to meet clinical target and all time critical tests are being completed on time.

Time expired platelets did not meet target in September. The most significant expiry occurred during the 1st week of the month, following the bank holiday which accounted for almost half the expiry for September. Given the variability of expired platelets over the past 12 months, the service carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups are being established in Noveber to implement the recommendations.

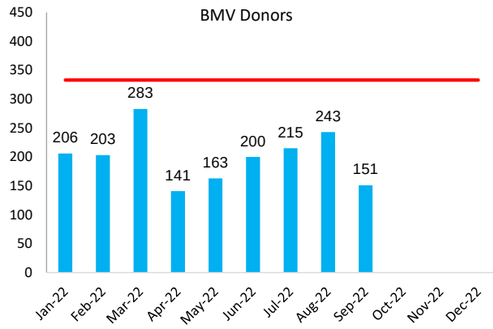
Manufacturing efficiency was just below target at 357.40 against a target of 392. Recent performance is due, in part, to manufacturing staff continuing to prioritise production of Fresh Frozen Plasma and Cryoprecipitate to support the swap out of products within the heath boards provision of Hepatitis B core tested blood components for the patients of Wales. This target is based on the Pre COVID operating model and is due to be reviewed as part of the ongoing development of the reporting framework. New staff have been recruited to vacancies in the department.

Performance did not meet the quarterly target (1544 against a target of 2750). Throughout July and August, WBS were in Blood Shortage Blue Alert and unable to sustain growth in O type blood supplies.
A measured approach to growing O type blood stocks was taken that involved using as many available existing donors as possible to ensure donors could be selected by their blood type. The high use of existing donors, as a mitigation to the national blood shortage position led to a significant reduction in available appointments for new donors. As the service starts to stabilise collections and returns to the pre covid operating model it is hoped this target will improve.

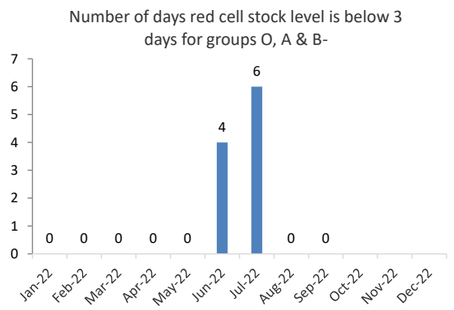
Reference Table

Measure	Target	Timeframe	National / Local
Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	Annual	Local
Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover	0 days	Monthly	Local
Number of bags of RBCs manufactured as a % of the number of issues to hospitals **(% Red Cell Demand Met)**	100%	Monthly	Local
Number of bags of platelets manufactured as a % of the number of issues to hospitals **(% Platelet Demand Met)**	100%	Monthly	Local
Number of Confirmatory Tests (CTs) requested and bled as a % of the total CTs requested **(Confirmatory Tests Bled)**	65%	Monthly	Local
Number of Stem Cell Collections	80	Annual	Local
Number of antenatal patient results provided to customer hospitals within 3 working days from receipt of sample **(Antenatal Turnaround Times)**	90%	Monthly	Local
Number of samples referred for red cell reference serology work ups provided to customer hospitals within 2 working days. **(Reference Serology Turnaround Times)**	80%	Monthly	Local
% of Quality Incident Records (recorded in DATIX), closed within 30 days over a rolling 3 month period	90%	Rolling	Local
Number of critical non-conformances through external audits or inspections	0	Annual	Local
Number of Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines and Healthcare products Regulatory Agency (MHRA)	0	Annual	Local
Number of whole blood donations that are collected on session which are below the minimum viable volume, as a % of the total number of whole blood donations collected **(% Part Bags)**	3%	Monthly	Local
Number of donors where venepuncture is attempted to be performed on but no blood enters the bag, as a % of the number of donors who have reached the donation chair **(% Unsuccessful Venepuncture)**	2%	Monthly	Local
The number of blood components (weighted) collected per Standardised FTE **(Blood Collection Efficiency)**	1.25 WTE	Monthly	Local
Number of components manufactured per Standardised FTE. **(Manufacturing Efficiency)**	392	Monthly	Local
Number of platelets which have time expired as a % of the total number of platelets manufactured **(Time Expired Platelets)**	10%	Monthly	Local
Number of RBC units which become non-viable during the manufacturing process which could have been avoided, as a % of the number of complete whole blood donations **(Controllable Manufacturing Losses)**	0.5%	Monthly	Local
Number of bags of RBC, including Paediatric bags, which have time expired as a % of the total number of RBC bags manufactured **(Time Expired Red Cells)**	1%	Monthly	Local
Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied with their overall donation experience after they have been registered on clinic to donate **(Donor Satisfaction)**	71%	Monthly	Local
Number of 'formal' and 'informal' concerns received from blood donors	~	~	~
% of 'formal' concerns received and treated under 'Putting things Right Regulations within 30 working days	100%	Monthly	National
% of all concerns (formal and informal) acknowledged within 2 working days as required by the 'Putting things Right' Regulations	100%	Monthly	National
Number of new Whole Blood Donors recruited to the donor panel	2,750	Quarterly	Local
Number of new Apheresis Donors recruited to the donor panel	14	Quarterly	Local
Number of Deceased Donor Typing / Cross Matching reported within given period	80%	Quarterly	Local
Number of Anti D & -c Quantitation patient results provided to customer hospitals within 5 working days	90%	Quarterly	Local

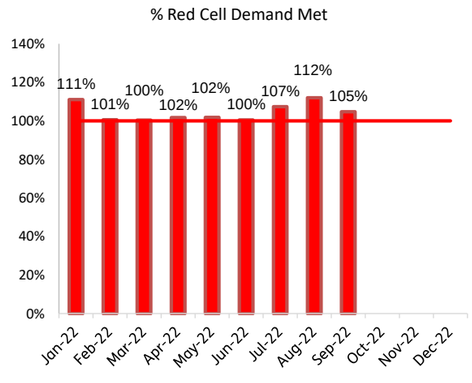
Monthly Reporting



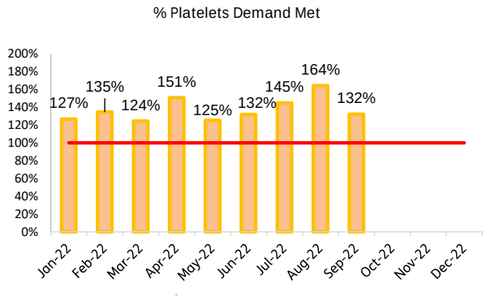
Annual Target: 4000 (ave 333 per month)	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) (151 against a target of 333). Recent performance is mainly attributed to the collection model used throughout COVID, which considerably reduced donor sessions at venues in educational and business settings, where we typically recruit donors eligible for bone marrow volunteer recruitment (resulting in a drop of 44.44% in eligible donors).	A Recovery Plan has been developed to explore new ways to increase recruitment of bone marrow volunteers avoiding dependence on recruiting at donation sessions. A Project Group has been established to implement the recovery plan. Existing promotional activity plans continue and include WBMDR staff attending school six forms, colleges and university fresher's fayres. Profiling bone marrow donor recruitment on social media and on the WBS website continues in earnest. The WBMDR five year strategy, re-appraising the existing collection model and its ambition, is in development.	Quarter 1, 2023 Ongoing Quarter 3



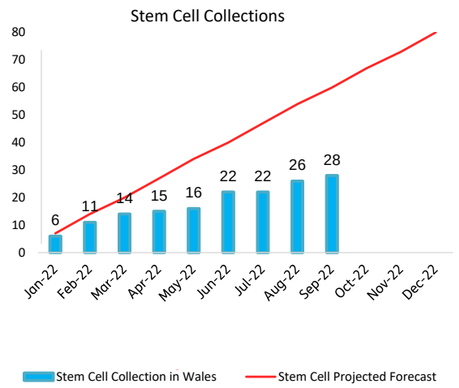
Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
During September, the red cell stock holding did not drop below 3 days for priority blood groups (O, A and B+). Stock levels are satisfactory across all groups.	The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain. At the meetings, business intelligence data is reviewed and facilitates operational responses to the challenges identified. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.	Reviewed daily to support responses to changes in demand.



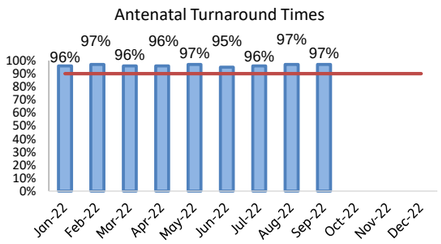
Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand was met in September without the need for mutual aid support and the service is in a good and stable position, with healthy stock levels across all priority groups. This has enabled the service to provide 20 O negative units to support the Northern Ireland Blood Transfusion Service on 26/09/2022 as part of mutual aid support. This is quite an achievement for the Welsh Blood Service as the rest of the UK supply chain remains extremely fragile and further support from WBS is anticipated. Demand in September (full weeks) averaged at 1401 units per week.	The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain.	Reviewed daily to support responses to changes in demand.



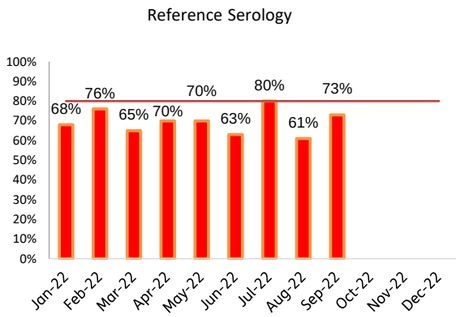
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand for platelets was met. For September, platelet demand was 155 units per week on average, which is up from August's weekly average of 149. Note: A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets.	Due to their short shelf life (7 days), platelet stocks are monitored on a daily basis to ensure adequate response time to any 'spikes' in demand. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. The service carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups are being established in Q3 to implement the recommendations. They cover optimising the clinic collection plan for Apheresis and creation of a forecasting tool to inform decisions around pooled platelet manufacture.	Reviewed daily Quarter 3



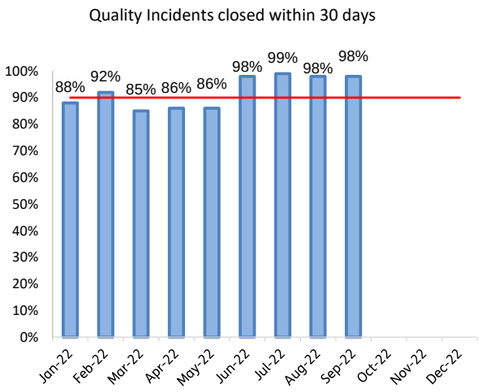
Annual Target: 80 (ave 7 per month)	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
2 stem cells were collected out of the 5 planned (2 collections were cancelled by the Transplant Centre and 1 donor failed medical evaluation). The pandemic has impacted on unrelated donor stem cell transplants globally, reducing the number of stem cell collection requests. In addition, the Service continues to experience a cancellation rate of approx. 30% compared to 15% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.	Currently, 2 requests for stem cell products are due for collection in October with a further 2 waiting to be booked and 2 collections for November. The WBMDR five year strategy, re-appraising the existing collection model and its ambition, is in development.	Quarter 3



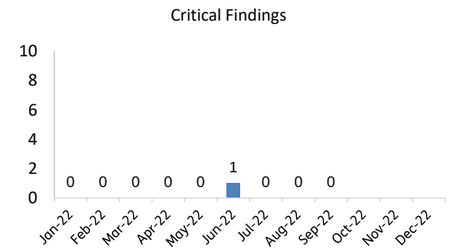
Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains above target.	Efficient and embedded testing systems are in place. Continued monitoring and active management remains in place, maintaining high performance against current target.	Business as Usual, reviewed daily



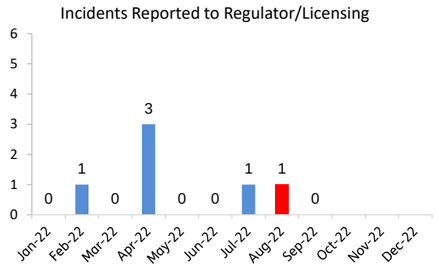
Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
In September, Reference Serology 'turnaround' performance improved to 73% against a target of 80%. Continued staff absence and continued high levels of testing requests and planned leave have contributed to this performance. Compatibility testing (47% of referrals) continues to meet clinical target and all time critical tests are being completed on time. At 229 the volume of testing requests has reduced slightly compared to Average 226/month for 2021 and 181/month in 2020.	The service conducts specialist tests to confirm hospital results that are difficult to interpret or will undertake additional testing which is not performed in the hospital blood banks. These tests must be performed within 7 days of the sample being taken and are prioritised appropriately to ensure the fastest turnaround possible. The service continues to prioritise compatibility referrals and safe provision of red cells for transfusion. All referrals are prioritised based on clinical need. A Business Case is to be submitted to Welsh Health Specialist Services Committee (WHSSC) to support the appointment of an additional Band 6 Specialist Biomedical Scientist resource to increase complex testing capacity to drive an improvement in performance against this metric. Validation the new automated analyser, which will improve efficiency, remains on schedule to be completed in the Autumn.	Quarter 3



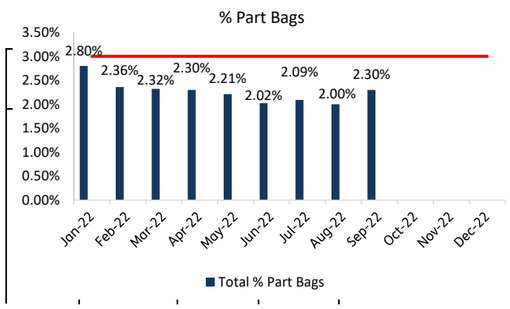
Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 98%, Quality Incident Records (recorded in DATIX & QPulse) closed within 30 days has met target (90%) for the three-month rolling period to September (QPulse at 100% and 94% for Datix). All QPulse incidents that have been 'Accepted' as GMP incidents have been risk assessed, investigated and CAPA assigned.	New reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The process has been revised to address the findings of the MHRA inspection and ensure that all low and moderate risk incidents have root cause assigned. The progress of actions to address incidents is closely monitored. The QA team continue to send weekly updates alerting owners/managers of actions recorded within QPulse that are likely to breach close-out deadlines .	Continue with close monitoring and early recognition of potential timeline breaches.



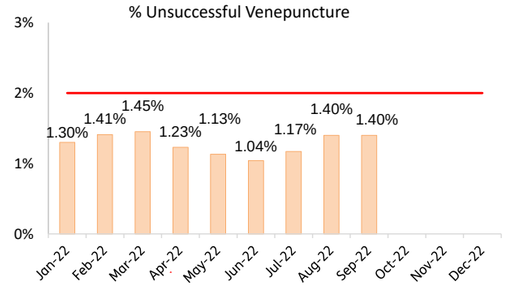
Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no major findings during the UKAS 17403 Surveillance Audit (29-30 Sep). There was one minor finding on the time period related to the review of documentation, and one recommendation relating to the process for capturing and recording non-conformances.	Significant progress is being made against the MHRA action plan arising from the North Wales inspection in June.	Completion of all action plans for external audits is monitored via the monthly RAGG meeting.



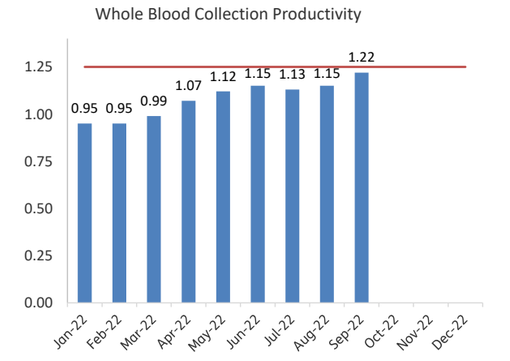
Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no adverse event reports submitted to the MHRA in September and no adverse event reports were submitted to the HTA. Also, no SHOT incidents were reported during the month.	Completion of CAPA, in respect of SABRE reports, is monitored via existing processes. Note: A suspected serious adverse event involving a stem cell donor was reported to the Human Tissue Authority in August. Following a review of information relating to the donor, the HTA has deemed that this incident is most likely to have resulted from a localised chest infection and not from the donation procedure itself. As a result it does not meet the criteria for a Serious Adverse Event (now marked in red in bar chart).	Progress of completion of the Datix investigation is monitored via monthly QA metrics reporting.



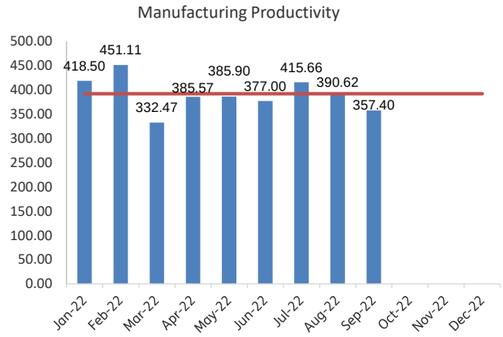
Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains within the required tolerance level (3%) at 2.30% during September. Analysis of the part bag rates shows that the only breach for September was the Mobile Donation Clinics (MDCs) with a rate of 4.5%. MDCs were taken out of service in March 2020 due to Infection, Prevention and Control measures during COVID and were re-introduced in September on a phased basis. Some teething problems have contributed to the breach in tolerance for September for the MDC (e.g. wrong appointment grid being used, some 'make ready' changes introduced, new staff deployed onto MDC). Causes of Part Bags are various (needle placement, clinical risk, donor is unwell, donor request to stop donation, late donor information and equipment failure) and at times cessation of donation resulting in a part bag is clinically appropriate. This is a separate factor to Failed Venepuncture (FVPs).	The majority if the issues identified on the MDC were resolved immediately. Work is ongoing to support staff as they re-familiarise themselves with working in an MDC environment. Part bags rates for MDCs will be closely monitored throughout October.	Continued close monitoring and trend analysis and intervention where required



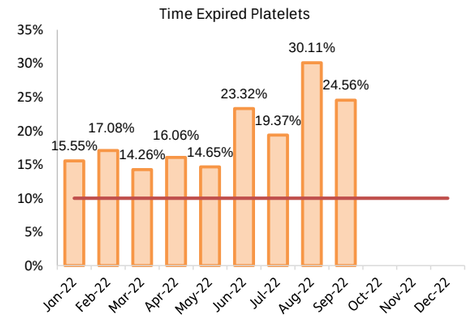
Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains constant and within the required tolerance (2%) at 1.40%. Analysis of the FVP rates shows that the majority of teams have no breaches for September. The exception is Bangor with a 3.4% FVP rate. (10 FVP's - 294 donors bled).	Work is ongoing to identify any potential trends on the Bangor team.	Continued close monitoring and trend analysis and intervention where required.



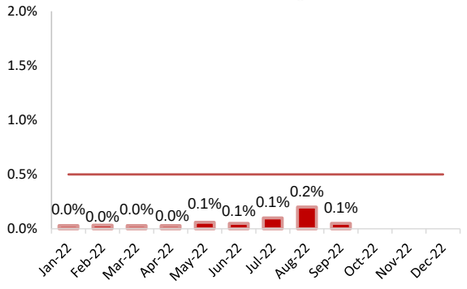
Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Collection efficiency was just below target in September at 1.22 but has moved closer to the target of 1.25 and is the highest it has been this year. There has been a steady increase in performance as we transition from the COVID model to the future model. This is attributable to a number of factors: 1. Growth in appointment uptake %. 2. Targeted DNA messaging. 3. Reintroduction of 10 chair clinics (due to removal of physical distancing). 4. Pilot study to map overbooking opportunities against specific DNA patterns. 5. Completion of training of new staff which improves flow and staff utilisation.	A pilot study is ongoing to review the impact on donor experience when booking donors into identified non attendance gaps, 'overbooking' or supporting 'controlled walk ins' at carefully selected clinics. Donor experience has been reviewed for September and there were no adverse incidents identified to date. It will be reviewed again in October to ascertain any trends emerging as part of the pilot study before considering if the pilot becomes business as usual. In addition, modifications to the 6 chair mobile donations units are now complete and the units have returned to communities in September. Mobile units will now form part of the planning process with the intension of full utilisation in the new year. Work is ongoing with local businesses to return to work place donor sessions. This is dependent on pre COVID models of working in each business due to staff now working from home.	October



Monthly Target 392	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Actions(s) bring taken to improve performance**	**By When**
Manufacturing efficiency was just below target at 357.40 against a target of 392. Recent performance is due, in part, to manufacturing staff continuing to prioritise production of Fresh Frozen Plasma and Cryoprecipitate to support the swap out of products within the heath boards provision of Hepatitis B core tested blood components for the patients of Wales. NB. This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department.	New staff have been recruited to vacancies in the department. This target is based on the Pre COVID operating model and is due to be reviewed as part of the ongoing development of the reporting framework.	Quarter 4

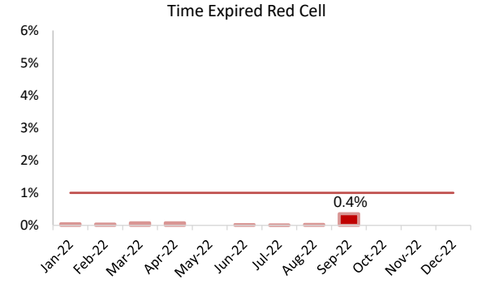


Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
This metric did not meet target in September. The most significant expiry occurred during the 1st week of the month, following the bank holiday which accounted for almost half the expiry for September. Platelet production is currently set at 180 units per week in September.	Given the variability of expired platelets over the past 12 months, the service has carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups are being established in November to implement the recommendations. They cover optimising the clinic collection plan for Apheresis and creation of a forecasting tool to inform decisions around pooled platelet manufacture.	Quarter 3



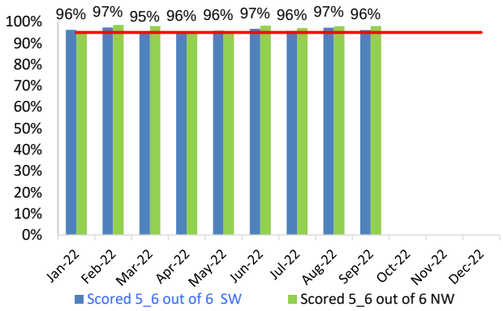
Monthly Target: Maximum 0.5%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Controllable losses were low at 0.05% and remain within tolerance of below 0.5%. The losses were (units): M&D Heat sealer : 1 unit M&D Operator - Automated Blood Press : 2 units These levels are well within tolerance and represent good performance. The monthly controllable losses should be considered against total production of approx. 1500 units per week.	Active management of the controllable losses in place, including vigilance and reporting of all units lost. Ongoing monitoring of losses when occurring in order to understand the reasons and consider appropriate preventative measures thus continuously improving practice through lessons learned and analysis.	Business as Usual, reviewed monthly

Time Expired Red Cell



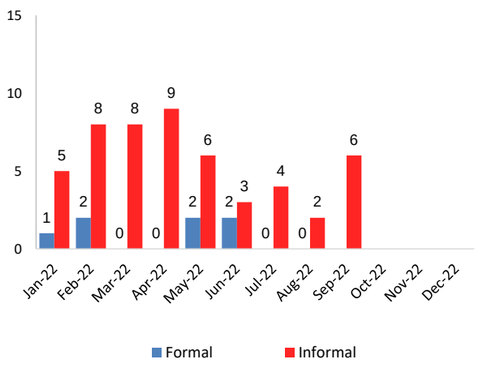
Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
This metric remains within the target and there are no concerns around expiry of red cells. COVID challenges continue to affect the blood collection numbers resulting in faster stock turnover preventing red cells stocks from ageing in storage.	Daily monitoring of age of stock as part of the resilience meetings. Red Cell Shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly. Continued effective management of blood stocks to minimise the number of wasted units.	Business as usual, reviewed daily

Donor Satisfaction

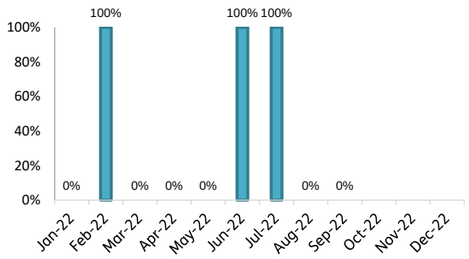


Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96.5% donor satisfaction continues to be above target for August. In total there were 1,103 respondents to the donor survey (some of which are non attributable).	Findings are reported to the Collections management team at the monthly Collections meeting to address any actions for individual teams.	Business as usual, reviewed monthly

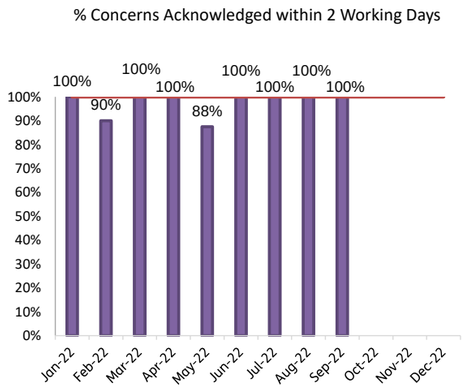
Number of Concerns Received



Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
No formal concerns were received during September 2022, with over 7,481 donors registered at donation clinics. 6 concerns (0.08%) were reported and closed as early resolutions in September. The concerns raised included: * Donor unhappy he was asked to wear a face mask when on donation session. * Donor unhappy to be turned away from session due to attending with her 7 month old baby. * 2 x donors unhappy they attended separate donation clinics that had been cancelled due to issues out of WBS control. * Donor raised concern he was unable to have his daughter translate the blood donation information for him throughout the process. * Donor unhappy with a particular member of staff, donor felt he was an inconvenience to staff member.	Each concern was dealt with as an early resolution and closed within the required timescale. Actions taken to resolve the concerns included: * Operation Managers to remind staff it is not an essential requirement for donors who attend session to donate blood to wear a face mask. * Operation Manager discussed concern with Clinical Governance team & Advanced Practitioner to establish a consistent approach to advise donors who attend session with children. * DCC Manager investigated concern and found processes were followed and a voicemail and email were sent to the Donors. There is no mobile number attached to one donor record so an SMS message could not have been sent. * Full explanation given to donor by Clinic and Specialist Nurses. Donor understands spoken English better than written English. During conversation on session, it was evident donor did not understand the consequences of donation. Following subsequent conversation with donor by Specialist Nurse in Donor Care the donor was happy with the outcome of conversation held. * Operational Manager discussed concern raised with staff member and clinic Nurse, neither could recall any issues on the day. Staff member has worked across the collection teams for over 19 years without any reason for concern.	Business as usual, reviewed daily



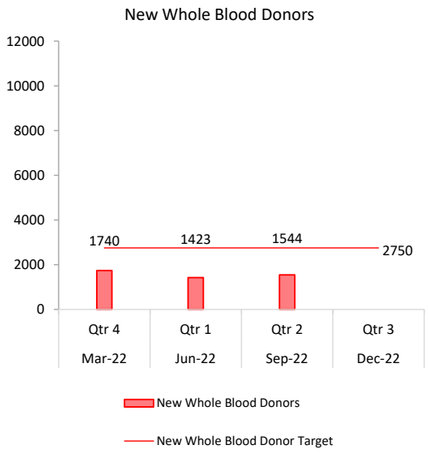
Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
No formal concerns were received during September 2022. All concerns are being monitored and actioned as appropriate. * Under PTR guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.	Continue to monitor formal complaint response progress, and 30 day target compliance.	Business as Usual



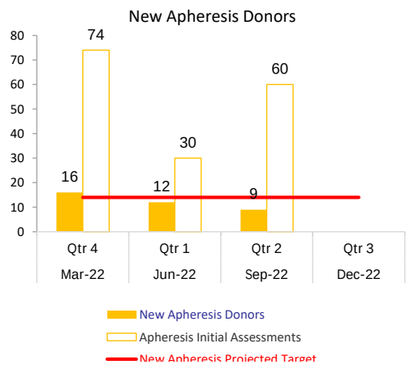
Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
All concerns received in September 2022 were managed within 2 working days as required by Putting Things Right (PTR) regulations.	Continue to monitor this measure against the 'two working day' target compliance. Timescale requirements communicated to all involved in concerns management.	Ongoing, reviewed daily

Quarterly Reporting

Equitable and Timely Access to Services



Quarterly Target: 2750	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance did not meet the quarterly target (1544 against a target of 2750). Throughout July and August, WBS were in Blood Shortage Blue Alert and unable to sustain growth in O type blood supplies. A measured approach to growing O type blood stocks was taken that involved using as many available existing donors as possible to ensure donors could be selected by their blood type. The high use of existing donors, as a mitigation to the national blood shortage position led to a significant reduction in available appointments for new donors. As the service starts to stabilise collections and returns to the pre covid operating model it is hoped this target will improve.	Whilst the UK blood stocks position remains unstable, with NHSBT in amber alert status, WBS has continued to grow all blood type stocks throughout September. This allows the Donor Engagement team to rebalance existing donors with new donors, while stocks remain at stable levels. The return of donation vehicles, re-introduction of business sessions and recommencement of University/College venues is expected to result in an increase in new donors. A pilot study to review the impact on donor experience when booking donors into identified non attendance gaps, which includes 'overbooking' or supporting 'controlled walk ins' at carefully selected clinics has started in August, results are positive to date. The future clinic model is being reviewed.	Ongoing, staffing reviewed daily, venue plan reviewed monthly.

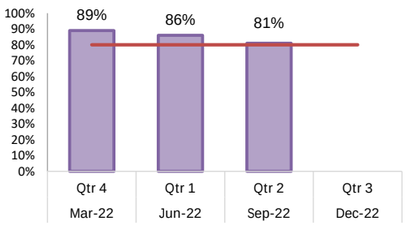


Quarterly Target: 14	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were 4 new apheresis donors in September, five short of the quarterly recruitment target.	17 blood donors registered their interest in becoming apheresis donors following a recruitment drive undertaken in September by the Donor Engagement Team. These donors will be assessed in the coming weeks.	Ongoing monitoring

New Apheresis Projected Target

Safe and Reliable service

Turnaround Times (Deceased Donor Typing/Crossmatching)



Quarterly Target: 80%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains above target.	Continue to monitor performance.	Quarter 3

Anti D & -c Quantitation

Quarterly Target: 90%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains above target.	Continue to monitor performance.	Business as Usual

Canolfan Ganser Felindre
Velindre Cancer Centre

Workforce Monthly Report

September 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR, Statutory and Mandatory training in all Divisions of the Trust, including Corporate Divisions, TCS and Research and Development (excluding hosted);
- Corporate Divisions include Finance, Workforce and OD, Corporate Estates and Planning, Corporate IT, Clinical Governance, Infection Control, Fundraising and Trust Management and Board;
- The report provides a 12 monthly trend report for Sickness
- Hotspots identified, with in month actions to explain improvement trajectory work in relation to sickness

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Sept-22	Aug22	
PADR	71.24%	70.45%	85%
Sickness	6.31%	6.46%	3.54%
S&M Compliance	85.49%	85.10%	85%

Workforce Dashboard

Data below highlights rolling figures for workforce KPI's. This provides a running total of the values of the last 12 months of an indicator providing trend data for the indicators. Granular monthly data is generated for divisions as separate reports. Data Rag Rated for ease of reading.

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude Trainee Doctors, those on Maternity, Starters within first 6 Months, those currently off on sickness absence.													
PADR	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	45.69	46.58	44.59	45.64	44.08	50.33	53.02	51.01	53.38	54.05	52.74	51.72	52.63
Research, Development & Innovation	66.67	72.09	90.91	88.37	84.09	80.00	60.87	60.98	64.29	56.10	57.14	53.66	60.00
Transforming Cancer Services	56.25	43.75	62.50	75.00	63.16	57.89	57.14	57.89	55.00	52.38	65.22	65.22	62.50
Velindre Cancer Centre	76.40	73.77	70.90	67.61	65.16	65.25	63.56	68.69	68.62	69.04	71.30	71.47	71.50
Welsh Blood Service	77.93	77.52	82.19	83.06	83.73	81..75	78.44	78.16	79.26	77.53	76.90	77.86	79.27
Velindre Organisations	73.67	71.69	72.11	70.83	69.21	69.75	66.86	69.24	69.81	69.29	70.45	70.61	71.24
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude those on Maternity and those currently off with sickness absence													
Stat and Mand Compliance (10x CSTF)	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	71.36	74.54	72.32	74.40	72.17	73.64	74.51	73.48	74.31	74.41	73.06	71.95	73.84
Research, Development & Innovation	86.25	84.89	84.58	85.83	84.26	80.42	80.21	80.23	79.56	82.95	81.09	80.22	84.77
Transforming Cancer Services	82.50	82.86	83.33	81.43	77.86	77.39	77.39	78.64	80.91	76.96	75.65	75.42	77.20
Velindre Cancer Centre	82.89	83.11	84.91	84.93	84.73	84.18	84.88	85.17	85.46	85.22	84.68	84.39	85.01
Welsh Blood Service	92.21	92.54	93.36	93.56	93.78	92.02	92.30	92.19	92.44	93.17	91.72	92.19	91.33
Velindre Organisations	84.95	85.10	86.06	86.40	85.97	85.26	85.77	85.76	85.08	86.20	85.27	85.10	85.49

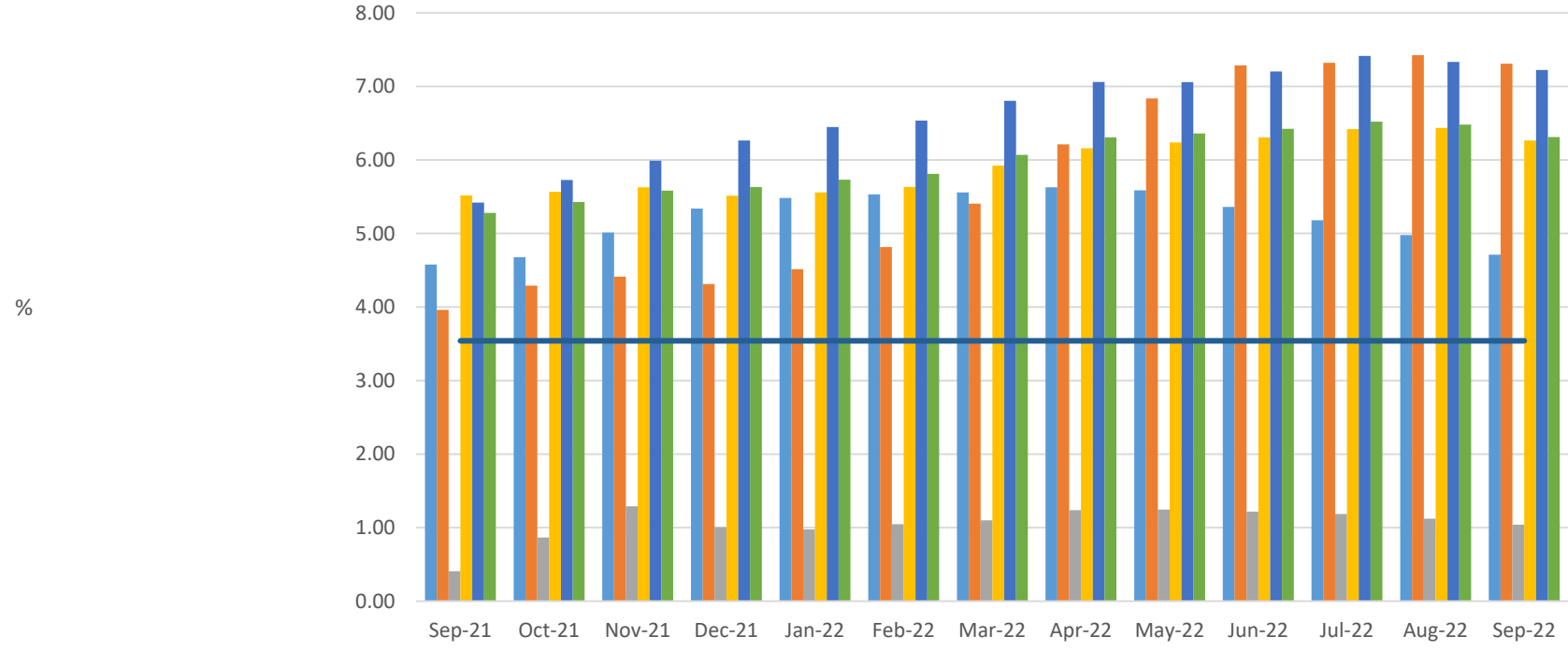
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	4.58	4.68	5.01	5.34	5.48	5.53	5.56	5.63	5.59	5.36	5.18	4.98	4.71
Research, Development & Innovation	3.96	4.29	4.41	4.31	4.51	4.81	5.41	6.21	6.84	7.29	7.32	7.42	7.31
Transforming Cancer Services	0.41	0.86	1.29	1.01	0.98	1.05	1.10	1.24	1.25	1.22	1.18	1.12	1.04
Velindre Cancer Centre	5.52	5.57	5.63	5.51	5.56	5.63	5.92	6.16	6.24	6.31	6.42	6.43	6.26
Welsh Blood Service	5.42	5.73	5.99	6.27	6.45	6.53	6.80	7.06	7.06	7.20	7.41	7.33	7.22
Velindre Organisations	5.28	5.43	5.58	5.63	5.73	5.81	6.07	6.31	6.36	6.42	6.52	6.48	6.31
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

Monthly Sickness Rolling Covid Only Absence %	0.00		0.01% - 0.49%		0.50 % & Above								
Sickness Leave Covid Related	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	1.34	1.46	1.57	1.64	1.71	1.73	1.69	1.66	1.63	1.57	1.54	1.48	1.36
Research, Development & Innovation	0.43	0.43	0.53	0.66	0.87	1.08	1.33	1.59	1.68	1.96	2.22	2.48	2.58
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.01	0.01	0.01	0.01	0.01
Velindre Cancer Centre	0.85	0.86	0.84	0.73	0.82	0.89	1.07	1.17	1.16	1.22	1.31	1.30	1.25
Welsh Blood Service	0.36	0.39	0.38	0.36	0.38	0.42	0.61	0.79	0.85	0.94	1.12	1.15	1.11
Velindre Organisations	0.72	0.75	0.74	0.70	0.77	0.83	0.99	1.10	1.12	1.18	1.29	1.29	1.24

Monthly Special Leave Absence Rolling %	0.00		0.01% - 0.49%		0.50 % & Above								
Special Leave Non Covid Related	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	0.03	0.09	0.09	0.09	0.09	0.10	0.10	0.12	0.13	0.14	0.14	0.14	0.14
Research, Development & Innovation	0.92	1.08	1.25	1.37	1.57	1.62	1.69	1.89	1.89	1.82	1.75	1.55	1.36
Transforming Cancer Services	0.55	0.54	0.41	0.25	0.08	0.07	0.07	0.07	0.07	0.06	0.05	0.02	0.02
Velindre Cancer Centre	0.48	0.53	0.57	0.61	0.66	0.67	0.73	0.79	0.79	0.81	0.81	0.78	0.74
Welsh Blood Service	0.59	0.59	0.58	0.56	0.53	0.51	0.49	0.50	0.48	0.47	0.43	0.40	0.38
Velindre Organisations	0.49	0.53	0.55	0.56	0.58	0.59	0.61	0.65	0.65	0.65	0.64	0.61	0.57

Monthly Special Leave Absence Rolling %	0.00		0.01% - 0.49%		0.50 % & Above								
Special Leave Covid Related	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	0.01	0.00	0.00	0.00	0.00	0.00	0.02	0.02	0.05	0.07	0.08	0.08	0.09
Research, Development & Innovation	0.13	0.15	0.10	0.15	0.20	0.20	0.21	0.30	0.30	0.31	0.31	0.24	0.24
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	0.69	0.71	0.64	0.65	0.70	0.69	0.75	0.83	0.85	0.88	0.89	0.90	0.85
Welsh Blood Service	0.67	0.67	0.68	0.65	0.63	0.61	0.59	0.63	0.69	0.69	0.68	0.64	0.52
Velindre Organisations	0.59	0.60	0.56	0.56	0.58	0.57	0.60	0.65	0.68	0.70	0.71	0.69	0.63

Sickness Data – The Figures



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	4.58	4.68	5.01	5.34	5.48	5.53	5.56	5.63	5.59	5.36	5.18	4.98	4.71
Research, Development & Innovation	3.96	4.29	4.41	4.31	4.51	4.81	5.41	6.21	6.84	7.29	7.32	7.42	7.31
Transforming Cancer Services	0.41	0.86	1.29	1.01	0.98	1.05	1.10	1.24	1.25	1.22	1.18	1.12	1.04
Velindre Cancer Centre	5.52	5.57	5.63	5.51	5.56	5.63	5.92	6.16	6.24	6.31	6.42	6.43	6.26
Welsh Blood Service	5.42	5.73	5.99	6.27	6.45	6.53	6.80	7.06	7.06	7.20	7.41	7.33	7.22
Velindre Organisations	5.28	5.43	5.58	5.63	5.73	5.81	6.07	6.31	6.36	6.42	6.52	6.48	6.31
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

Sickness – The Narrative

Performance Indicator	RAG/ Change from previous month	September Figure	Hotspot	%	Comment
Sickness absence (3.42%)	**6.46%** ↓	6.31%	**Welsh Blood Service (7.33%)**		
			Collections	9.64%	Decrease from previous month (11.99%)
			Laboratory Section	3.85%	Decrease from previous month (8.43%)
			Quality Assurance Section	2.69%	Decrease from previous month (4.76%)
			Velindre Cancer Centre (6.41%)		
			Radiotherapy	9.63%	Increase from previous month (8.85%)
			Outpatients	7.04%	Decrease from previous month (11.99%)
			Operational Services	7.27%	Increase from previous month (6.74%)
			Information Section	7.88%	Decrease from previous month 10.75%)

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 30 SEPTEMBER 2022 (MONTH 6)

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB QSP COMMITTEE	26.10.2022 10.11.2022	NOTED

ACRONYMS	
IMTP	Integrated Medium Term Plan
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre
MMR	Monthly Monitoring Returns
HTW	Health Technology Wales
QSP	Quality, Safety & Performance Committee

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of September 2022.

1.2 This financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as they are directly accountable to WG for their financial performance. Only the balance sheet (SoFP) and cash flow provides the full Trust position as this is reported in line with the WG monthly monitoring returns (MMR).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	(0.002)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.335	5.954	23.063
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	93.9%	95.4%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget (excl Covid and the exceptional cost pressures) 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 September 22 is an underspend of **£0.002m**, with an underachievement against income offset by an underspend within both Pay and Non Pay.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid and decreased activity. The Trust is expecting to receive WG funding to cover during the first 6 months of the year, with strategic plans having been put in place to mitigate the risk exposure during the latter part of the year.

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

Two saving schemes relating to service redesign and supportive structures currently remain RAG rated amber and whilst contingency plans have been put in place which are non-recurrent in nature it is still important that those schemes that have not yet gone live are reviewed at divisional level with a view to implement before the end of the financial year.

The Trust is reporting a year end forecast breakeven position; however, this assumes that all additional Covid-19 costs along with the Exceptional National cost pressures will be fully reimbursed by both WG and the Trust Commissioners, that all other planned additional income is received, and the savings targets are achieved.

2.3 PSPP Performance

During September '22 the Trust (core) achieved a compliance level of **93.9%** (August 22: 96.31%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.4%** as at the end of month 6, and a Trust position (including hosted) of **95.6%** compared to the target of 95%.

A task and finish group has recently been established to target key areas of underperformance and ensure that the target continues to be achieved during 2022-23.

2.4 Covid Expenditure

Covid-19 Revenue Spend/ Funding 2022/23			
	WG £m	Commissioners £m	Total £m
Mass Vaccination	0.225		0.225
PPE	0.070		0.070
Cleaning	0.407		0.407
Other Covid Response	0.261		0.261

Covid Recovery - Internal Capacity		3.645	3.645
Covid Recovery - Outreach		0.261	0.261
	0.963	**3.906**	**4.869**

The overall gross funding requirement related to Covid has reduced further and currently stands at £4.869m, with £0.963m being recognised although not confirmed for funding from WG, and the balance of £3.906m being sought from our Commissioners.

The £4.869m represents a significant reduction in outsourcing costs from the Trust IMTP plan as of 31st March, largely due to the liquidation of the Rutherford Cancer Centre (RCC).

Other funding / cost reduction reflects control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

2.5 Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

At this stage only unavoidable costs pressures are being considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that all Covid related expenditure and Exceptional National cost pressures will be funded by WG and / or Commissioners.

2.6 Financial Risks

Covid

The Trust continues to be in dialogue with Commissioners with regards to the costs of additional capacity required to meet the demands placed on our Planned Care services. To date, the full requirement of £3.906m, which has been invested in securing additional capacity, has not been agreed by Commissioners.

The Trust has received signed Long Term Agreements (LTA's) from our Commissioners. However, the funding for Planned care & Covid backlog capacity remains a risk as the marginal income that the Trust is forecast to receive will not cover the additional costs being incurred.

The expectation at this stage is that Covid response costs will be funded from WG, however the Trust has not yet received formal confirmation.

Savings

Due to the ongoing pandemic and the potential inability to enact two of the Trust savings schemes there is a risk that some of the savings that are RAG rated amber may not be fully achieved which will have a recurrent impact on the Trust position. Those schemes with risk of delivery are being reviewed at divisional level with a view to ensure delivery before the end of the year.

TCS

A non-recurrent revenue funding request of £0.104m has been made by the TCS Programme relating to shortfalls in funding on the PMO and nVCC project. This was presented to EMB Run on 1st July and agreed. Latest forecast requirement currently stands at £0.133m which reflects additional Judicial fees of £0.029m (total to date £0.043m).

The revenue financial information provided within the main body of the report and the TCS Programme Board paper differ slighlty which is due to both a timing difference, and the authorisation of budget virements from the Core Trust to the TCS Programme.

Pay Award

The Trust has been informed that the pay ward will be paid on actual staff in post which will exclude both vacancies and incremental drift. This is expected to leave a funding gap of between circa £0.500m and £0.700m which is required in order to support the full Trust staff establishment.

Other Exceptional National Cost Pressures

The Trust is anticipating full funding for the additional Employers NI has reduced to (£0.339m) following the decision to reverse the increase.

The incremental increase in energy prices has significantly decreased to £0.898m following the introduction of the price cap.

All other financial risks are expected to be mitigated at divisional level, however there is a risk that operational cost pressures may materialise during the year which is beyond divisional control or the ability to be managed through the overall Trust funding envelope.

2.7 Capital

a) All Wales Programme

Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget, however there is potential risk of an underspend on the nVCC Enabling works with update on spend and funding requirement being provided to WG by the end of October.

Other Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, WBS Hemoflows, Scalp Coolers, VCC Outpatients & Ventilation and Plasma Fractionation.

b) Discretionary Programme

The Trust discretionary capital allocation for 2022/23 is £1.454m. This represents a 24% reduction in capital allocation compared to £1.911m in 2021/22 and is reflective of the reduced overall NHS capital budget position.

The Trust Discretionary Programme for 2022/23 was approved by EMB in August.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of September 2022 is an underspend of £0.002m with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

Trust Board is asked to **NOTE**

4.1 The contents of the September 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs.

4.2 The TCS Programme financial report for September 2022 attached as **Appendix 1**.

To Note: The Transforming Cancer Services Finance report was discussed in the Transforming Cancer Services Scrutiny Sub-Committee on 17th Novembers. Members of the Sub-Committee requested the report be displayed in a clearer way, particularly in relation to the relationship between the Programme spend and Trust reserves. This action was agreed to be completed for the next reporting period.

Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED SEPTEMBER 2022/23

TRUST BOARD
24/11/2022

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 2022-23.

2. Background / Context

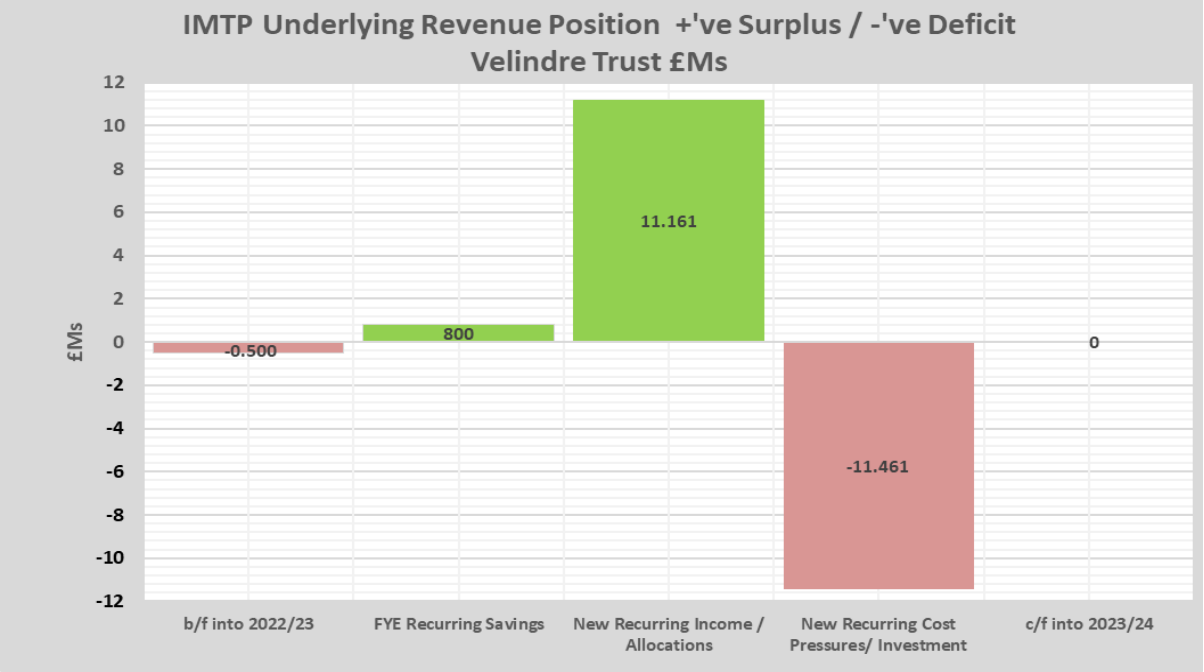
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2022-23 to 2024-25 to Welsh Government on the 31 March 2022.

- For 2022-23 the Plan (excl Covid) included;
  - an underlying **deficit of -£0.5m** brought forward from 2021-22,
  - FYE **of new cost pressures / Investment** of **-£11.461m,**
  - offset by **new recurring Income** of **£11.161m,**
  - and Recurring FYE **savings schemes** of **£0.8m,**
  - Allowing **a balanced position** to be carried into 2023-24.

- The underlying deficit is expected to be eliminated during 2022/23 through the discretionary uplift in funding, enabling a balanced position to be carried into 2023/24.

- **To eliminate the brought forward underlying deficit, the savings target set for 2022-23 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 2022/23	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2023/24
Velindre NHS Trust	-0.500	0.800	11.161	-11.461	0

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	(0.002)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.335	5.954	23.063
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	93.9%	95.4%	95.0%

Performance against Planned Savings Target

Efficiency / Savings	Variance	0	0	0

Revenue

The Trust has reported a £(0.002)m overspend for September '22, with a cumulative position of £0.002m underspent, and an outturn forecast position of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at September '22 is **£23.063m**. This represents all Wales Capital funding of **£21.069m**, and Discretionary funding of **£1.454m.** The Trust reported Capital spend to September'22 of £5.954m and is forecasting to remain within its CEL of £23.603m for 2022-23.

The Trust's CEL is broken down as follows:

	£m Opening	£m Movement	£m September 2022
Discretionary Capital	1.454	0.000	1.454
All Wales Capital:			
Fire Safety	0.500	0.000	0.500
CANISC Cancer Project	0.000	0.579	0.579
TCS Programme	23.902	-3.372	20.530
Total CEL	**25.856**	**-2.793**	**23.063**

With WG agreement, slippage on the TCS Programme has led to £3.372m Capital funding being pushed back into 2023/24, reducing the WG Capital allocation to £20.530m for this financial year.

PSPP

During September '22 the Trust (core) achieved a compliance level of **93.9%** (August 22: 96.31%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.4%** as at the end of month 6, and a Trust position (including hosted) of **95.6%** compared to the target of 95%.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2022-23, with contingency plans having been put in place to support under delivery on those schemes still rated amber.

Revenue Position

Cumulative				Forecast		
£0.002m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(86.875)	(86.442)	(0.433)	(179.442)	(178.753)	(0.689)
Pay	38.073	37.608	0.465	74.072	73.700	0.372
Non Pay	48.802	48.832	(0.030)	105.371	105.053	0.318
Total	**0.000**	**(0.002)**	**0.002**	**0.000**	**(0.000)**	**0.000**

The overall position against the profiled revenue budget to the end of September 2022 is an underspend of **£0.002m**, with a Pay underspend offsetting an Income under achievement.

The Trust is reporting a year end forecast breakeven position, however this assumes that all additional Covid-19 costs, along with the Exceptional National cost pressures will be fully reimbursed by both WG and the Trust commissioners, that all other planned additional income is received, and the planned savings targets are achieved during 2022-23.

4.1 Revenue Position Key Issues

Income Key Issues

Income underachievement to September is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS, with plans being put in place to support recovery in the latter part of the year.

Pay Key Issues

The total Trust vacancies as at September 2022 is 121wte, VCC (67wte), WBS (32wte), Corporate (6wte), R&D (7wte), TCS (2wte) and HTW (7wte).

The total pay award for 2022/23 which is required to cover the core Trust full establishment including vacancies and increments is expected to be circa £3.4m. The Trust is currently working on the assumption that this will be fully funded by WG, although expectation is that the Trust will only receive funding for actual staff in post (excluding vacancies) which will leave a funding shortfall of between circa £0.500m - £0.700m.

Increase in Employers NI rates (1.25%) is currently being offset by divisional reserves, however funding requirement of circa £0.339m (previously £0.551m) until the 6th November the date that the increase will be reversed is currently expected to be secured from WG through the recognition of the Exceptional National Cost pressures however remains a risk.

Vacancies throughout the Trust although reducing remain high, however several posts in both VCC and WBS have been appointed at risk in response to Covid activity backlog and additional capacity required for forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. In addition, work is underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Both VCC and WBS hold a £0.450m vacancy factor target, which will need to be achieved during 2022/23 in order to balance the overall Trust financial position.

Non Pay Key Issues

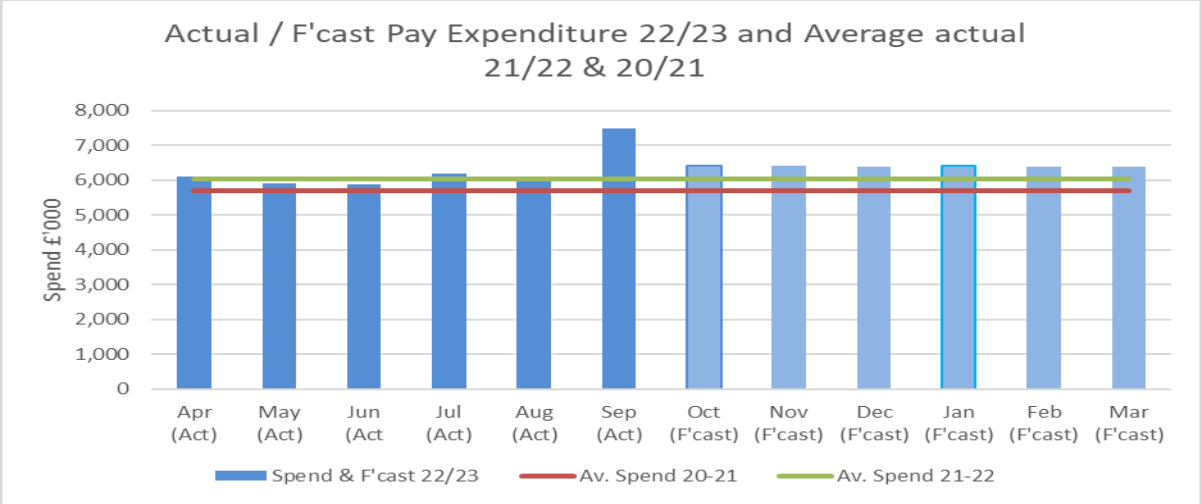
The expected increase in energy prices as significantly reduced to circa £0.898m August (£3.016m) which is following the introduction of the price cap. The stepped increase has been recognised as an Exceptional National cost pressures by WG with the Trust expectation that these costs will be fully funded during 2022/23, although this is yet to be confirmed.

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The savings target for each division was set as VCC £0.700m, WBS £0.500m and Corporate £0.100m as part of the IMTP for 2022/23.

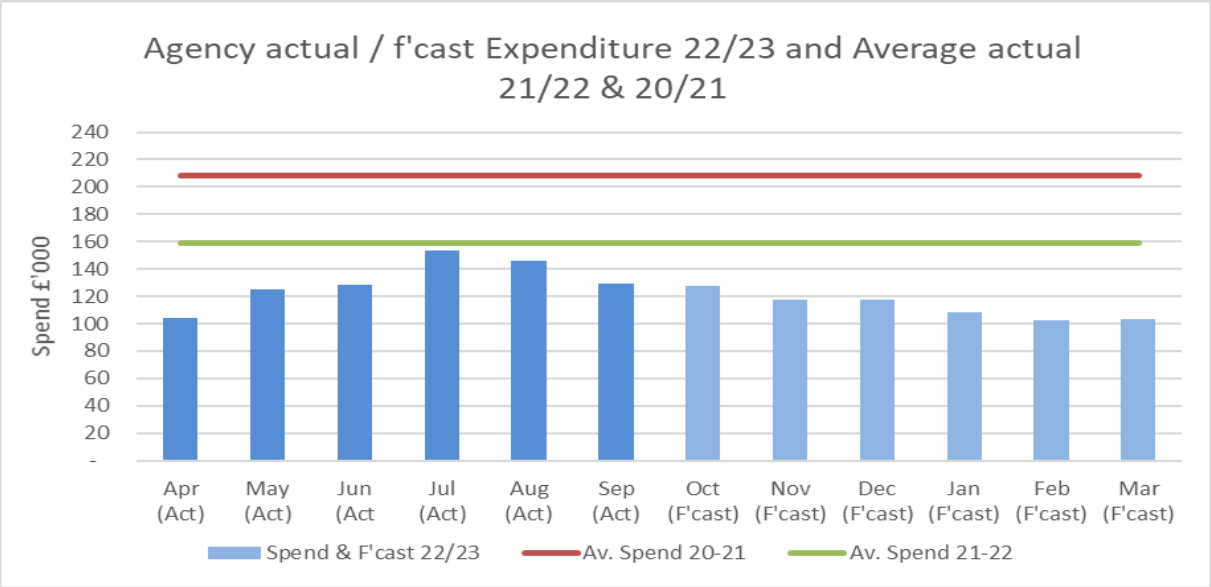
The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

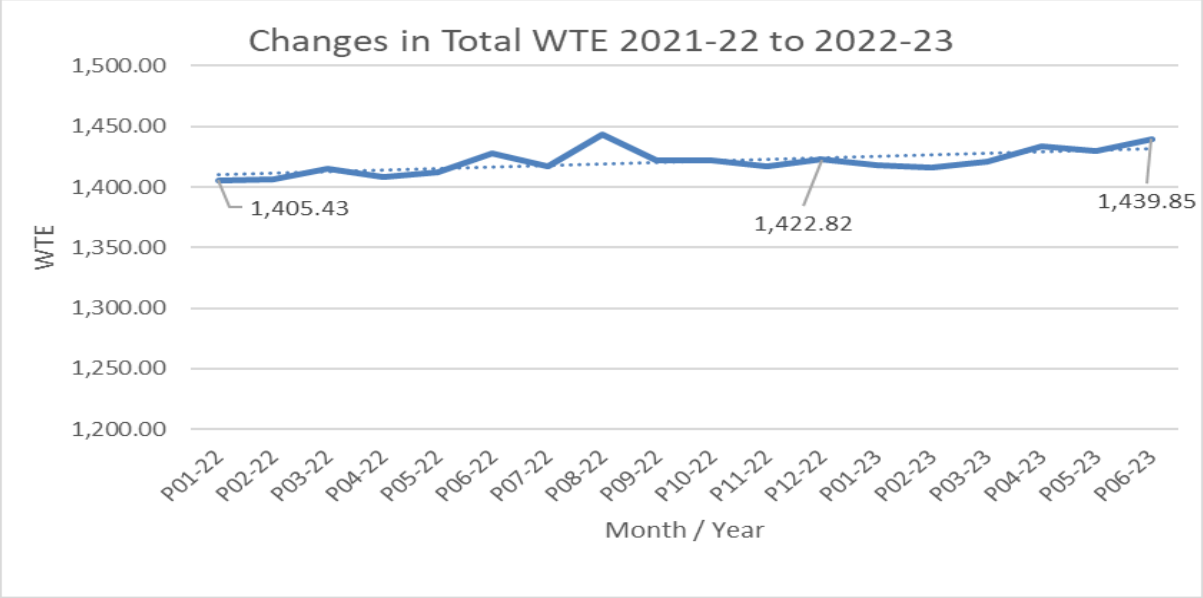
4.2 Pay Spend Trends (Run Rate)

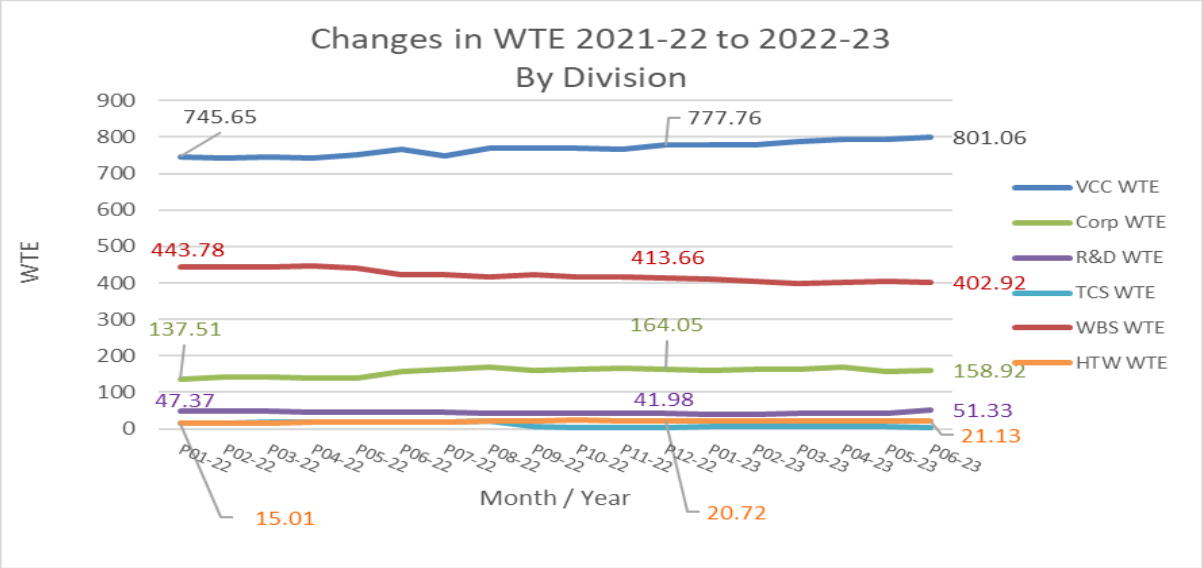
The pay award for 2022/23 was paid in September (back dated to April) as demonstrated in the spike in pay spend shown in the graph below. Agency costs have decreased this year from the 2021/22 levels largely due to the reduction of agency staff that was previously recruited to support Covid. It is hopeful that further reductions will be generated through the recruitment into vacancies.



The spend on agency for September 22 was £0.129m (August £0.146m), which gives a cumulative year to date spend of **£0.787m** and a current forecast outturn spend of circa **£1.465m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of September is £0.185m and forecast spend is circa £0.346m (£0.826m 2021/22).

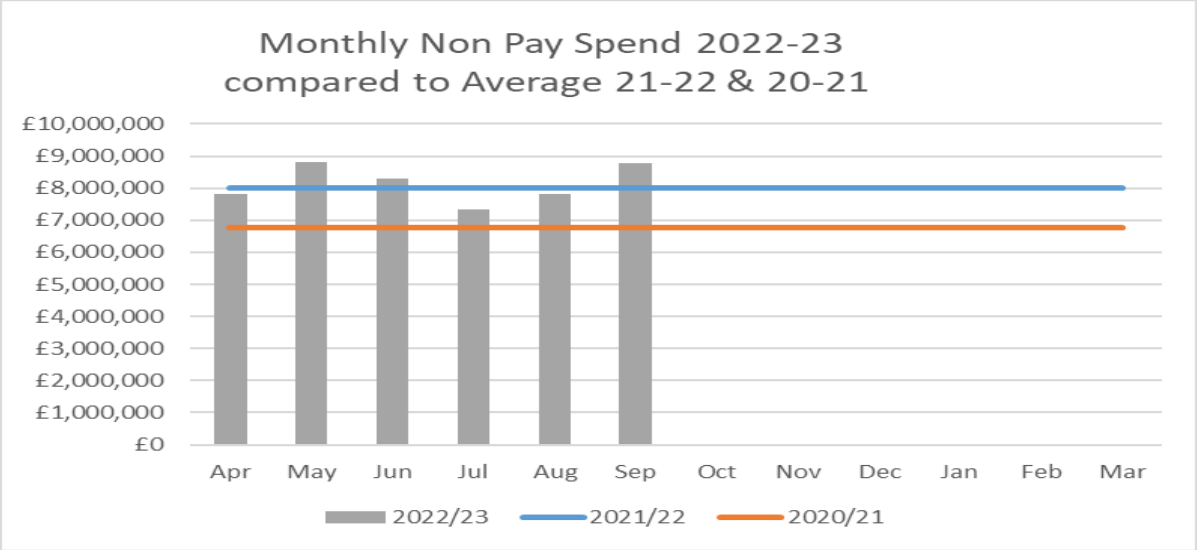






4.3 Non Pay

Non-pay 21/22 (c£96m) av. monthly spend of £8m was £1.2m higher than the reported monthly average spend for 20/21 (£6.8m). Most of the monthly average increase (circa £0.9m) related to the growth in NICE / High Cost drug usage following the recovery and associated surge related to Covid and increase in WBS wholesaling (circa £0.3m). The average monthly spend for 22-23 is currently £8.1m which is currently in line with 21/22 expenditure.



4.4 Covid-19

The latest forecast funding requirement as at 30th September in relation to Covid for 2022-23 has been further revised down to £4.869m (August £5.022m) which is a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £4.869m total Covid requirement £0.963m (IMTP plans £2.104m) is being requested directly from WG, and the balance of £3.906m (IMTP plans £10.206m) being sought from our commissioners.

Covid-19 Revenue Spend/ Funding 2022/23

	WG £m	Commissioners £m	Total £m
Mass Vaccination	0.225		0.225
PPE	0.070		0.070
Cleaning	0.407		0.407
Other Covid Response	0.261		0.261
Covid Recovery - Internal Capacity		3.645	3.645
Covid Recovery - Outreach		0.261	0.261
	0.963	**3.906**	**4.869**

The latest forecast spend and funding requirement from WG has decreased by a further £0.153m from £1.116m reported in August to £0.963m. The reduction is due to further utilisation of PPE with current stock levels expected to last until the end of the financial year based on the review of daily usage.

WG funding has been assumed for programme related Covid costs of £0.295m (Mass Vaccination and PPE), along with other Covid response funding of £0.667m in relation to ongoing cleaning, increase in workforce costs, and other support costs per letter received from Judith Paget dated 14th March 2022. The Trust has received funding for QTR 1 costs in relation to Mass Vaccination and PPE.

The Trust Covid expenditure is based on activity demand forecast modelling which commenced in 2021/22 and has been updated regularly since. The Trust has already invested £2.943m in additional capacity. Following news that The Rutherford has gone into liquidation, the funding previously required for outsourcing has significantly reduced (by the full £4.150m). In response the Trust is has now established additional outreach Capacity at Prince Charles Hospital (from October) for SACT with forecast additional cost above that already invested in Covid capacity of circa £0.261m and has developed plans for Radiotherapy capacity internally looking to weekend working which will require WLI and enhanced pay rates. The full cost of this additional capacity is currently still being worked up. These additional investments in capacity to meet the activity demand from Health Boards will not be fully covered through LTA marginal income leading to an additional financial risk to the Trust

Other cost reduction from IMTP plans reflects financial control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as actual saving schemes and £0.550m being income generation.

The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

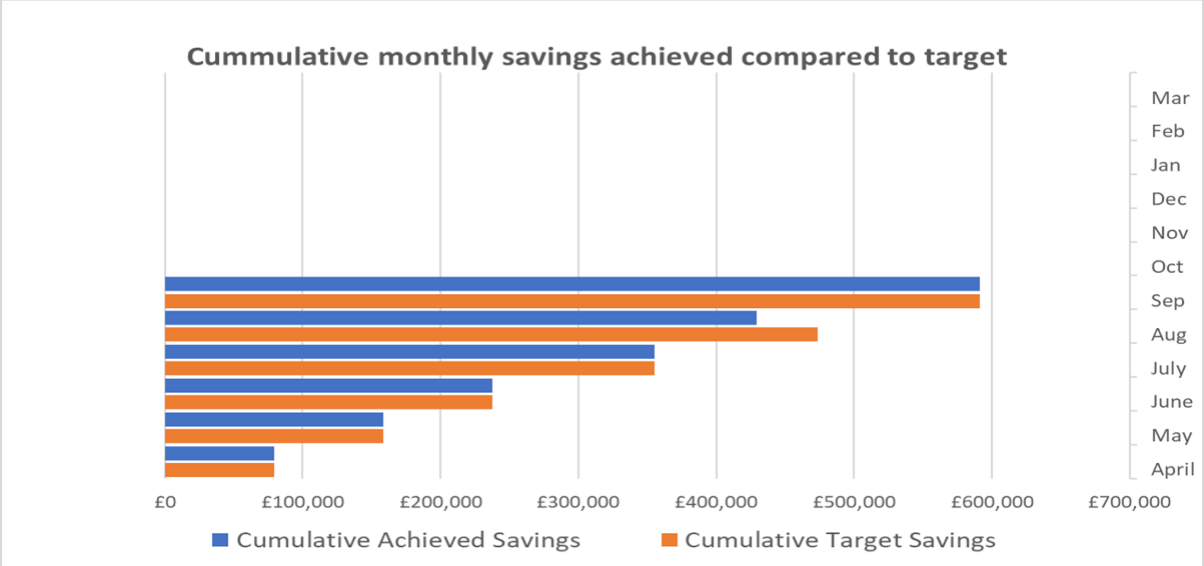
Currently two of the schemes relating to service redesign and supportive structures are still RAG rated amber which are those that continue to be impacted by Covid during 2022-23 and have underachieved by £0.066m year to date.

Service redesign and supportive structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. These plans are aligned to a number of the Trust VBHC bids that sought funding for new posts to support medical workforce redesign but were unsuccessful. The ability to enact these saving schemes is proving to be difficult due to the legacy of the pandemic and current workforce situation, particularly the high number of vacancies along with the high level of sickness that is currently being experienced throughout the Trust. Plans are still being developed by the Trust divisions however, it is recognised due to the current challenges that these saving schemes will not be achieved in the short term and therefore the date expected to go live has been pushed back further to January.

Contingency measures have been put in place on the basis that these savings schemes will not be fully achieved this year, however these are non-recurrent in nature. **It is extremely important that divisions review their current savings schemes, and where delivery may not be achieved that alternative schemes are implemented to ensure that the savings target is met for 2022-23. Consideration should also be giving to the impact of not achieving recurrent savings may have on next year's financial position.**

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	700	292	226	(66)	566	(134)
			77%		81%	
WBS TOTAL SAVINGS	500	250	250	0	500	0
			100%		100%	
CORPORATE TOTAL SAVINGS	100	50	50	0	100	0
			100%		100%	
TRUST LEVEL TOTAL SAVINGS			66	66	134	134
TRUST TOTAL SAVINGS IDENTIFIED	1,300	592	526	(66)	1,300	0
			89%		100%	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Establishment Control (Corporate)	Green	100	50	50	0	100	0
Laboratory & Collection Model (WBS)	Green	50	25	25	0	50	0
Laboratory & Collection Model (WBS)	Green	50	25	25	0	50	0
Stock Management (WBS)	Green	100	50	50	0	100	0
Stock Management (WBS)	Green	150	75	75	0	150	0
Procurement - Supply Chain (WBS)	Amber	50	25	25	0	50	0
Service Redesign (VCC)	Amber	100	33	0	(33)	33	(67)
Supportive Stuctures (VCC)	Amber	100	33	0	(33)	33	(67)
Procurement - Supply Chain (VCC)	Green	50	25	25	0	50	0
Bank Interest (Trust - In Year)	Green		0	33	33	67	67
Vacancy Factor (Trust - In Year)	Green		0	33	33	67	67
Total Saving Schemes		**750**	342	342	0	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	25	25	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Geen	50	25	25	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Amber	150	50	50	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	50	50	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	100	100	0	200	0
Total Income Generation		**550**	250	250	0	550	0
TRUST TOTAL SAVINGS		**1,300**	**592**	**592**	**0**	**1,300**	**0**
				100%		100%	



5. Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

Summary of Total Recurrent Reserves Remaining Available in 2022/23	£m
Recurrent Reserves Available for investment	1.241
Previously Committed Reserves Bfwd 2021-22	(0.137)
Previously agreed Exec Investment	(0.973)
New Commitments	(0.131)
Emergence of Slippage against Recurrent Reserves Commitments	
Remaining Balance	**0**

Summary of Total Non-Recurrent Reserves Remaining Available in 2022/23	£m
Non-Recurrent Reserves Available for investment	1.471
Previously Committed Reserves Bfwd 2021-22	(0.102)
Previously Agreed Exec Investment	(1.302)
New Commitments	(0.067)
Emergence of Slippage against Non-Recurrent Commitments	
Remaining Balance	**0**

At this stage only unavoidable costs pressures should be considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that both the Exceptional National costs pressures and all Covid related expenditure is funded.

6. End of Year Forecast / Risk Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are a number of risks which are being managed and closely monitored. The table below summarises the key financial risks & opportunities highlighted to Welsh Government.

Non-Delivery of Savings - *Risk £0.066m, Likelihood - Low*

The Trust as part of the IMTP identified £1.300m of Savings and Income Generation to be achieved during 2022/23. Due to the ongoing pandemic and impact on sickness levels that remain significantly above pre Covid levels at this stage the Trust is unable to implement service redesign and changes to supportive structures, therefore there is a risk that the savings target against these schemes may not be fully achieved. The Trust will continue to review the savings schemes with a view of ensuring delivery, though contingency plans have now been developed in order to support any underperformance.

The conclusion of the Microsoft 365 National Deal led to a £0.157m (incl. VAT) in-year cost pressure, which will be assigned as a Cost Improvement Programme to the Digital Services Team. This includes the standing down of legacy IT infrastructure which is not required due to the MS 365 deal.

Covid Funding via Commissioners – *Risk £500k, Likelihood - Medium*

The Trust continues to have discussions with its commissioners who recognise our Covid funding requirement, however they have not committed to providing the full funding ask of £3.906m. Commissioners have all stated that any funding required to cover additional Covid recovery costs will only flow through the LTA under the national funds flow mechanism. This mechanism whilst providing enhanced income protection over the normal LTA would not cover the additional costs of premium rates through enhanced pay rates for WLI's or additional costs above marginal when establishing new capacity. The Trust has received signed LTA's back from our commissioners, however the funding for planned care & Covid backlog capacity will remain a risk for the Trust.

Other C-19 Response Costs – *Risk £0.963m, Likelihood - Medium*

Following further Covid de-escalation related activity and a review of operational costs in line with the updated guidance, the latest forecast spend and funding requirement from WG has reduced by a further £0.153m from £1.116m reported in August to £0.963m.

Other Exceptional National Cost Pressures – *Risk £1.237m - Medium*

The Trust is still anticipating full funding for the Employers NI increase and the incremental increase in Energy prices. The Employers NI costs have reduced from £0.551m to £0.339m following the Government announcement that the increase will be reversed from the 6th November. The incremental increase in Energy prices has significantly reduced from £3.016m in August to £0.898m following the introduction of the price cap and reflects the latest forecast provided by NWSSP Colleagues during October.

Pay Award – *Risk £0.500m - High*

The Trust has been informed that the pay ward will be paid on actual staff in post which will exclude both vacancies and incremental drift. This is expected to leave a funding gap of between circa £0.500m and £0.700m which is required in order to support the the full Trust staff establishment.

Management of Operational Cost Pressures – *Risk £0.250m, Likelihood - Low*

Cost pressures that have / will surface through the year are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a small risk that pressures may materialise beyond divisional control or be able to be managed through the overall Trust funding envelope.

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 £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M6 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme						
nVCC - project costs	2.089	1.709	0.000	0.380	2.883	-0.794
nVCC - Enabling Works	18.441	3.362	0.000	15.079	17.647	0.794
Canisc Cancer Project	0.579	0.450	0.000	0.129	0.579	0.000
Fire Safety	0.500	0.051	0.000	0.449	0.500	0.000
Total All Wales Capital Programme	21.609	5.572	0.000	16.037	21.609	0.000
Discretionary Capital	1.454	0.382	0.000	1.072	1.454	0.000
Total	23.063	5.954	0.000	17.109	23.063	0.000

The approved 2022/23 Capital Expenditure Limit (CEL) as at September 2022 was £23.063m. This includes All Wales Capital funding of £21.609m, and discretionary funding of £1.454m. The approved CEL has been reduced by £3.372m to reflect the latest forecast requirement on the nVCC Enabling works project for 2022/23. Following agreement with WG the £3.372m will be re-provided to the programme during 2023/24.

WG colleagues have been notified of an additional request to move £0.794m (previously £0.450m) from the nVCC enabling works to support the additional costs associated with the nVCC project fees and advisory activities. In addition, there is a further potential risk of underspend on the nVCC Enabling works with an update on spend ad funding requirement being provided to WG by the end of October.

In January 2022 WG informed the Trust that the discretionary allocation will be significantly reduced during 2022/23 (previously £1.911m), which is reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme was approved by EMB Shape on the 27th August.

The discretionary allocation has ringfenced £0.434m to support the Integrated Radiotherapy Solution (IRS). Discussions are currently taking place with WG colleagues with the ambition that the Trust may be reimbursed for the costs incurred in supporting the procurement phase of the scheme once the IRS FBC is approved.

The Trust is working collaboratively with Commissioners to progress the IRS FBC through the governance structures of each organisation in order to secure the funding requirements to deliver the solution. The Trust has required the need to place an order with the provider ahead of contract signature to allow the provider to secure the available resource within its supply chain.

Whilst there is a reduction in availability of Capital funding this year, WG colleagues have indicated that they are keen for organisation to continue to develop capital proposals should additional funding become available later in the financial year.

A list of prioritised bids to try and secure any WG yearend Capital opportunities have been endorsed by the Capital planning group for approval by EMB at today's meeting.

Whilst the financial position is challenging it is expected that capital requirements will be managed through the Trust discretionary allocation during 2022/23 or additional funding will be agreed and secured from WG.

Performance to date

The actual cumulative expenditure to September 2022 on the All-Wales Capital Programme schemes was £5.572m, this is broken down between spend on the nVCC enabling works £3.362m, nVCC project costs of £1.709m, Canisc Cancer Project £0.450m, and fire safety £0.051m.

Spend to date on Discretionary Capital is currently £0.382m leaving a remaining balance of £1.072m as at the 30th September.

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.

Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include:

	Scheme	Scheme Total	Stage (i.e. OBC development, FBC development, scoping etc.)	22/23 £m	23/24 £m	24/25 £m	25/26 £m	26/27 £m	27/28 £m	28/29 £M
1	WBS HQ	34.125*	FBC being developed	1.016	12.808	9.996	4.434	5.215	0.608	0.048
2	IRS	46.921*	FBC has been approved by HBs and awaiting final approval from WG	7.453	9.533	22.832	7.103	0.000	0.000	0.000
3	Hemoflows	0.224	SBAR being Completed	0.224	0.000	0.000	0.000	0.000	0.000	0.000
4	Scalp Coolers	0.250	SBAR being Completed	0.250	0.000	0.000	0.000	0.000	0.000	0.000

*Cash flow of these schemes is still under review alongside WG.

Other Major schemes which are under discussion internally and WG are sighted on include VCC outpatients, ventilation, and plasma fractionation.

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 22	Closing Balance End of Sep-22	Movement from 1st April Sep-22	Forecast Closing Balance End of Mar 23
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	143.136	150.510	7.37	155.420
Intangible assets	8.667	7.803	(0.864)	8.200
Trade and other receivables	1,092.008	1,303.720	211.71	1,303.720
Other financial assets	0.000	0.000	0.00	0.000
Non-Current Assets sub total	1,243.811	1.462	0.22	1.467
Current Assets				
Inventories	65.207	54.503	(10.704)	54.503
Trade and other receivables	540.227	265.860	(274.367)	294.287
Other financial assets	0.000	0.000	0.00	0.000
Cash and cash equivalents	30.404	52.234	21.83	18.500
Non-current assets classified as held for sale	0.000	0.000	0.00	0.000
Current Assets sub total	635.838	372.597	(263.241)	367.290
TOTAL ASSETS	1,879.649	1,834.630	(45.019)	1,834.630
Current Liabilities				
Trade and other payables	(277.601)	(227.480)	50.12	(227.480)
Borrowings	0.00	0.00	0.00	0.00
Other financial liabilities	0.00	0.00	0.00	0.00
Provisions	(341.123)	(342.901)	(1.778)	(342.901)
Current Liabilities sub total	(618.724)	(570.381)	48.34	(570.381)
NET ASSETS LESS CURRENT LIABILITIES	1,260.93	1,264.25	3.32	1,264.25
Non-Current Liabilities				
Trade and other payables	(7.336)	(7.336)	0.00	(7.336)
Borrowings	0.00	0.00	0.00	0.00
Other financial liabilities	0.00	0.00	0.00	0.00
Provisions	(1,094.206)	(1,091.599)	2.61	(1,091.599)
Non-Current Liabilities sub total	-1,101.542	-1,098.935	2.61	-1,098.935
TOTAL ASSETS EMPLOYED	159.383	165.314	5.93	165.314
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.00	0.000
Revaluation reserve	30.935	30.934	(0.001)	30.934
PDC	112.982	118.911	5.93	118.911
Retained earnings	15.466	15.471	0.01	15.469
Other reserve	0.000	0.000	0.00	0.000
Total Taxpayers' Equity	159.383	165.316	5.933	165.314

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 £5m of stock had been purchased by NWSSP and an additional £2m 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.

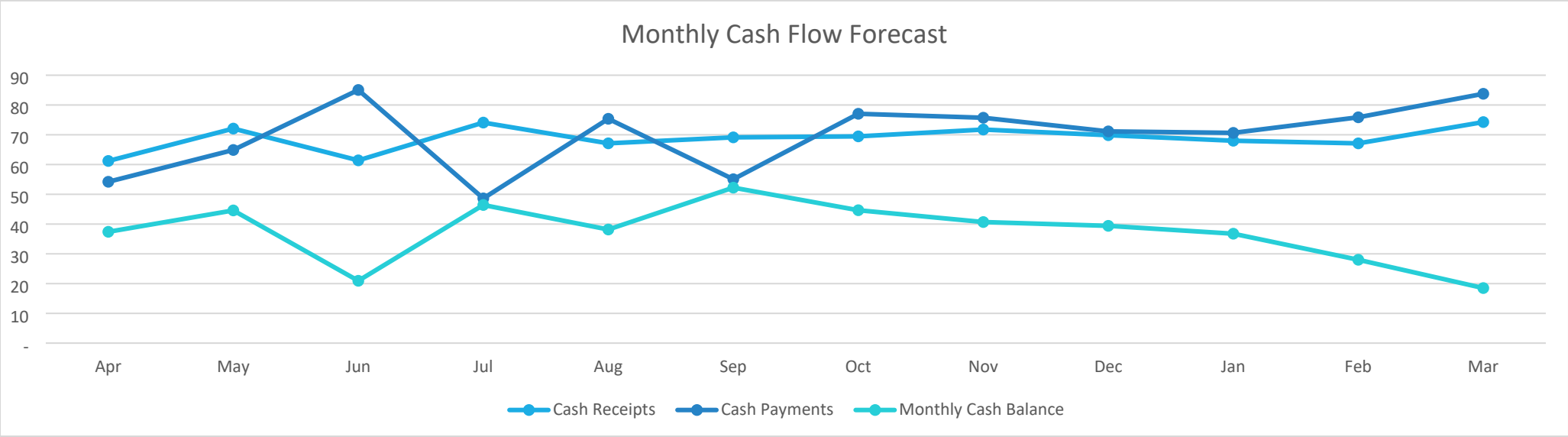
To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP are continuing to liaise with WG regarding the level of Brexit stock to maintain but it is anticipated that the repayment of the additional cash will take place later this year but will be dependent on the stock being released.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual, however by the end of this financial year expectation is that cash balances should return to pre-Covid levels.

Following a request from WG the Trust transferred £5.9m of cash into the Escrow holding account during May for the nVCC programme. These funds were consequently drawn down in July from WG to reimburse the Trust ensuring that there was no cash risk to the organisation.

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	LHB / WHSSC income	33.135	40.208	40.042	37.491	47.836	36.522	41.602	40.388	40.100	40.000	39.725	35.218	472.267
2	WG Income	20.937	24.551	17.010	24.552	15.002	26.148	24.620	28.155	24.468	24.458	24.187	24.982	279.069
3	Short Term Loans													0.000
4	PDC				5.928								8.596	14.524
5	Interest Receivable	0.019	0.027	0.030	0.025	0.037	0.062	0.015	0.015	0.015	0.015	0.015	0.015	0.290
6	Sale of Assets													0.000
7	Other	7.106	7.289	4.321	6.094	4.246	6.395	3.223	3.190	5.271	3.520	3.183	5.447	59.286
8	TOTAL RECEIPTS	**61.197**	**72.074**	**61.403**	**74.090**	**67.121**	**69.127**	**69.460**	**71.748**	**69.854**	**67.993**	**67.110**	**74.258**	**825.435**
	PAYMENTS													
9	Salaries and Wages	21.735	29.243	29.483	29.705	29.549	34.417	32.962	32.971	32.942	32.976	32.970	33.478	372.433
10	Non pay items	30.543	33.079	54.139	17.703	44.384	20.200	42.570	39.288	35.638	33.760	40.496	41.331	433.131
11	Short Term Loan Repayment												7.000	7.000
12	PDC Repayment													0.000
14	Capital Payment	1.926	2.567	1.420	1.215	1.428	0.446	1.513	3.458	2.551	3.898	2.402	1.952	24.776
15	Other items													0.000
16	TOTAL PAYMENTS	**54.205**	**64.889**	**85.042**	**48.623**	**75.361**	**55.063**	**77.046**	**75.716**	**71.131**	**70.635**	**75.868**	**83.762**	**837.340**
		1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
17	Net cash inflow/outflow	6.993	7.185	-23.639	25.467	-8.240	14.064	-7.586	-3.969	-1.277	-2.642	-8.757	-9.503	
18	Balance b/f	30.404	37.397	44.582	20.943	46.410	38.170	52.234	44.648	40.679	39.402	36.760	28.003	
19	Balance c/f	37.397	44.582	20.943	46.410	38.170	52.234	44.648	40.679	39.402	36.760	28.003	18.500	



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	(18.238)	(18.238)	(0.000)	(37.280)	(37.280)	0.000
RD&I	(0.289)	(0.288)	(0.000)	0.323	0.323	0.000
WBS	(10.097)	(10.098)	0.000	(20.303)	(20.303)	0.000
Sub-Total Divisions	**(28.624)**	**(28.624)**	**(0.000)**	**(57.259)**	**(57.259)**	**0.000**
Corporate Services Directorates	**(5.177)**	**(5.174)**	**(0.003)**	**(10.337)**	**(10.337)**	**0.000**
Delegated Budget Position	**(33.801)**	**(33.798)**	**(0.003)**	**(67.597)**	**(67.597)**	**0.000**
TCS	(0.280)	(0.280)	0.000	(0.556)	(0.556)	0.000
Health Technology Wales	(0.034)	(0.033)	(0.000)	(0.048)	(0.048)	0.000
Trust Income / Reserves	34.115	34.113	0.002	68.200	68.200	0.000
Trust Position	(0.000)	0.003	(0.003)	0.000	0.000	0.000

VCC

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**33.792**	**34.070**	**0.278**	**71.793**	**71.793**	**0.000**
Expenditure						
Staff	**22.540**	**22.430**	**0.110**	**43.884**	**43.884**	**0.000**
Non Staff	**29.490**	**29.878**	**(0.388)**	**65.189**	**65.189**	**0.000**
Sub Total	**52.030**	**52.308**	**(0.278)**	**109.073**	**109.073**	**0.000**
Total	**(18.238)**	**(18.238)**	(0.000)	**(37.280)**	**(37.280)**	**0.000**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of September 2022 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 6 represents an overachievement of **£0.278m**. This is largely from an increase in activity from providing SACT homecare and the additional VAT savings, an over achievement on private patient income due to drug performance, which is above general private patient performance, along with a one-off drug rebate. This is offsetting the divisional income savings target of £0.392m.

VCC have reported a year to date underspend of **£0.110m** against staff. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly within Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting the cost of agency (£0.585m to end of September, £0.159m being directly related to Covid). Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures, however with social distancing measures reducing a review of service model is being undertaken which considers both recruitment requirement, but also additional ambulatory care to help reduce inpatient flow.

Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. Additionally, enhanced out of hours service, for advanced life support which will be nursing led is currently still being partly covered by Jnr Dr's with transition to nursing having started from August.

Early recruitment to the delayed Integrated Radiotherapy Solution (IRS) has led to year to date committed cost of £0.260m.

Non-Staff Expenditure at Month 6 was **£(0.388)m** overspent. The overspend largely relates to the facilities management office pressures which were previously supported by Covid, maintenance and repair of the Linacs, transport SLA overspend, consumable spend from increased activity, and unexpected prior year invoices being received from Virgin Media, which are being partly offset by an underspend on general drugs. The affect from the increase in price for utilities is included as an exceptional national costs pressure with the expectation that the costs will be funded by WG.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**13.082**	**12.558**	**(0.524)**	**23.730**	**23.160**	**(0.570)**
Expenditure						
Staff	**8.580**	**8.588**	**(0.008)**	**16.971**	**16.942**	**0.029**
Non Staff	**14.599**	**14.068**	**0.532**	**27.062**	**26.521**	**0.542**
Sub Total	**23.180**	**22.656**	**0.524**	**44.032**	**43.463**	**0.570**
Total	**(10.097)**	**(10.098)**	0.000	**(20.303)**	**(20.303)**	**0.000**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of September 2022 was **breakeven** with an outturn forecast position of **breakeven** currently expected.

Income underachievement to date is **£(0.524)m**, where activity is lower than planned on Bone Marrow and Plasma Sales. Targeted income generation from plasma sales to research is not achieving desired levels, contract award for increased selling price for new supplier is to be awarded on 1st October and secondary supplier expected from February, however volume of product to sell remains low and a risk. Transitional operating sites for Bone Marrow and

increasingly curtailed procedures is resulting in activity being considerably lower than target. Assumed WHSSC income for supressed income is reflected within the non-pay position.

Staff reported a small year-to-date overspend of **£(0.008)m** to September. Overspend from posts supported without identified funding source which includes advanced recruitment and service developments have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured. WG bid has been submitted to support Plasma Fractionation staffing costs.

Work is still underway to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff underspend of **£0.532m** is largely due to reduced costs from suppressed activity underspends on Laboratory Services, WTAIL, and General Services which is primarily timing of proactive and reactive building maintenance. Bone Marrow underspend reflected to contra income underachievement.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**0.497**	**0.537**	**0.039**	**0.974**	**0.991**	**0.017**
Expenditure						
Staff	**4.577**	**4.401**	**0.177**	**9.002**	**8.840**	**0.162**
Non Staff	**1.097**	**1.310**	**(0.213)**	**2.310**	**2.488**	**(0.178)**
Sub Total	**5.675**	**5.711**	**(0.036)**	**11.311**	**11.328**	**(0.017)**
Total	**(5.177)**	**(5.174)**	0.003	**(10.337)**	**(10.337)**	**0.000**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of September 2022 was an underspend of **£0.003m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust is currently benefiting from receiving greater returns on cash being held in the bank due to the rise in interest rates which will be utilised to support the WRP contribution which is now expected to become recurrent in nature.

Staff expectation is that vacancies within the division, will help offset use of agency and achieve the £0.100m divisional savings target.

Non pay overspend is **£(0.213)m** as at month 6 largely relates to the divisional savings target £(0.078)m as at end of September which is expected to be met in year via staff vacancies and the additional income being received in response to the increase in interest rates. Other large pressures include the increased running costs for the hospital estate with work still ongoing to understand the total cost for 2022-23.

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	**1.128**	**1.028**	**(0.100)**	**3.190**	**3.054**	**(0.136)**
Expenditure						
Staff	**1.347**	**1.239**	**0.108**	**2.684**	**2.503**	**0.181**
Non Staff	**0.070**	**0.077**	**(0.008)**	**0.183**	**0.183**	**(0.045)**
Sub Total	**1.416**	**1.316**	**0.100**	**2.867**	**2.686**	**0.136**
Total	**(0.289)**	**(0.288)**	(0.000)	**0.323**	**0.368**	**0.000**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of September 2022 was **breakeven** with a current forecast outturn position of **breakeven**.

Staff vacancies are offsetting the innovation income target with the stretched target for this year currently proving to be difficult to meet.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.280**	**0.280**	**0.000**	**0.556**	**0.556**	**0.000**
Non Staff	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Sub Total	**0.280**	**0.280**	**0.000**	**0.556**	**0.556**	**0.000**
Total	**(0.280)**	**(0.280)**	0.000	**(0.556)**	**(0.556)**	**0.000**

TCS Key Issues

The reported financial position for the TCS Programme at the end of September 2022 is **Breakeven** with a forecasted outturn position of **Breakeven.**

TCS will achieve breakeven on the assumption that the Trust reserves again supports the forecasted non-pay costs of £0.030m, along with associated costs of the judicial review which is currently expected to be £0.043m.

The TCS report assumes budget for the above Trust reserves allocation and pay award which is pending formal approval along with previously approved funding, therefore the report reflects inflated figures to what is currently in the Trust ledger.

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	**0.832**	**0.706**	**(0.126)**	**1.664**	**1.664**	**0.000**
Expenditure						
Staff	**0.748**	**0.669**	**0.079**	**1.476**	**1.476**	**0.000**
Non Staff	**0.118**	**0.070**	**0.048**	**0.235**	**0.235**	**0.000**
Sub Total	**0.866**	**0.739**	**0.127**	**1.712**	**1.712**	**0.000**
Total	**(0.034)**	**(0.033)**	(0.000)	**(0.048)**	**(0.048)**	**0.000**

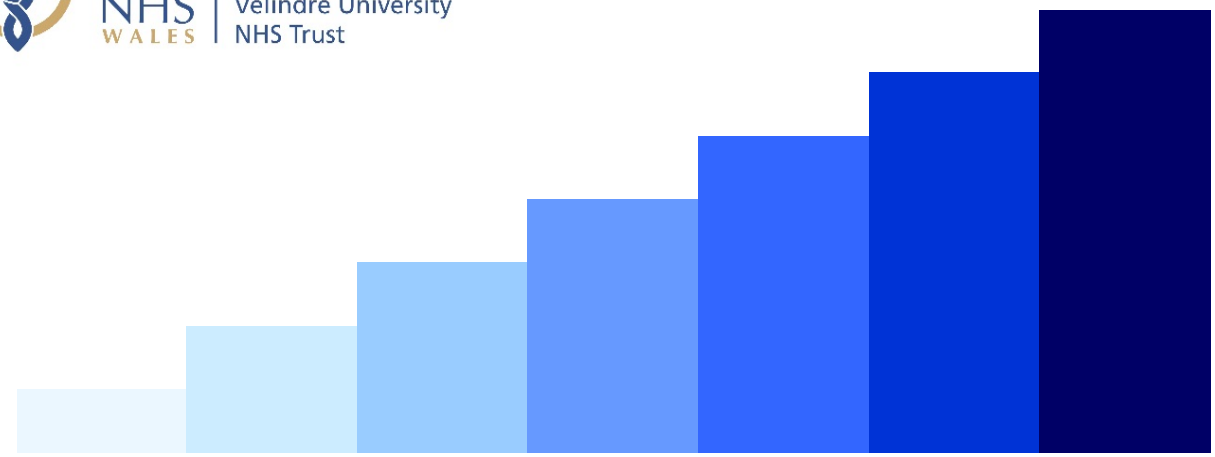
HTW Key Issues

The reported financial position for Health Technology Wales at the end of September 2022 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage will be handed back to WG.

Appendix 1 – TCS Programme Board Finance Report

TCS Programme Board Finance Repo

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



TCS PROGRAMME FINANCE REPORT 2022/23

Period Ending September 2022

Presented to the
TCS Programme Delivery Board on
13th October 2022

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1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2022/23, outlining spend to date against budget as at Month 06 and the current 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 2022/23 as at 30th September 2022 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	2022-23 Full Year		
		Budget	Forecast	Variance
Capital	£5.234m	£20.964m	£20.964m	£0
Revenue	£0.311m	£0.704m	£0.704m	£0
Total	**£5.544m**	**£21.668m**	**£21.668m**	**£0**

2.2 The Programme is currently forecasting an overall breakeven position for capital and revenue expenditure for the financial year 2022/23. The Enabling Works forecast position reflects an under-spend of £0.794m, which will support the nVCC Project. The financial support will be provided from the Enabling Works QRA and does pose a low financial risk for the Enabling Works Project. The approach needs to be agreed with WG.

2.3 Following a review in August 2022, WG have agreed a virement of £1.472m of the Enabling Works Project capital funding from 2022/23 into 2023/24. This reduces the overall capital funding for 2022/23 to £21.648m. The Project will make an assessment to 'slip' funding into 2023-24 as per agreement with WG. To date the EW Project has undertaken the following adjustments into 2023-24:

- Adjustment of £1.9m in May 22 – delay in Enabling Works Project
- Adjustment of £1.472m in August 22 – delay in the Asda works

2.4 Provisional pay award revenue funding of £0.020m was provided to the Programme in September 2022 from the WG allocation to the Trust. The revised revenue budget is now £0.704m for 2022/23, and the overall budget has increased to £21.668m for this financial year.

2.5 There are currently two financial risks to the Programme:

- A further underspend within the Enabling Works Project as a result of the delay in key project activities; and

- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage.

2.6 These risks have mitigation plans in place or being developed by the relevant Project Teams. There are currently no other financial risks for the TCS Programme.

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 2022, the Welsh Government (WG) had provided a total of £25.904m funding (£23.283m capital, £2,261m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.111m from 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 and £0.420m thereafter.

3.4 The current funding provided to support the TCS Programme in 2022/23 is £20.964m capital and £0.684m revenue, as outlined in Appendix 2.

4. CAPITAL POSITION

4.1 There is a revised Capital Expenditure Limit (CEL) from WG of £18.441m for the Enabling Works Project and £2.089m to support the nVCC Project in 2022/23.

4.2 WG funding for the Integrated Radiotherapy Solution Procurement (IRS) Project was utilised in previous years, therefore no CEL has been issued for this Project in 2022/23. The capital funding requirement of £0.434m will be provided from the Trust's discretionary capital allocation.

4.3 The capital position as at 30th September 2022 is outlined below, with a forecast breakeven outturn for 2022/23 against an overall budget of £20.964m.

Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£3.350m	£18.441m	£17.646m	£0.794m
nVCC Project	£1.719m	£2.089m	£2.883m	-£0.794m
IRS Procurement Project	£0.165m	£0.434m	£0.434m	£0
Total	**£5.234m**	**£20.964m**	**£20.964m**	**£0**

4.4 The forecast overspend of £0.794m for the nVCC Project will be supported by the Enabling Works Project underspend of £0.794m.

5. REVENUE POSITION

5.1 Revenue funding for the Programme Management Office (PMO) and the Service Development & Transformation (SDT) Project continues to be provided by the Trust and the NHS Commissioners.

5.2 To date, the Trust has ring-fenced £0.073m revenue funding for the nVCC Project, as no revenue funding has been provided by WG this year. Formal delegation of this budget is pending.

5.3 In September 2022, the annual NHS pay award was implemented, back dated to April 2022. As such, a provisional pay award of £0.010m was provided to the PMO and another £0.010m to the SDT Project from the assumed WG allocation to the Trust. These will be confirmed in October 2022 following a mid-year review of revenue pay and non-pay budgets and forecast spend.

5.4 The revenue position as at 30th September 2022 is outlined below, with a forecast breakeven outturn for 2022/23 against a revised budget of £0.704m.

Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
PMO	£0.114m	£0.310m	£0.310m	£0
nVCC Project	£0.049m	£0.073m	£0.073m	£0
SDT Project	£0.147m	£0.321m	£0.321m	£0
Total	**£0.311m**	**£0.704m**	**£0.704m**	**£0**

6. CASH FLOW

6.1 This update is currently being developed.

7. PROJECT FINANCE UPDATES

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

Programme Management Office

7.2 In 2022/23, the PMO has been allocated £0.060m from the phased funding of £0.250m for the Strategic Transformation Programme from 2021/22 to 2023/24 to support the transition between Programmes. This additional funding was released in May 2022, increasing the total revenue funding from £0.240m (Commissioners' funding) to £0.300m for 2022/23.

7.3 In September 2022, provisional pay award funding of £0.010m was allocated to the PMO, resulting in a revised budget of£0.310m for this financial year.

7.4 There is no capital funding requirement for the PMO in 2022/23.

7.5 The revenue position for the PMO as at 30th September 2022 is shown below.

PMO Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.112m	£0.293m	£0.293m	£0
Non Pay	£0.002m	£0.017m	£0.017m	£0
Total	**£0.114m**	**£0.310m**	**£0.310m**	**£0**

7.6 There are currently no financial risks relating to the PMO.

Enabling Works Project

7.7 A CEL of £18.441m has been provided by WG for the Enabling Works Project in 2022/23. This is a revised amount from the £21.813m CEL initially allocated in 2022/23 from the total capital funding for the Project of £28.089m. An overall virement to date of £3.372m into 2023/24 has resulted in the current revised CEL.

7.8 The Project's financial position for 30th September 2022 is shown below, with a further breakdown provided in Appendix 3. The forecast position reflects an underspend of £0.793m due to a delay in key activities, which will be used to support the nVCC Project as agreed by WG.

Enabling Works Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.109m	£0.220m	£0.219m	£0.001m
Non Pay	£3.241m	£18.221m	£17.428m	£0.793m
Total	**£3.350m**	**£18.441m**	**£17.646m**	**£0.794m**

7.9 There is a risk of a further underspend within the Enabling Works Project as a result of the delay in key project activities. The Project will review and confirm to WG in October 2022 the funding required in 2022/23 to deliver the Project. Any further slippage after this point will be managed by the Trust's Capital programme or returned to W with no reprovision.

New Velindre Cancer Centre Project

Capital

7.10 In March 2021, the Minister for Health and Social Services approved the nVCC OBC. This has provided capital funding of £5.550m in total, with a CEL of £2.089m in 2022/23.

7.11 The capital financial position for the nVCC Project for 30th September 2022 is shown below, with a further breakdown provided in Appendix 4. The forecast position reflects an overspend of £0.794m, which will be supported from the Enabling Works Project as agreed by WG.

nVCC Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.631m	£1.413m	£1.326m	£0.087m
Non Pay	£1.088m	£0.676m	£1.557m	-£0.881m
Total	**£1.719m**	**£2.089m**	**£2.883m**	**-£0.794m**

7.12 There is a financial risk relating to increased advisory fees in the range of £0.100m to £0.200m required to conclude the tender evaluation stage and Successful Participant to Financial Close stage. The Project's financial position will be monitored closely over the remaining months of the financial year.

Revenue

7.13 No revenue funding has been provided for the nVCC Project by WG in 2022/23. Therefore the Trust has ring-fenced a revenue budget of £0.030m for nVCC Project Delivery, and a further £0.043m for the Judicial Review Matter. Formal delegation of both budgets is pending.

7.14 The revenue financial position for the nVCC Project for 30th September 2022 is shown below, reflecting a forecast breakeven spend against a budget of £0.073m.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Project Delivery	£0.016m	£0.030m	£0.030m	£0
Judicial Review	£0.033m	£0.043m	£0.043m	£0
Total	**£0.049m**	**£0.073m**	**£0.073m**	**£0**

7.15 Following the closure of the Judicial Review matter, the budget and forecast spend for this matter will be reviewed once of any outstanding and final fees have been presented to the Project.

7.16 There are currently no financial risks relating to the nVCC revenue expenditure.

Integrated Radiotherapy Solution Procurement Project

7.17 Due to a delay in the procurement process, the IRS Project has been extended to September 2022. This has resulted in an additional capital requirement of £0.434m in 2022/23, which has been ring-fenced by the Trust from its 2022/253 discretionary capital allocation.

7.18 There is no revenue funding requirement for the Project in 2022/23.

7.19 The capital position for the IRS Project for 30th September 2022 is outlined below, with a breakeven position forecast for the year.

IRS Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.072m	£0.072m	£0.081m	-£0.009m
Non Pay	£0.093m	£0.362m	£0.353m	£0.009m
Total	**£0.165m**	**£0.434m**	**£0.434m**	**£0**

7.20 Closure of the Project is expected in October 2022, at which time any unused funding will be returned to the Trusts discretionary capital allocation.

7.21 There are currently no financial risks relating to the IRS Procurement Project.

Service Delivery and Transformation Project

7.22 The SDT Project has received revenue funding of £0.131m from the Trust and £0.180m funding from the NHS Commissioners' contribution to support pay and non-pay costs in 2022/23.

7.23 In September 2022, provisional pay award funding of £0.010m allocated to the Project, resulting in a revised budget of£0.321m for this financial year.

7.24 There is no capital funding requirement for the Project in 2022/23.

7.25 The SDT Project revenue position as at 30th September 2022 is shown below.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.147m	£0.298m	£0.298m	£0
Non Pay	£0.000m	£0.023m	£0.023m	£0
Total	**£0.147m**	**£0.321m**	**£0.321m**	**£0**

7.26 There are currently no financial risks relating to the SDT Project.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are currently two financial risks to the Programme:

- A further underspend within the Enabling Works Project as a result of the delay in key project activities; and
- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage.

8.2 These risks have mitigation plans in place or being developed by the relevant Project Teams.

8.3 There are currently no other financial risks for the TCS Programme.

9. TCS SPEND REPORT SUMMARY

9.1 This update is currently being developed.

APPENDIX 1: TCS Programme Budget and Spend 2022/23 as at 30th September 2022

CAPITAL	Year to Date			Financial Year		
	Budget Sep-22	Spend Sep-22	Variance Sep-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	104,388	104,281	107	208,776	210,475	-1,699
Project 1b - Enabling Works FBC	109,872	109,002	870	219,744	218,600	1,144
Project 2a - New Velindre Cancer Centre OBC	621,394	526,303	95,091	1,203,913	1,115,688	88,225
Project 3a - Radiotherapy Procurement Solution	72,101	71,854	248	72,101	80,934	-8,832
Capital Pay Total	**907,755**	**811,440**	**96,315**	**1,704,534**	**1,625,696**	**78,838**
NON-PAY						
nVCC Project Delivery	37,470	34,742	2,728	84,000	84,000	0
Project 1b - Enabling Works FBC	3,606,141	3,240,755	365,386	18,221,033	17,427,861	793,171
Project 2a - New Velindre Cancer Centre OBC	592,311	1,053,630	-461,319	592,311	1,472,950	-880,639
Project 3a - Radiotherapy Procurement Solution	250,487	93,304	157,183	361,899	353,066	8,832
Capital Non-Pay Total	**4,486,409**	**4,422,431**	**63,978**	**19,259,243**	**19,337,878**	**-78,635**
CAPITAL TOTAL	**5,394,164**	**5,233,871**	**160,293**	**20,963,777**	**20,963,574**	**203**

REVENUE	Year to Date			Financial Year		
	Budget Sep-22	Spend Sep-22	Variance Sep-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	115,519	112,342	3,177	292,993	292,993	0
Project 6 - Service Change Team	146,001	147,124	-1,124	298,390	298,390	0
Revenue Pay total	**261,519**	**259,466**	**2,053**	**591,383**	**591,383**	**0**
NON-PAY						
nVCC Project Delivery	16,338	16,412	-75	30,000	30,000	0
nVCC Judicial Review	32,956	32,956	0	43,417	43,417	0
Programme Management Office	3,000	1,626	1,374	17,007	17,007	0
Project 6 - Service Change Team	11,305	133	11,172	22,610	22,610	0
Revenue Non-Pay Total	**63,599**	**51,128**	**12,471**	**113,034**	**113,034**	**0**
REVENUE TOTAL	**325,118**	**310,594**	**14,524**	**704,417**	**704,417**	**0**

APPENDIX 2: TCS Programme Funding for 2022/23

Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0m**	**£0.310m**
Commissioner's funding (April 2022)		£0.240m
Year 1 Trust revenue funding for Strategic Transformation (April 2022)		£0.060m
Pay Award Funding (September 2022)		£0.010m
Enabling Works OBC	**£18.441m**	**£0m**
2022/23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£21.813m	
Virement of funds from 2022/23 to 2023/24 financial year (May 2022)	-£1.900m	
Virement of funds from 2022/23 to 2023/24 financial year (August 2022)	-£1.472m	
New Velindre Cancer Centre OBC	**£2.089m**	**£0.073m**
2022/23 CEL from Welsh Government funding for nVCC OBC (March 2021)	£2.089m	
Trust revenue funding for nVCC Project Delivery (May 2022)		£0.030m
Trust revenue funding for Judicial Review matter (May 2022)		£0.014m
Additional Trust revenue funding for Judicial Review matter (June 2022)		£0.029m
Integrated Radiotherapy Procurement Solution	**£0.434m**	**£0m**
Trust Discretionary Capital Allocation (June 2022)	£0.434m	
Radiotherapy Satellite Centre	**£0m**	**£0m**
No funding requested or provided for this project to date		
SACT and Outreach	**£0m**	**£0m**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0m**	**£0.321m**
Commissioner's funding (April 2022)		£0.180m
Trust Funding (April 2022)		£0.131m

Description	Funding Type	
	Capital	Revenue
Pay Award Funding (September 2022)		£0.010m
VCC Decommissioning No funding requested or provided for this project to date	**£0m**	**£0m**
Total	**£20.964m**	**£0.704m**

APPENDIX 3: Enabling Works Project Budget and Spend 2022/23 as at 30th September 2022

Description		Year to Date Budget Sep-22 £	Year to Date Spend Sep-22 £	Year to Date Variance Sep-22 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY							
Project 1b - Enabling Works FBC		109,872	109,002	870	219,744	218,600	1,144
Pay Capital Total		**109,872**	**109,002**	**870**	**219,744**	**218,600**	**1,144**
NON-PAY - PROJECTS							
EF01	Construction Costs	0	51,662	-51,662	0	51,662	-51,662
EF02	Utility Costs	62,576	62,576	0	1,850,895	1,850,895	0
EF03	Supply Chain Fees	293,057	292,557	500	596,047	596,047	0
EF04	Non Works Costs	80,753	182,826	-102,073	495,847	618,920	-123,073
EF05	ASDA Works	297,743	275,023	22,720	4,570,654	4,547,934	22,720
EF06	Walters D&B	2,247,249	2,247,249	0	8,735,418	8,735,418	0
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	174,000	153,000	21,000
EFQR	Quantified Risk	624,763	165,237	459,526	1,351,828	456,281	895,547
EFQS	QRA - SCP	0	0	0	454,080	454,080	0
EFRS	Enabling Works FBC Reserves	0	-36,375	36,375	-7,736	-36,375	28,639
Enabling Works Project Capital Total		**3,606,141**	**3,240,755**	**365,386**	**18,221,033**	**17,427,861**	**793,171**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**3,716,013**	**3,349,757**	**366,256**	**18,440,777**	**17,646,461**	**794,316**

APPENDIX 4: nVCC Project Budget and Spend 2022/23 as at 30th September 2022

Description	Year to Date Budget Sep-22 £	Year to Date Spend Sep-22 £	Year to Date Variance Sep-22 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership	104,388	104,281	107	208,776	210,475	-1,699
Project 2a - New Velindre Cancer Centre OBC	621,394	526,303	95,091	1,203,913	1,115,688	88,225
Pay Capital Total	**725,782**	**630,584**	**95,198**	**1,412,689**	**1,326,163**	**86,526**
NON-PAY						
nVCC Project Delivery	**37,470**	**34,742**	**2,728**	**84,000**	**84,000**	**0**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	592,311	1,014,771	-422,460	592,311	1,431,271	-838,960
VC10 Legal Advice	0	2,460	-2,460	0	2,460	-2,460
VC11 S73 Planning	0	99,918	-99,918	0	99,918	-99,918
VCRS nVCC Reserves	0	-63,518	63,518	0	-60,698	60,698
nVCC Project Capital Total	**592,311**	**1,053,630**	**-461,319**	**592,311**	**1,472,950**	**-880,639**
TOTAL nVCC fbc CAPITAL EXPENDITURE	**1,355,563**	**1,718,956**	**-363,393**	**2,089,000**	**2,883,113**	**-794,113**

ID	Risk Title - New	Risk Type	Approval status	Division	Risk Owner	Exec/Director Lead	Risk (in brief)	Action Plan	Rating (current)	Review Date
2187	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing.	Safety	Accepted	Velindre Cancer Centre	Rebecca Windle	Cath O'Brien	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in patient treatment delay, Radiotherapy treatment errors, key projects not keeping to time e.g. commissioning of essential systems, suboptimal treatment, either due to lack of planning time or lack of developmental time Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice, Inability to provide engineering cover during weekend quality control activities, MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice, Development of workflow processes to increase efficiency, Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN), vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C), MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background	1. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. 2. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. 3. Development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment.	15	30.12.2022
2612	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced resulting in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	Workforce and OD	Accepted	Velindre Cancer Centre	Sam Johnstone	Cath O'Brien	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	1. Consultant on call is made aware of the AOS gap and will take responsibility for the 24 hour period that they are on call. 2. AOS sessions have been put into consultant job plans going forward.	15	28.12.2022
2253	CANISC failure	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	David Mason-Hawes	Cath O'Brien	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc.	1. Implement DHCR (WPAS / WCP), to replace 'core' CANISC functionality in VCC. DHCR go-live schedled	15	01.12.2022

2205	CANISC failure	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Dewi Johns	Cath O'Brien	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no “fall-back” method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. IRMER-lite form in WPAS will go live in November 2023	Replacement for CANISC Go Live 11th Nov 22	15	01.12.2022
2407	Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	Performance and Service Sustainability	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependancies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk.	1) RSC project requires a clear view IRS Project Risk landscape and links between the 2 projects in terms of risk registers and project plans 2) Ensure design is flexible and futureproof to allow for IRS solution 3) Review impact of delays to IRS Project on RSC Timeline 4. IRS contract to be signed imminently. Implementation plan in development to align with RSC, VCC and equipment	15	31.10.2022
2400	Risk that there is lack of project support	Workforce and OD	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC 3. Programme report completed and more additional recruitment undertaken	15	30.09.2022
2528	There is a risk that Programme Master Plan objectives & outcomes are delayed and/or not met	Performance and Service Sustainability	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that Projects remain 'On Hold' and / or incur delays impacting on the key interdependencies with other projects resulting in Programme Master Plan objectives & outcomes being delayed / not being met	1. Review Programme and Project resources / gaps and make approporiate investments where required. 2. Introduce new ways of working - VF & Strategic Infrastructure Board 3. Programme stocktake review undertaken. Risk of lack of capacity for SACTin new hospital (project 5) considered managable.	15	01.12.2022

2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Tony Millen	Cath O'Brien	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	Mitigations is we are managing rotas and leave tightly. Action is in expansion of service via the WHSSC business case which will aid sustainability. Current capacity development in Medical Physics will support the wider provision of Brachytherapy.	15	25.07.2022

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	24.11.2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	MEL FINDLAY, BUSINESS SUPPORT OFFICER
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	**26.10.2022**	**Discussed and Noted**
QULAITY, SAFETY AND PERFORMANCE COMMITTEE	**10.11.2022**	**Discussed and Noted**

Acronyms

VCC	Velindre Cancer Centre	SLT	Senior Leadership Team
WBS	Welsh Blood Service	SMT	Senior Management Team
TCS	Transforming Cancer Services	EMB	Executive Management Board

1. BACKGROUND

The purpose of this report is to:

Share the current extract of risk registers to allow the Trust Board to have effective oversight and assurance of the way in which risks are currently being managed across the Trust.

- Summarise the feedback, and progress against that to date, on the process from the previous cycle of Committees and Trust Board.
- Summarise the final phase in implementing the Risk Framework.
- Update on approach to risk appetite review for autumn 2022.

2. ASSESSMENT OF MATTERS FOR CONSIDERATION

2.1 Key points for the Trust Board:

- There remains substantial work required from Velindre Cancer Service to clarify the SMART action plans in Datix for their risks rated 15 and above.
- Note the discussion on risk appetite in the Trust Board development session on 8th November.

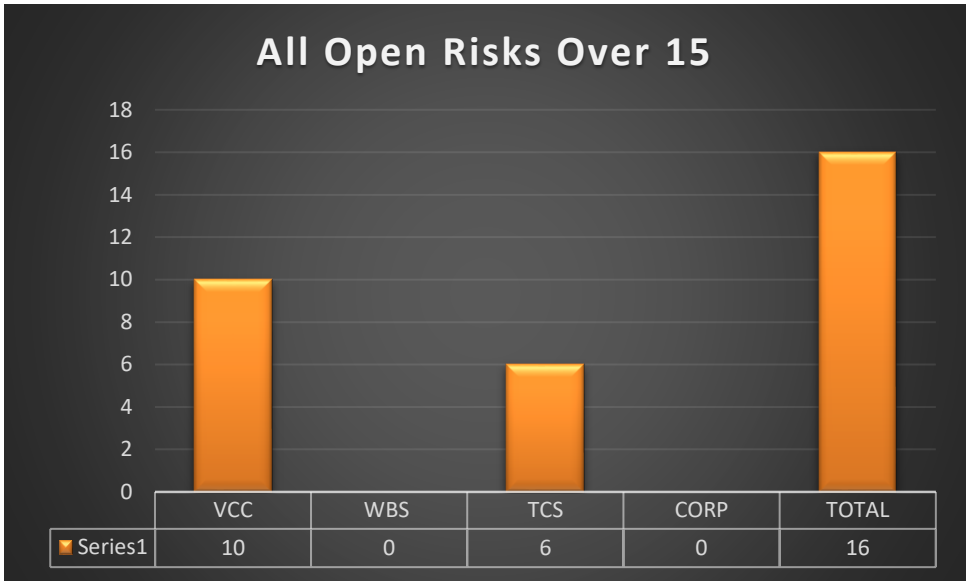
2.2 Trust Risk Register

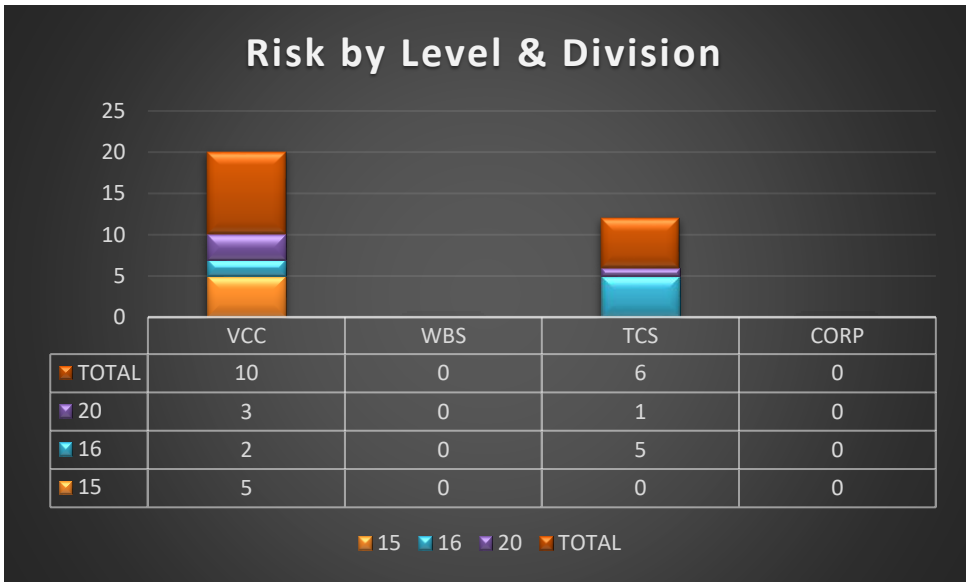
2.2.1 Total Risks

There are a total of 16 risks with a current risk level over 15 recorded on Datix 14.

2.2.2 Risks by Level

The graph below provides a breakdown of risks by level across the Trust. A further breakdown of risks by level and division is also included.





2.2.3 **Analysis of risks**

An analysis of risks by level is provided below. Tables provide detail of each risk including risk type, risk ID, review date and title of the risk.

Of the risks recorded there are ten risks for Velindre Cancer Service, six risks for Transforming Cancer Services and no risks over 15 for the Welsh Blood Service and the Corporate functions.

Risks level 20

The table below provides a breakdown of level 20 risks**.**

ID	Risk Title - New	Risk Type	Approval status	Division	Risk Owner	Exec/Director Lead	Risk (in brief)	Action Plan	Rating (current)	Review Date
2701	Digital Health & Care record DHCR098(R) - There is a risk that not all the required triggers are accessible in the current SACT PDF treatment summary as a result of only two triggers being made available in WCP to select from (These triggers are when treatment is authorised and when treatment is given to a patient). This may lead to the PDF document not being kept up to date and becoming out of sync with the Chemocare system which has 9 additional triggers. These triggers are currently the same triggers that send SACT Treatment Summaries into Canisc, no additional triggers can be implemented to the live HL7 feed that is currently feeding Canisc.	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Phillip Allen	Cath O'Brien	The current design of the SACT PDF Treatment Summary will only be updated in WCP by two triggers from Chemocare. These triggers are when treatment is authorised and when treatment is given to a patient. These triggers are currently the same triggers that send SACT Treatment Summaries into Canisc, no additional triggers can be implemented to the live HL7 feed that is currently feeding Canisc. The additional triggers are:- CARE - Message sent when a Programme is created or modified UNAUTH - Message sent when treatment is Unauthorised DISP - Message sent when Drugs Prepared time is set in the Chemolist FINISH - Message sent when Treatment Finished time is set in the Chemolist ALLO - Message sent when a Drug or Treatment containing a Drug id Allocated DEFER - Message sent when Treatment is deferred or moved DEL - Message sent when Drug or Treatment containing a drug is deleted MODIFY - Message sent when a drug is modified SUBS - Message sent when a drug is Substituted	1. VCC Propose a disclaimer be added to the document stating the latest information is held within the VCC Chemocare system. 2. Phase II development to include the additional triggers start as soon as WPAS is implemented and the existing SACT Treatment Summary interface into Canisc is decommissioned.	20	17.10.2022
2735	Q-Pulse end of life	Compliance	Accepted	Velindre Cancer Centre	Rebecca Windle	Cath O'Brien	There is a risk of Physics working instructions and quality documentation being unavailable to staff after April 2023 due to the current version of Q-Pulse going end of life. A new system is required before the end of 2022 to ensure migration of documentation can be resourced alongside other projects.	1.looking to extend current contracts as an interim measure. Plans to particpate in Trust wide procurement process being led by WBS. Service specification being developed.	20	24.10.2022

2630	Digital Health & Care Record DHCR062(R) - There is a risk that as a result of suspensions and other reasons causing patients to still be 'live' in Canisc at the end of the 12-week dual running period, which may lead to the need to manually migrate IRMER forms that are nearly complete or fully complete, which would take a significant amount of time and may impact staff from physics, radiotherapy and consultant groups. This may impact BAU activities, such as the Mosaiq upgrade.	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Phillip Allen	Cath O'Brien	Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period.Following decision to run dual entry up to 12 weeks, there will be a resource requirements, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales.	1. Phil is writing an impact assessment and project plan, requiring further review. 2. Following the dual running period, may have to consider manual input of admissions and increased number of manually migrated IRMERs at the end of the duel running period.	20	30.12.2022

Risks level 16

The work undertaken to further review risks have also resulted in a change in the number of level 16 risks.

ID	Risk Title - New	Risk Type	Approval status	Division	Risk Owner	Exec/Director Lead	Risk (in brief)	Action Plan	Rating (current)	Review Date
2710	Price Hold - There is a risk that if the project is delayed beyond the anticipated financial close date (w/c 20th March 2023) that the cost of the project will increase due to the financial model being increased in line with changes to RPI.	Financial Sustainability	Accepted	Transforming Cancer Services	David Powell	Carl James	There is a risk that if the project is delayed beyond the anticipated financial close date (w/c 20th March 2023) that the cost of the project will increase due to the financial model being increased in line with changes to RPI.	1. Maintain the contingency within the current budget. Ongoing 2. Confirm with funders a new price hold. To be undertaken, 3 months before financial close. Seek additional funder if required. Not started 3. If an increase occurs due to delay there is an option to proceed to a new funding competition. Action not required at present. 4. Monitor project workstreams and related projects and manage risk that may impact on March 2023 financial close. Ongoing	16	28.11.2022

2714	There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	Accepted	Transforming Cancer Services	Craig Salisbury	Carl James	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	1. Discuss with Welsh Government. CAPEX was increased during CD. Complete 2. Undertake a debt funding competition. If required this will be undertaken 3-4 months before financial close. Not started 3. Monitor interest in line with the financial index. Ongoing	16	27.10.2022
2465	Number of emails medics are receiving, especially those related to clinical tasks.	Safety	Accepted	Velindre Cancer Centre	Eve Gallop-Evans	Jacinta Abraham	The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	1. An audit has been proposed to be undertaken on clinical emails, this will identify how many emails per day, time spent on clinical queries, where the emails originate from, how clinicians communicate that this is not the best route to forward clinical queries. 2. Task and finish group to be established with key staff members in attendance.	16	30.11.2022
2513	Brachytherapy capacity	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Tony Millen	Cath O'Brien	There is a risk that patient treatment is delayed as a result of a lack of medical workforce holding a prostate brachytherapy practitioners licence	1. Clinical service is dependent on a single handed consultant. A second consultation is undergoing training to obtain his licence. In order to achieve his license there is a requirement to see a number of patients which is taking time due to limited number of patients requiring this treatment	16	30.11.2

Risks level 15

Summary of level 15 risks are detailed in the table below.

ID	Risk Title - New	Risk Type	Approval status	Division	Risk Owner	Exec/Director Lead	Risk (in brief)	Action Plan	Rating (current)	Review Date

2187	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing.	Safety	Accepted	Velindre Cancer Centre	Rebecca Windle	Cath O'Brien	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in patient treatment delay, Radiotherapy treatment errors, key projects not keeping to time e.g. commissioning of essential systems, suboptimal treatment, either due to lack of planning time or lack of developmental time Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice, Inability to provide engineering cover during weekend quality control activities, MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice, Development of workflow processes to increase efficiency, Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN), vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C), MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	1. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. 2. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. 3. Development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment.	15	30.12.2022

2612	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced resulting in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	Workforce and OD	Accepted	Velindre Cancer Centre	Sam Johnstone	Cath O'Brien	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	1. Consultant on call is made aware of the AOS gap and will take responsibility for the 24 hour period that they are on call. 2. AOS sessions have been put into consultant job plans going forward.	15	28.12.2022
2253	CANISC failure	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	David Mason-Hawes	Cath O'Brien	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc.	1. Implement DHCR (WPAS / WCP), to replace 'core' CANISC functionality in VCC. DHCR go-live schedled	15	01.12.2022
2205	CANISC failure	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Dewi Johns	Cath O'Brien	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no "fall-back" method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling.IRMER-lite form in WPAS will go live in November 2023	Replacement for CANISC Go Live 11th Nov 22	15	01.12.2022

2407	Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	Performance and Service Sustainability	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependancies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk.	1) RSC project requires a clear view IRS Project Risk landscape and links between the 2 projects in terms of risk registers and project plans 2) Ensure design is flexible and futureproof to allow for IRS solution 3) Review impact of delays to IRS Project on RSC Timeline 4. IRS contract to be signed imminently. Implementation plan in development to align with RSC, VCC and equipment	15	31.10.2022
2400	Risk that there is lack of project support	Workforce and OD	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC 3. Programme report completed and more additional recruitment undertaken	15	30.09.2022
2528	There is a risk that Programme Master Plan objectives & outcomes are delayed and/or not met	Performance and Service Sustainability	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that Projects remain 'On Hold' and / or incur delays impacting on the key interdependencies with other projects resulting in Programme Master Plan objectives & outcomes being delayed / not being met	1. Review Programme and Project resources / gaps and make approporiate investments where required. 2. Introduce new ways of working - VF & Strategic Infrastructure Board 3. Programme stocktake review undertaken. Risk of lack of capacity for SACTin new hospital (project 5) considered managable.	15	01.12.2022

2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Tony Millen	Cath O'Brien	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required.There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day.""There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	Mitigations is we are managing rotas and leave tightly. Action is in expansion of service via the WHSSC business case which will aid sustainability. Current capacity development in Medical Physics will support the wider provision of Brachytherapy.	15	25.07.2022

3. Development of Risk Framework

3.1 Three levels of training to be delivered:

- All staff Level - training covering: why is risk management important, what is my role, first form of Datix 14, which is the simple input from which all staff in the organisation have access to in order to raise a risk. This training will be delivered via online learning on ESR. This training is in the later stages of the process with Shared Services and is anticipated to be life on the online learning portal by the end of November 2022.
- Management level – covering the Policy and Corporate Management Level Procedure and second form on Datix 14, which requires scoring, articulation of controls, setting actions and assigning ownership. It is following this step that a risk is confirmed onto the risk register. The Manager level then has the on-going responsibility for the overall management of that risk. Level 2 training has been completed at the Welsh Blood Service and the Corporate division, and training for Velindre Cancer Service will be completed by early December, with some sessions already delivered via their away day and additional sessions. .
- Leadership level – covering the Policy and oversight roles - Divisional Leadership Teams, Executive Management Board and Trust Board. Training has been completed for Board members and Executive Management Board members, including Divisional leadership.

3.2 Oversight of the development of the risk framework is via the Audit Committee. This includes specific action tracking following Internal Audit's report on the Risk Framework at the end of 2021.

3.3 The November Board Development Session agreed the following next steps:

- Proposal of new levels to EMB Shape in December 2022 for

endorsement to Trust Board in January 2023 for approval

- Refreshed Framework document to Audit Committee for endorsement to Trust Board in January 2023.

Further steps discussed to embed included:

- Link to IMTP clear and transparent.
- Level 2 access cohort will also receive specific regular risk briefings – including on Risk Appetite refresh outcome.
- Embedded into new cover paper format in risk section to encourage active consideration.
- All challenging each other in strategic decision making to make the risk appetite strategic direction active and relevant.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Is considered to have an impact on quality, safety and patient experience
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Risks open for extended periods of time without indication that work is being undertaken could expose the Trust that may have legal implications.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	If risks aren't managed / mitigated it could have financial implications.

4. RECOMMENDATIONS

The Trust Board is asked to:

- **NOTE** the risks level 20, 16 and 15 reported in the Trust Risk Register and highlighted in this paper.
- **NOTE** the on-going developments of the Trust's risk framework.

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2400	Risk that there is lack of project support	Workforce and OD	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC 3. Programme report completed and more additional recruitment undertaken	15
2528	There is a risk that Programme Master Plan objectives & outcomes are delayed and/or not met	Performance and Service Sustainability	Accepted	Transforming Cancer Services	Bethan Lewis	Carl James	There is a risk that Projects remain 'On Hold' and / or incur delays impacting on the key interdependencies with other projects resulting in Programme Master Plan objectives & outcomes being delayed / not being met	1. Review Programme and Project resources / gaps and make approporiate investments where required. 2. Introduce new ways of working - VF & Strategic Infrastructure Board 3. Programme stocktake review undertaken. Risk of lack of capacity for SACTin new hospital (project 5) considered managable.	15

2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	Performance and Service Sustainability	Accepted	Velindre Cancer Centre	Tony Millen	Cath O'Brien	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	Mitigations is we are managing rotas and leave tightly. Action is in expansion of service via the WHSSC business case which will aid sustainability. Current capacity development in Medical Physics will support the wider provision of Brachytherapy.	15

Review Date
30.12.2022
28.12.2022
01.12.2022

01.12.2022
31.10.2022
30.09.2022
01.12.2022

25.07.2022

TRUST BOARD

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Emma Stephens, Head of Corporate Governance and Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	**26/9/22**	**Discussed**
STRATEGIC DEVELOPMENT COMMITTEE	**13/10/22**	**Discussed**
QUALITY, SAFETY AND PERFORMANCE COMMITTEE	**10/11/22**	**Discussed – Specific risks within scope**

1. SITUATION / BACKGROUND

1.1 The purpose of this paper is to provide the Trust Board with an update on:

- The status of the Principal Risks identified in the Trust Assurance Framework (TAF) included at ***Appendix 1,*** which may affect the achievement of the Trust's Strategic Objectives, and the level of assurances in place to evidence the effectiveness of the management of those risks.
- The ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework across the organisation, since the last meeting of the Board.
- Provide an update on the Trust Board development session on 8th November.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Updated on key developments previously noted to the Board:

2.1.1 Link to Risk Register, Performance Framework and Quality & Safety Framework

It was agreed through the July governance reporting cycle that the first step change in the triangulation and linking of the Trust Assurance Framework with the Trust's other key frameworks will be to develop the link between the Trust Risk Management Framework. A preliminary exercise has been undertaken to link the Trust Assurance Framework Strategic Risks to the agreed risk domains on Datix, the outcomes of which are recorded on the Trust Assurance Framework Dashboard in ***Appendix 1.***

In addition, following the development of the Trust Performance Management and Quality & Safety Management Frameworks, key metrics relating to the strategic risks will also be linked during Q3.

2.1.2 Reverse Stress Testing

Reverse stress testing is the identification of a pre-defined adverse outcome, for instance the point at which an organisation may be considered as failing, and severe, but plausible, risks materialising that might result in this outcome are then explored. This is an important development in the organisation's risk maturity and capability.

Following a targeted Trust Board Development session on 8th November 2022, it has been agreed that two reverse stress testing exercises be undertaken utillising a tailored approach aligned to each of the core service divisions, i.e. Welsh Blood Service and Velindre Cancer Service. These will be planned for December 2022 and the outcomes reported through the January governance reporting cycle.

2.1.3 Link to Strategy Development

In reviewing the risk profile, in addition to the reserve stress testing exercise described above, there are two further key suggested inputs:

- Using research and insight on global organisational and health care trends to challenge and support our thinking on macro strategic risks.
- Frame the review in the Trust approved Strategy and Enabling Strategies.

Within this context, alignment to the agreed Trust Destination 2032 Strategy and Enabling Strategies was discussed as part of the Trust Board Risk Board Development session on 8th November 2022.

2.1.4 Trust Assurance Framework Strategic Risks – Next Steps

The November Board Development Session agreed the following next steps:
Already underway:

- Links to Risk Register, Performance Framework and Quality Framework
- Revised reporting mechanism - Integration of Trust Assurance Framework into Datix.
- Mapping Trust Assurance Framework to governance cycle – Committee oversight - plus mechanisms of cycles of business and agenda setting
- Link to Audit tracker – also regarding monitoring assurance levels

Strategic Risk Refresh

- Further work as EMB, SLT/SMT and ELT to develop articulation of strategic risks – aligned to IMTP process – for Trust Board approval, following endorsement by Strategic Development Committee.

2.1.5 Revised reporting mechanism - Integration of Trust Assurance Framework into Datix.

Collaborative work continues with the Datix Team at Hywel Dda Health Board to support increased automation of the Trust Assurance Framework regarding the development of Principal risks within Datix Version 14. We now have baseline reference information, which is under review and in the process of being cross referenced with the principle risk information for the Trust Assurance Framework for the Trust. Progress to date in taking forward the cross referencing has been limited due capacity constraints contained within the Datix Team.

Discussions took place in the Audit Committee regarding Power Business Intelligence for reporting against the Trust Assurance Framework and the benefits this can deliver. Options to explore availability of external resource and support across NHS Wales was discussed. It was agreed that colleagues in Audit Wales will assist in exploring any opportunities that may be available for the Trust to access and tap into the Data Analytics Team within Audit Wales.

Preliminary discussions have taken place with Audit Wales detailing the Trust requirements on this basis. Scoping work has been initiated by Audit Wales to identify what resource is available to support this programme of work.

In addition, there is a further possibility of limited Power Business Intelligence resource to be made available within the Trust to support the development and automation of the Trust Assurance Framework in early December 2022.

2.2 Further developments discussed and agreed through September to November 2022:

2.2.1 Mapping Trust Assurance Framework to governance cycle

In line with the Board development discussions with Internal Audit and Audit Wales it has been agreed that there should be a clearer link between the Trust Assurance Framework and the governance cycle. This work has commenced and will continue to be progressed during the next reporting period and includes:

- Ensuring that cycles of business provide appropriate consideration of each of the TAF controls and sources of assurance.
- Mapping the relevant actions into governance cycles.
- Ensure each committee scrutinise progress to address gaps in controls and Assurances within its scope – from November Committees onwards.
- EMB agreed the following Committee oversight:

01	Demand and Capacity	QSPC
02	Partnership Working / Stakeholder Engagement	SDC
03	Workforce Planning	QSPC
04	Organisational Culture	SDC
05	Organisational Change / 'strategic execution risk'	SDC
06	Quality & Safety	QSPC
07	Digital Transformation – failure to embrace new technology	SDC
08	Trust Financial Investment Risk	QSPC
09	Future Direction of Travel	SDC
10	Governance	AC

During the reporting cycle of October and November embedding the Trust Assurance Framework into the Governance cycle has commenced; the Trust Assurance Framework has been submitted to Audit Committee (full Trust Assurance Framework dashboard), Strategic Development Committee (full Trust Assurance Framework dashboard) and Quality, Safety and Performance Committee (cut of Trust Assurance Framework dashboard for risks 01, 03, 06 and 08) for discussion.

2.2.2 Link to Audit tracker

Executive Management Board also agreed to map the Audit tracker to the third line of defence mapping in the Trust Assurance Framework in order to provide assurance that all current insight, including the impact of open actions on the effectiveness of the control framework, are taken into account. In the September meeting, Executive Management Board agreed to complete this for the January reporting period..

2.3 Trust Assurance Framework Dashboard

2.3.1 The updated Trust Assurance Framework Dashboard Report is included at ***Appendix 1.***

2.3.2 Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since the September 2022 Trust Board in respect of the following Principal Risks.

2.3.3 To also note that in the November Strategic Development Committee and Audit Committee, the summary of each strategic risk was discussed and reviewed, in line with the scope of that Committee to ensure that the Principal Risks are being managed in an effective way in order to enable the realisation of the Trust's strategic objectives.

			NO REVIEW TAKEN PLACE
			REVIEWED NO CHANGES
			REVIEWED AND UPDATED

			APR	MAY	JUN	JUL	SEP	NOV
01	Demand and Capacity	**COB**						
02	Partnership Working / Stakeholder Engagement	**CJ**						
03	Workforce Planning	**SFM**						
04	Organisational Culture	**SFM**						
05	Organisational Change / 'strategic execution risk'	**CJ**						
06	Quality & Safety	**NW**						
07	Digital Transformation – failure to embrace new technology	**CJ**						
08	Trust Financial Investment Risk	**MB**						
09	Future Direction of Travel	**CJ**						
10	Governance	**LF**						

2.3.4 Actions on specific strategic risks

- **TAF 01: Demand and Capacity**
  - **Residual Risk Score –** 12. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes to the sources of assurance.
  - **Action Plan for Gaps Identified –** The action plan has been updated is largely progressing on target.

- **TAF 02: Partnership Working and Stakeholder Engagement**
  - **At present Residual Risk Score –** 8.This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes to the sources of assurance.
  - **Action Plan for Gaps Identified –** There have been additional actions included since the last review.

- **TAF 03: Workforce Planning**
  - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
  - **Action Plan for Gaps Identified –** The action plan has been updated to provide a further level of detail and assurance on the planned timetable for delivery of the associated programme of work to mitigate this risk.

- **TAF 04: Organisational Design**
  - **At present Residual Risk Score –** 9. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
  - **Action Plan for Gaps Identified –** The action plan has been further developed to include the Trust Values Project, which will fulfil a wider brief under the Organisation Design Approach, this work has included engagement work with Board members in the first round of engagement. Additionally, work continues with further programmes being added to the portfolio to ensure this work meets objectives.

- **TAF 05: Organisational Culture**
  - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** A thorough review of the levels of control effectiveness has been carried out resulting in an overall Control Effectiveness rate of Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
  - **Action Plan for Gaps Identified –** The action plan is progressing on target.

- **TAF 06: Quality and Safety**

  The description of the risk has been amended during this review, now detailed as:

  'Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.'

  - **At present Residual Risk Score –** 15. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** This remains as Partially Effective (PE), unchanged since the last review.
  - **Sources of Assurance –** Gaps in controls and assurance have been amended following review;
    - Following approval of the Quality and Safety Framework approved in July 2022, implementation commenced.
    - Quality and Safety Operational Group Planning meeting held, inaugural meeting arranged in October 2022.

    An additional gap in assurance has been identified:
    - The current mapped meeting reporting structure does not cover floor to board at divisional level.
  - **Action Plan for Gaps Identified –** Amendments have been made to the action plan to address the gaps identified and target dates reviewed.

- **TAF 07: Digital Transformation**
  - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
  - **Overall Level of Control Effectiveness –** This remains as Partially Effective (PE) despite a shift in some key control ratings individually.

- **Sources of Assurance –** Amendments and additions to the lines of defence have taken place as part of the review; specifically cyber assurance controls being in place and digital transformation guided by an agreed digital architecture have been added. Gaps in controls have also been highlighted around the development of a digital architecture, appropriate external standards for benchmarking being agreed and the establishment of a digital programme.
- **Action Plan for Gaps Identified –** Three additional actions have been added to the action plan:
    1. Create the Trust Digital Reference Architecture
    2. Review the scope/scale/need for a Digital Programme
    3. Confirmation on the SIRO/Cyber Security roles and responsibilities

- **TAF 08: Trust Financial Investment**
    - **At present Residual Risk Score –** 12. This remains unchanged since the previous review.
    - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
    - **Sources of Assurance –** The reviewed sources of assurance have resulted in some additions:
        1. Key objectives of investment framework and relationship to contract performance and value identified.
        2. Investment framework to be articulated and agreed by Divisions and Executive Team.
        3. Investment framework to be applied within IMTP process.
    - **Action Plan for Gaps Identified –** There has been extensive review of the action plan resulting in the addition of new actions being added, detail below the main actions can be seen in Appendix 1:
        1. Review of contracting model for impact of COVID related measures.
        2. Establish Trust Investment Prioritisation Framework

- **TAF 09: Future Direction of Travel**
    - **At present Residual Risk Score –** 8. This remains unchanged since the previous review.
    - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE).
    - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review.
    - **Action Plan for Gaps Identified –** Dates have been added to the action plan where possible. There remain some dates awaiting dependent on committee outcomes.

- **TAF10: Governance**
    - **At present Residual Risk Score –** 12. There has been no change since the previous review.
    - **Overall Level of Control Effectiveness –** This remains as ‘Effective’ (E).

- **Sources of Assurance –** No amendments have been made nor additions since the last review.
- **Action Plan for Gaps Identified –** A formal programme of work for Governance, Assurance and Risk has been developed reporting into the wider Organisational Development programme for the Trust, this encompasses 20 key projects underpinning the further development and operationalisation of the Trust Assurance Framework. Key aspects are summarised in Appendix 1.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes
	Please refer to ***Appendix 1*** for relevant details.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report

4. RECOMMENDATION

The Trust Board is asked to:

a. **DISCUSS AND REVIEW** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 2.

b. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1.***

RISK ID:	TAF 01	We fail to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result of capacity or demand planning or the operational service challenges
LAST REVIEW	Sep-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Oct-22	RISK DOMAIN Performance and Sustainability
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventativ	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Blood stock planning and management function WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual SLA meetings with Health Boards to review supply. Benchmarking against national and international standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience and inform and predict any surge demand.	PA	Senior Management Team, COO review and EMB Review, QSP committee and Board.	PA	Welsh Government Quality, Planning and Delivery Review.	PA

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 arrangement	Director WBS	X			E	Department Head review with escalation to Director	PA	Performance Report Senior Management Team and EMB Review, QSP committee and Board	PA	Welsh Government Quality, Planning and Delivery Review	PA
C3	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCC (VCS)	X	X		PE	SE Wales Group	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C4	Demand and Capacity Plan for each service area	Heads of Service - Each Area	X	X		PE	Service area operational planning meeting	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA
C5	Active operation engagement with health boards on demand	Director VCC (VCS)	X	X	X	PE	SLT	IA	Performance Report - SLT, EMB, QSP and Board	IA	Welsh Government Quality, Planning and Delivery Review	IA

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing this gap would need digital systems to be in place which are out of WBS control. Projects are progressing externally.	
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 inapproprite use if blood, which impacts demand.	
Lack of visibility of granular level planning data and Health Board activity plans to clear backlog at VCC.	
Lack of a formal oversight of capacity and demand management at a divisional level to recognise the complexity of interdependencies of various functions and services at VCC.	Executive Team oversight of the more detailed capacity and demand plans

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	Project is underway in Cardiff and Vale, supported by WBS. Funding options are being sought	Dec-23
Blood Health National Oversight Group project is underway identifying inappropriate use of blood.	Lee Wong	Gap anaylysis is underway across Health Boards. The IBI lens will be used on this project	Dec-22
Engaging with Health Boards to seek further information on recovery and wider operational plans; such as waiting time initiatives and to formalise a route for planning and managing demand variation, including clinical choices.	Lisa Miller	Contact has been made with HBs and work has been done on data sets and will continue to be reviewed in regular VCS/HB meetings	Complete
A formal demand and capcity review meeting has been established at VCC	Lisa Miller	The group has been established and is currently meeting weekly to address the impact on capacity due failure of third party provision. Currently expericencing above usual demand for SACT	Complete
There is a weekly meeting between the Executive Team and Senior Leadership Team established to provide an opportunity for collaboration and oversight for addressing the immediate challenge at VCC	Steve Ham	This meeting is a short term focused meeting pending revised capacity plans	Complete

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Nov-22	RISK DOMAIN: Partnership

EXECUTIVE LEAD	Carl James	RISK SCORE (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	2	4	8	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

GAP IN CONTROLS							GAPS IN 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
1.1	System structures – core cancer services commissioning arrangements		X			PE	Commissioning contracting reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
1.2	Strategic partnerships which support effective delivery of working/ work programmes			X		PE	Supply and demand reporting	IA	Strategic Development Committee/ Quality Safety and Performance Committeee	IA	Wales Audit Office/Welsh Government	PA
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA

2.1	Blood - core blood services commissioning arrangements			X		PE	Commissioning contracting reporting	IA	Strategic Development Committee/ Quality Safety and Performance Committeee	IA	Regulatory scope re MHRA tbc	PA
3.1	Local Partnership Forum		X	X		PE	Feedback from LPF	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office	PA
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region		X			PE	Agreed to model for next phase	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				

GAP IN CONTROLS	GAPS IN ASSURANCE
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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James	Linked to developments in ways of working for the Trust, the actions to enhance the effectiveness of the controls will be specifically developed and reported on.	Complete

1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James		Complete
1.3	Development of CCLG leadership and goverancne arrangements: towards Alliance System: agree next steps with CEOs	Carl James		Complete

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Nov-22	RISK DOMAIN Workforce and Organisational Development
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	4	3	12	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Draft Trust People Strategy clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Internal Audit Reports	PA	To be completed as per compliance/ reg tracker update	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/ reg tracker update	PA
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	reports via divisional and committee structures	PA				
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation Sheets	PA				

TAF DASHBOARD

WORKFORCE PLANNING

C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE	Staff meeting to feedback on implementation plan	PA				
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE	Recruitment and retention repots via Board	PA				
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Reports via Trust Committee cycle on updates	PA				
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports via divisional and committee structures	PA				
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	PE	Agile Project and Programme Board	PA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls

TAF DASHBOARD

WORKFORCE PLANNING

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and a range of outputs defined to deliver between September 2022 and February 2023.	Feb-23
1.2	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	The Trust has appointed a staff psychologist to support mental health and wellbeing. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform allowing them to be more easily accessible for staff.	Dec-22
1.3	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	The Trust has approved a set of Hybrid working principles. There are now task and finish groups working under the Hybrid working project to develop the operational systems and toolkits that will allow the Trust to fully relaise the benefits of hybrid working arrangements.	Dec-22

TAF DASHBOARD

ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.**								
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Nov-22	**RISK DOMAIN**					**Performance and Service Sustainability**			
EXECUTIVE LEAD	Sarah Morley	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		3	4	**12**	3	3	**9**	2	2	**4**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) to be agreed to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA
C2	Developing Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training Steering Group	PA	Trust Board reporting on strategy and controls via cycle of business	PA	To be completed as per compliance/ reg tracker update	PA

TAF DASHBOARD

ORGANISATIONAL CULTURE

C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training Steering Group	PA				
C4	Values to be reviewed and Behaviour framework to be considered Values of the Organisation used in induction, recruitment and via PADR processes	Susan Thomas	X			PE	Healthy and Engaged Steering Group Education and Training Steering Group	PA				
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				
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health & Wellbeing Steering Group	PA				
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board	PA				
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group	PA				

TAF DASHBOARD

ORGANISATIONAL CULTURE

C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings	PA				
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings Education and Training Steering Group	PA PA				
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined	PA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defence assurance to be completed
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Development of Organisational Design approach for the Trust to encapsulate both process and cultural elements that need to be inplace to allow the organisation to achieve its strategic goals	Sarah Morley	takeholder engagement has taken place on the rationale for this work and an overview of some of the elements of work that may sit within it with the Executive Team, Divisional Senior Leadership Teams and the Board. The scope of the programme and governance arrangements will be developed and agreed in November, during which the timelines associated with the main elements will be determined. Further programmes have been added to the portfolio to ensure this work meets its objectives.	Nov-22
1.2	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	It has been decided that the Trust Values Project will fulfill a wider brief under the Organisational Design Approach. Interviews have taken place with Board members as first round of engagement activity. This will be followed by wider engagement across the Trust.	Dec-22

TAF DASHBOARD ORGANISATIONAL CULTURE

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Nov-22	**RISK DOMAIN** **Performance and Service Sustainability**
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	2	2	**4**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

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
1.1	Trust strategy to provide clear set of goals, aims and priorities	Carl James	x			E	Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.2	Integrated Medium Term Plan to translate strategy into clear delivery plans	Carl James	x			E	Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.3	Performance reporting in place to ensure delivery of required quality/performance in core service	Carl James	x		x	PE	Executive Management Board review/ patient and donor feedback	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA

1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x		E	Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.5	Well defined change programmes at a local level to manage change effectively (WBS Change programme & Velindre Futures)	Cath O'Brien	x			PE	Executive Management Board review / staff feedback	IA	Strategy Committee/QSP/Internal Audt Review / CHC	IA	Audit Wales	IA
1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x			PE	Executive Management Board review / staff feedback	IA	Internal Audt Review	PA	Audit Wales/HIW	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Currently gap in ability to measure all desired outcomes	
Lack of capacity in business intelligence to develop range of information and automate it	
Revised performance management framework not fully implemented	
Not all supporting strategies approved by the Board	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Finalise all strategies and plans	Carl James	Drafts well developed with final engagement exercise ongoing - Board approval in May 2022 (on track for May 26th 2022). Trust strategy and enabkers developed and approved (with launch in Sept 2022)	Complete
Develop IMTP to provide priority for action and application of resource	Carl James	Final draft going to Board for approval March 2022	Complete
Information requirements being scoped	Cath O'Brien	First phase to support new performance measures (on track for September 2022)	Sep-22

Implement revised performance management framework	Carl James	New scorecards being finalised for implementation (on track for September 2022). Additional cycle agreed to test PMF (october board edevelopment session) - target date for live PMF Dec 22 / Jan 23 Cycle	Sep-22

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.		
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Nov-22	Goal 1	RISK DOMAIN	Quality and Safety/ Comliance and Regulatory

		RISK SCORE (See definitions tab)								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
EXECUTIVE LEAD	Nicola Willams	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		5	5	**25**	3	5	**15**	2	5	**10**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE
C2	CIVICA pt/donor feedback system being implemented	Nicola Williams			X	PE
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Staff feedback	IA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
Patient/Donor Feedback	IA	Quality, Safety & Performance Committee	IA	HIW Inspect	Not Assessed
15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
EMB	IA			Professional bodies	Not Assessed
Divisional Q&S Groups	IA			Delivery Unit	Not Assessed
PMF	IA				Not Assessed

TAF DASHBOARD

QUALITY AND SAFETY

C5	PMF in place & under review to include experience & outcomes	Carl James			X	NE	Perfect Ward audits	IA				
							PMD	IA				
C6	Trust Risk Register in place	Lauren Fear	X	X	X	PE	Mortality reviews	IA				
C7	Regular Staff Feedback sought	Sarah Morley			X	PE						
C8	Staff Q&S training & Education	Nicola Williams	X			PE		IA	Internal Audit Reviews	Not Assessed		

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework approved in July 2022, implementation commenced. Quality & Safety Operational Group Planning meeting held, inagural meeting arranged in October 2022.	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality statutory guidance 12 week consulation due in October 2022 & Duty of Candour regulation changes 12 week consultation commenced on 20th September 2022.	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognized Floor to Board lines accountability & responsibility for Quality & Safety	The current mapped meeting reporting structure does not cover floor to board at divisional level
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	Quality & Safety Operational Group requires full establishment - to operationally pull together all stands and feed into EMB & QSP

TAF DASHBOARD **QUALITY AND SAFETY**

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	Nicola Williams	Framework finalised and approved by Board in July 2022	COMPLETE
1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Alan Prosser Paul Wilkins	Corporate OCP completed and recruitment commenced. WBS Quality Hub requirements determined – minor changes required from existing arrangements VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	Oct-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Implementation plan developed and approved	Mar-23
1.4	Instigate a Quality & Safety operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Planning meeting held, draft terms of reference developed and membership agreed. Inagural meeting planned for October 2022	Oct-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Being picked up through the Datix project Board	Dec-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley	Compassionate Leadership is woven through the Trust 'Inspire' Leadership Programme. A broader Trust wide programme is being developed for all leaders and managers which forms part of the 'Building our Future Together' Portfolio.	Apr-23
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Investigation training provided to officers within corporate quality & safety team and both divisions	Jun-22
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group. Consultations planned for Autumn 2022.	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23

TAF DASHBOARD

QUALITY AND SAFETY

1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear	Governance and Assurance mechanisms have been agreed and established for Shared Services, reporting through to the Quality, Safety and Performance Committee, Shared Services Audit Committee and Shared Services Partnership Committee. A review is underway of Health Technology Wales and required Governance and Assurance mechanisms. This will be progressed in quarter 1 2022/23. Update 06.10.2022 - Defined project as part of the Building Our Future Together work programme.	Jan-22
1.11	Complete Risk Register Review, transmission onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear	Regular reviews are taking place and work is ongoing to transfer of all risks to Datix V14, followed by Once for Wales when available.	COMPLETE

TAF DASHBOARD

DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e. assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.
LAST REVIEW	Oct-22	5 - A sustainable organisation that plays it part in creating a better future for people across the globe
NEXT REVIEW	Nov-22	**RISK DOMAIN** Performance and Service Sustainability
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	3	3	**9**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Trust Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			E
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

TAF DASHBOARD

DIGITAL TRANSFORMATION

C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE	Staff feedback	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C4	Training & Education packages for donors, patients	Chief Digital officer	X			NE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA	Wales Audit Office	PA
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			E	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office/Centre for Digital Public Services	PA
C7	Digital inclusion – in wider community	Chief Digital officer	X			NE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	Not Assessed
C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

TAF DASHBOARD

DIGITAL TRANSFORMATION

C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PA
C11	Trust digital governance	Carl James		X		NE	Trust digital governance reporting	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	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	Review via EMB / Trust Board	PA	Wales Audit Office	PA
C13	Cyber assurance controls in place	Chief Digital officer		X		PE	Review via Divisional SMT / SLT. Cyber Security eLearning (Stat. & Mand.) Board Development Sessions.	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office. 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 established. Architectural Review Board	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	Not Assessed

TAF DASHBOARD

DIGITAL TRANSFORMATION

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls (with exception of c1,c2) requires further development and progression, the plans for which are at varying levels of maturity – see action 1.1	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker see action 1.2.
Digital architecture needs to be developed to guide digital transformation activities.	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls, as per action 1.1.
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.	Confirmation on SIRO / Chief Digital Officer responsibilities for cyber assurance alongside Information Governance.
Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Chief Digital officer	CDO started on 1st July as anticipated, key controls in the TAF reviewed and can be presented at a future SDC	Nov-22
1.2	Create the Trust Digital Reference Architecture to support C14 and	Chief Digital	New Action	Jan-23
1.3	Review the scope/scale/need for a Digital Programme to provide	Chief Digital	New Action	Jan-23
1.4	Confirmation of the SIRO/Cyber Security roles and responsibilities	Chief Digital officer	New Action	Oct-22

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.								
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Nov-22	**Goal 2**			**RISK DOMAIN**		**Financial Sustainability**			
EXECUTIVE LEAD	Matthew Bunce	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		4	4	**16**	3	4	**12**	2	4	**8**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Trust Financial Strategy	Matthew Bunce	X			PA	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives and Senior Management Teams	PA	Internal Audit cycle of assurance on financial strategy	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PA	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	PA	Quarterly Directorate financial reviews established across both Divisions	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE	Chief Executive Consideration of Investment at a Trust Level	IA	Divisional Senior Management Team investment review	IA		

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify mitigations.	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas. Welsh Government and Commissioners engaged on current and future consequences.
C7 – Trust Investment Prioritisation Framework to be established.	Investment is limited in it's prioritisation to the Executive Team and Senior Management Teams discretion and not formally supported by a framework for decision making.

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	**Support the embedding of investment framework within Divisions**	**David Osborne**	**Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.**	**Dec-22**
	Investment scrutiny with services against commitments made and intended.	David Osborne	Completed and subject to continuous review	Completed
	Key objectives of investment framework and relationship to contract performance and value identified	David Osborne	Completed	Completed
	Investment framework to be articulated and agreed by Divisions and Exec	David Osborne	Due through Q3	Dec-22
	Investment framework to be applied within IMTP process	David Osborne	Due through Q3	Dec-22
1.2	**Review of contracting model for impact of COVID related measures**	**David Osborne**	**Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.**	**Dec-22**

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

	Protected Enhanced rates secured for 22-23	David Osborne	Completed	Completed
	Contract currencies of concern identified and impact assessed	David Osborne	Impact of hyperfractionation reviewed	Completed
	Business Cases completed for Brachytherapy	David Osborne	Business case prepared and agreed	Completed
	Engage with National Funding Flows Group for contract agreements for future financial years	David Osborne	Ongoing, due November	Dec-22
1.3	**Establish Trust Investment Prioritisation Framework**	**Matthew Bunce**	**Initial proposals prepared, Executive discussions to shape and take forward**	**Dec-22**

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.								
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Nov-22	Goal 2			RISK DOMAIN			Research and Development		
EXECUTIVE LEAD	Carl James	RISK SCORE (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	2	4	8	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			E	Executive Management Board review	PA	Strategic Development Committee	PA	Audit Wales Reviews	PA
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel	Jacinta Abraham				PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C4	Development of improved local, regional and national clinical commissioning arrangements	Matthew Bunce	x			PE	Executive Management Board review	IA	Strategic Development Committeen and performance management framework	IA	Audit Wales Reviews	PA

C5	Agreement of system leadership roles for primary services: 1. Blood Services 2. Cancer Services	Cath O'Brien	x			PE	Executive Management Board review/ patient and donor feedback	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C6	Change in strategic workforce plan to recognize/address any new leadership/clinical/management skills related to strategic growth	Sarah Morley	x			PE	Executive Management Board review	IA	Strategic Development Committee	IA	Audit Wales/MHRA & HIW/ regulators	PA
C7	Refresh of Investment and Funding Strategy	Jacinta Abraham	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance Management	IA	Audit Wales/External Research organisations & Welsh	PA
C8	Development of commercial strategy	Matthew Bunce	x			PE	Executive Management Board review	IA	R< D & I Sub-Committee and Performance Management Framework	IA	Audit Wales/External Research organisations & Welsh Government	PA
C9	Attraction of additional commercial and business skills	Matthew Bunce		x		PE	Executive Management Board review	IA		IA	Audit Wales/External Research organisations & Welsh Government	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of clinical and scientific strategy	New PMF not yet in place with revised measures to track delivery of Trust strategy
Limited commercial expertise (capacity) within the Trust	Local commissioning/regional commissioning processes unchanged with no new ways of measuring effectiveness
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	
Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capability to leverage the strategic oppor	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James	On track for May 2022. The overarching Trust Strategy "Destination 2032" was approved in the January Trust Board. The Enabling Strategies were subsequently approved, as outlined below, in the May 2022 Trust Board.	COMPLETE
1.2	Board decision on strategic areas of focus/to pursue	Board	Final enabling strategies on track for may 2022 - allowing prioritisation to occur in future IMTPs. Trust Enabling Strategies were approved by the Trust Board in May 2022.	COMPLETE
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board decisions)
1.4	development of clinical and scientific strategy	Jacinta Abraham		tbc

1.5	Development of KPIs and PMF to track strategy delivery	Carl James	Draft KPIs developed and PMF being plioted	Dec 22/January 23 Board reporting cycle
1.5	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions)

TAF DASHBOARD

GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.									
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience									
NEXT REVIEW	Nov-22	**Goal 1**			**RISK DOMAIN**		**Compliance and Regulatory**				
EXECUTIVE LEAD	Lauren Fear	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		4	4	**16**	3	4	**12**	2	4	**8**	

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	E		

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: **Code of Good Practice 2017**	PA	Audit Committee Trust Board	PA	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	PA
C2	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Annual Review	PA	Audit Committee Trust Board	PA	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment	PA

TAF DASHBOARD

GOVERNANCE

												Audit Wales Review of Quality Governance Arrangements	
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**
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial assurance) Audit Wales review outcomes of report as part of Annual Report - Accountability Report	PA
C4	Board Development Programme	Lauren Fear	X			PE	Programme established PA	IA	Independent Member Group repurposed and second meeting now held. Further embedding through 2022/23	IA		
C5	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	PA		PA	Audit Wales review of Quality Governance Arrangements	PA

TAF DASHBOARD

GOVERNANCE

C6	Quality of assurance provided to the Board	Lauren Fear	X			E	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role. IA	IA	Trust Board assessment via formal annual and additional effectiveness review exercises. IA	IA	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
None	Third line of defence in respect of C4 – Board Development Programme: no course of action is proposed

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.	Lauren Fear	Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Complete
Ongoing input from the Independent Members via the repurposed Integrated Governance Group	Lauren Fear	Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.	Complete
Develop and iplement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	This will be picked up in the overall Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work	Dec-23
Appropriate frameworks will be aligned with the Trust Assurance Framework	Lauren Fear	Project TAF1.0 within the Governance, Assurance and Risk (GAR) programme of work is underway to align frameworks with the Trust Assurance Framework. The Risk Framework is currently being mapped.	Mar-23
Refresh of Trust Assurance Framework risks	Lauren Fear	Project TAF 2.0 withint he GAR Programme has started, risks are reveiwed on a monthly basis and reported through governance routes accordingly	Dec-23
Revised reporting mechanism to be developed	Lauren Fear	Project TAF 3.0 withint he GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams, led by Execs	Mar-23
Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	Work is ongoing mapping the 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	Mar-23

TRUST BOARD

NURSE STAFFING LEVELS (WALES) ACT 2016

DATE OF MEETING	24th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-Applicable

PREPARED BY	Rhian Wright, Nurse Staffing Programme Lead, Anna Harries, Senior Nurse Professional Standards & Digital
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHP & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHP & Health Science

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/22	Discussed and noted
Quality, Safety & Performance Committee	10/11/2022	Approved

1. SITUATION

This paper is to provide the Trust Board with the mid-year position in respect of Nurse Staffing Act (Wales) compliance. This report provides the position up to the 30th September 2022.

The Trust Board is asked to **NOTE** the current position in relation to Nurse Staffing Act compliance.

2. BACKGROUND

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

- Enable the provision of safe nursing care to patients at all times;
- Improve working conditions for nursing and other staff; and
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Since the 1st April 2021 the Velindre Cancer Service First Floor Ward was re-classified 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 Act reporting requirements. Through establishment reviews of all nursing areas, a triangulated approach to each area has been considered despite not requiring national reporting this information is vital to quality indicators. The full detailed report will follow however part of this is considered in the assessment/summary below.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Nurse Staffing Act Reporting

There is a statutory requirement to provide annual and 3 yearly reports to the Board. However, as 6 monthly establishment reviews are undertaken a mid year status report has been drafted for noting by the Board. While reporting is mandatory for first floor ward on all sections of the Act since April 2021 the wider areas within

nursing workforce have also been included in part. The Staffing Act review has been completed and the report (using the national reporting template) is attached in ***Appendix 1***. This report highlights:

- Nurse staffing levels calculated using the triangulated approach
- ***No impact on patient care reported due to not maintaining staffing levels***
- There have been some occasions when the required roster has not been met due to sickness absence. Every effort has been made to fill any gaps in the roster and the vacancies that have gone out to advert should help to alleviate such issues. ***There have been no incidences reported where staffing levels have impacted adversely of the First Floor Ward to provide the required care or treatment to patients.***
- The implementation of SafeCare (new acuity tool) will enable us to bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients being cared for at Velindre Cancer Centre.
- Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor.

3.2 Establishment Reviews

Following each national benchmarked acuity review (twice yearly) an establishment review is undertaken across all areas of the Trust that require registered nurses in 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:

- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of Roster
- Patient Feedback (CIVICA)
- Audits (Tendable)
- Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
- KPI review
- Service plans or Clinic Templates as applicable (not all areas)

In summary of the three areas reviewed with nursing workforce, evident knowledge of areas data and information available. No incidents or complaints effecting care linked to staffing. PADR compliance good and in some areas 100% with plans for those that are below. Training very good with reference to specific training focus and working at top of license. Discussions also held around consideration of Band 4 Practitioners based on NHS Wales agreed standards.

3.3 Electronic Rostering

Consolidation of electronic nurse rostering (six nursing units in VCS) – Health Roster (ALLOCATE) - Health roster is now fully utilised and reporting to payroll (since Sept 2021) in all 6 nursing areas and for the nurse bank. The data reports are producing Key Performance Indicators (KPI) which are scrutinised locally for efficiency and effectiveness. These KPI's are reviewed through establishment reviews and are now generated very easily through the system, reducing workload. In addition, all rosters are reviewed easily to aid assurance that staffing levels are safe across all nursing areas. These rosters are legible, auditable and viewed in one centralised location for visibility of responsible staff.

3.4 Additional plans to further enhance monitoring & compliance with Nurse Staffing Act Requirements

The following actions are being taken by Velindre University NHS Trust to further enhance its ability to robustly evidence that it is meeting the Nurse Staffing Act Requirements:

- ***Implementation of Allocate SafeCare Module*** – The SafeCare module of Allocate (acuity tool) will facilitate 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 just commenced the implementation and it is expected that this will be completed by January 2023.

- ***Tendable (Name change from Perfect ward on 1st December 2021) –*** The application based digital audit tool that provides real time reporting of audits which are standard-based and all tagged (linked) to the health care standards. Tendable application is now live in 15 areas including Welsh Blood service (WBS).

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	There is a strong evidence base that links nurse staffing levels with patient experience and outcomes.
RELATED HEALTHCARE STANDARD	Safe Care
	Individual care, Timely care, Dignified Care, Staff & resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

	However, a wider nurse workforce equality review is required
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
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Given the duty of the act, in the event of patient acuity and / or numbers increasing the staffing levels will need to be increased accordingly. This will have a financial impact

5. RECOMMENDATION

The Trust Board is asked to **NOTE** the mid-year position in relation to compliance with the Nurse Staffing Act (Wales) requirements.

Appendix 1	Annual Presentation of Nurse Staffing Levels to the Board
Health Board / Trust	Velindre University NHS Trust
ate of annual presentation of Nurse Staffing Levels to Board	November 2022
Period covered	1st October 2021 to 30th September 2022
Number and identity of section 25B wards during the reporting period. • **Adult acute medical inpatient wards** • **Adult acute surgical 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. During the COVID pandemic, beds were reduced from 32 to 22 to allow for appropriate social distancing. This has remained in place since 2020, however, due to the national relaxation of Covid 19 guidance and increasing demand from May 2022 bed numbers have increased back up to the full capacity of 32 beds. The bi-annual calculation cycle took place as planned in both January and June 2022; no further calculations have taken place outside of this cycle, however, First floor ward continues to document acuity daily through the Healthcare Monitoring System. Following a review of the previous Whole Time Equivalent (WTE)) calculations, some inaccuracies have been identified. These inaccuracies have been corrected and a more robust system of calculation has been utilised. The recalculated WTE RN for first floor is 30.95 (inclusive of the ward manager and co-ordinator) and the WTE for HCSW is 14.21, both figures are inclusive of the 26.9% headroom based on 32 bed occupancy.
Using the triangulated approach to calculate the nurse staffing level on section 25B wards	The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews take place bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. Patient acuity is scored daily using the Welsh Levels of Care Toolkit. The ward manager has remained in a supernumerary capacity throughout this period, supported by a ward co-ordinator that can assist with patient care if the need arises. The ward manager and band 6 nurses measure patient acuity in a consistent manner using lay descriptors and then clinical descriptors if required. The acuity data reveals that patients are predominantly scored at an acuity level of 4 and 3 respectively. This correlates with an increase in reported acuity across health boards and trusts in Wales. There have been instances where the planned roster has not been met, however, professional judgement has been utilised and it was deemed safe due to the reduced number of beds, skill mix and patient acuity levels. Occasionally the planned roster has not

	been met due to staff sickness and unavailability of bank staff to fill the shift at short notice. Quality indicators and complaints in relation to nursing care have been scrutinised, there have been no instances of reportable quality indicators in relation to patient falls and pressure damage. There has been one medication error which resulted in low harm that was not attributable to nurse staffing levels. There has been one complaint in relation to nursing care since the Annual Assurance report in May but again this was not linked to nurse staffing levels. Health roster is in place in Velindre VCC, we are currently awaiting the implementation of SafeCare which will help inform our nursing establishment and requirements for each shift based on patient acuity. SafeCare will assist in avoiding the over or under use of staff and helps in assuring that there is an appropriate and safe skill mix. SafeCare will bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients at Velindre Cancer Centre. It will ensure consistency in recording and reporting data across organisations and support the Once for Wales Approach. Until now, health boards have only provided a narrative to describe the extent to which the nurse staffing levels have been maintained. It is anticipated that health boards/trusts will be able to collate, review and report numerical data to demonstrate the extent to which the planned roster has been maintained once SafeCare is implemented.
Finance and workforce implications	The first-floor ward establishment is historic and had not had any year-on-year increase to support increasing patient acuity and complexity until the implementation of the Nurse Staffing Act 2016. The establishment was reviewed to ensure that in order to provide care sensitively to patients, the establishment included the required 26.9% headroom to account for sickness, study leave, annual leave etc. The nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor. First Floor reduced bed capacity to 22 beds during the pandemic. After undertaking a review of the current funded nursing establishment against the required establishment for First Floor Ward, the directorate is of the opinion that the current establishment is sufficient to manage and deliver care sensitively to 32 beds from September 2022. First floor is currently carrying some vacancies which have gone out to advert and interviews are taking place imminently. The development of Band 4 assistant practitioners through published national framework is also under consideration in all areas across the Trust.
Conclusion & Recommendations	
	• This is the first annual presentation to the board for Velindre University NHS Trust in relation to section 25b. • Previous reports have been submitted in line with the requirements of the Act (Annual Assurance Report May 22). • Nurse staffing levels are being recorded and reported appropriately in line with the Nurse Staffing (Wales) Act. • First floor is now back up to full capacity of 32 beds. • There are no concerns in relation to reportable quality indicators for falls, pressure damage.

	• There have been some occasions when the required roster has not been met due to sickness absence. Every effort has been made to fill any gaps in the roster and the vacancies that have gone out to advert should help to alleviate such issues. • The nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor. • The implementation of SafeCare will enable us to bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients being cared for at Velindre Cancer Centre.

Summary of Nurse Staffing Levels forwards where section 25B applies.

Health Board/Trust:	Velindre University NHS Trust	
Period being reported on :	Start date: Oct 1st 2021	End Date: Sept 30th 2022
Number of wards where section 25B has applied during the period:	**Medical:**	**Surgical:**
	1	

***Supernumerary i.e. 1 WTE supernumerary ward sister/charge and 1 WTE supernumerary co-ordinator qualified nurse included in the establishment.**

Medical

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2022)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
First	E			23.68	23.68	Yes	E			30.95	14.21	Yes	Yes	No		No		

Floor	**L**						**L**									NA	
	LD	**5**	**3**				**LD**	**5**	**3**								
	TW						**TW**										
	N	**5**	**2**				**N**	**5**	**2**								
	E					**Yes**	**E**					**Yes**	**NA**	**NA**		**NA**	**NA**
	L						**L**										
	LD						**LD**										
	TW						**TW**										
	N						**N**										

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty

TRUST BOARD

INFECTED BLOOD INQUIRY

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Suzanne Jones, Project Support Officer
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/2022	Noted
Quality, Safety and Performance	10/11/2022	Noted

ACRONYMS	
IBI	Infected Blood Inquiry

NHSBT	National Health Service Blood and Transplant (England)
NIBTS	Northern Ireland Blood Transfusion Service
SNBTS	Scottish National Blood Transfusion Service
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 The Infected Blood Inquiry is the independent public statutory inquiry into the use of infected blood particularly since the 1970's.

1.2 The Inquiry has been established to examine why men, women and children in the United Kingdom were given infected blood and / or infected blood products; the impact on their families; how the authorities (including government) responded; the nature of any support provided following infection; question of consent; and whether there was a cover-up.

1.3 VUNHST has core participant status in the Inquiry in relation to The Welsh Blood Service (WBS).

1.4 The Inquiry has been in operation for over 4 years and has been taking evidence from those affected and infected together with a number of individuals representing relevant organisations. The activity of the IBI has continued during the COVID 19 pandemic. We are now approaching the stage of the inquiry that will enable Core Participants to submit a written statement in response to the evidence that has been heard.

1.5 During the majority of the period under review, WBS was legally an entity within a number of Welsh NHS organisations and operated in effect as a regional center under a collaborative working arrangement across England and Wales. As such, the evidence given by NHSBT has in the main covered England and Wales.

1.6 In addition to WBS, VUNHST also includes NWSSP as a hosted service and evidence has been provided for the Wales Infected Blood Support Scheme in partnership with VCC support services.

1.7 The approach to engagement with the IBI has been in line with the Charter for Families Beavered through Public Tragedy.

1.8 VUNHST has submitted responses to Rule 9 requests made by IBI as well as oral evidence by the Director of the WBS predecessor Regional Transfusion Centre (Wales).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 VUNHST Engagement with the IBI team

The Inquiry team continues to review the WBS archive and to extract documents of interest which are then sent to the WBS team to consider if they wish to make a request for redaction. No requests have been made to date. Currently documents provided by the VUNHST are being reviewed by the IBI and these are being sent through on a weekly basis.

2.2 Hearings

The Hearings will continue until the end of this year, with additional hearings held to consider Core Participant submissions. Recommendations by Core Participants for consideration by the Chair were invited by the IBI in June and may form the basis of these hearings.

In January the Chair will hear oral submissions from Core Participants about the conclusions they think the Chair should reach about factual findings and recommendations.

2.3 Written submissions to IBI

There is a final opportunity for Core Participants to submit a written response to the Inquiry by 16th December 2022. Such a submission will be required to enable the VUNHST to make a final oral submission to the Inquiry before the Chair retires to consider his findings should it require. The Chair has indicated that where Core Participants with a common area of interest agree on issues, then they do not need to submit separate submissions. The UK Blood Services have been given permission to peer review each other's statements prior to submission to the IBI.

Areas for inclusion in the submission are being worked through with the VUNHST legal representatives. There will be final oversight by the VUNHST appointed KC prior to submission at the 16th December deadline.

In recognition of the wishes of the IBI to avoid duplication, WBS will be considering the submissions being made by NHSBT and SNBTS and only making an individual submission on areas where there is a specific Welsh service context or difference. Due to the ongoing provision of documents and evidence, and recognising the wide range of issues and evidence, the work to draft and share statements will have to continue right up to the deadline.

VUNHST did not take up the offer to make any recommendations to the IBI in June 2022, recognising that it should not duplicate areas of mutual interest with others and advised

the IBI in this regard. WBS is sighted on SNBTS and NHSBT submissions which have been considered and the Welsh context for these determined via a short Task and Finish Group. These will be included in the VUNHST final submission.

The period of time being reviewed by the Inquiry relates in the main to historic periods of time that pre date the establishment of the Welsh Assembly Government in 1999. During this period, the policy set for the Cardiff regional transfusion centre, RTC Wales was the UK Department of Health and issued via the Welsh Office. The Cardiff Regional Transfusion Centre (RTCWales) operated in effect as a region of England, where RTCs worked as quasi-independent bodies within local NHS management structures and came together to work through informal co-operation. Furthermore, the RTC Wales staff were not in the main contributors to the highly specialist expertise that was drawn on to inform developments, rather it drew on guidance produced by the collective.

WBS does not have the expertise nor did it historically have a lead or even major contributory role in forming policy or guidance in the areas being considered. More it followed government guidance in implementation. That notwithstanding operational decisions were made. As such, WBS, VUNSHT is not in a position to inform opinion or challenge views, particularly when our records have not included information to the contrary. As such, we recognise that, unless there are areas where there are specific Wales differences that are included in evidence, that the NHSBT submission will cover England and Wales.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	The Inquiry relates to historic timelines.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Standard 2.8 Blood Management
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	The Inquiry relates to historic timelines.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	The Inquiry will identify in relation to its' Terms of Reference, any individual responsibilities as well as organisational and systematic failures.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Funding for this work was confirmed with the Welsh Government to continue for the duration of the Inquiry

4. RECOMMENDATION

The Board members are asked to NOTE the update for the final Written Statement to IBI by the December 16th deadline.

TRUST BOARD

TRUST BOARD ACCOUNTABILITY CONDITIONS & IMTP 2022/23 QUARTERLY ACTIONS PROGRESS

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Meeting held in private

PREPARED BY	Peter Gorin, Head of Strategic Planning & Performance
PRESENTED BY	Carl James, Director Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/22	Approved
Quality safety and Performance	10/11/22	Noting

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Gov.t Review Meeting)

1. SITUATION/BACKGROUND

1.1 The Integrated Medium Term Plan 2022-2025 was approved by the Minister for Health and Social Service in July 2022. Integral to the IMTP was a range of Quarterly Action Plans to further delivery of the Trust's Strategic Aims, covering:

- Cancer Services
- Blood and Transplant Services
- Trust-wide Programmes
- Enabling Support Services

1.2 The approval was followed by a letter to Steve Ham from the Director General and NHS Wales Chief Executive, which set out some general comments regarding expectations regarding the Trust Board's role in the process and a series of Requirements and Accountability Conditions on which the approval was made.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Accountability Conditions have been taken from the Director General and NHS Wales Chief Executive's letter and are set out in the Accountability Conditions Monitoring Document (**Appendix A).** The template outlines, at a high level, the key quarterly actions proposed to ensure full compliance with both the general and the VUNHST specific accountability conditions.

2.2 The General Accountability Conditions include a requirement to provide quarterly progress reports on IMTP Actions for 2022/23 to Trust Board and Welsh Government IQPD monitoring meetings. To this end, IMTP Quarterly Actions Progress Monitoring templates have been prepared for cancer, blood, support services and Trust-wide programme IMTP actions in **Appendices B, C, D and E** respectively.

2.3 The purpose of this paper is for Trust Board to approve the proposed ways in which the conditions will be fulfilled in Appendix A and to review the progress updates provided by service leads against their specific IMTP actions for Q1 and Q2 in Appendices B to E.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

4.1 The Trust Board is asked to NOTE the paper which sets out the progress made in delivering the requirements set out in the Accountability Conditions and the IMTP 2022 – 2025.

Integrated Medium Term Plan 2022 – 2025 Accountability Conditions Letter Monitoring Document

Accountability Conditions (Judith Paget Letter dated 22/07/22)	Quarterly Actions Progress to comply with IMTP Accountability Conditions			
	Q1	Q2	Q3	Q4
General comment from Approval Letter: Expect the Board to scrutinise the plan and that progress is monitored effectively over the forthcoming year, in particular against the Ministerial Priorities set out in the NHS Planning Framework, the Minister's delivery measures and the specific accountability conditions for Velindre NHS Trust	Quarterly monitoring reports via QSP Committee and Trust Board Reports and cover papers to ensure there is explicit clarity on progress against: - Ministerial Priorities - Ministers Delivery Measures - Specific Accountability Conditions	Quarterly monitoring reports via QSP Committee and Trust Board Revised Performance Management framework to track expected outputs and benefits of the IMTP		
General comment from Approval Letter: Where necessary, any risks or challenges that need to be further addressed will need to be discussed and agreed at your Board and communicated to Welsh Government via the routine governance arrangements (e.g., IQPD meetings or quarterly reporting against your IMTP). Where this necessitates any	Routine/regular reporting against IMTP delivery Chair of QSP Committee and Trust Board Chair focused on IMTP delivery. Risks and issues registers routinely discussed and minuted	Regular discussion at IQPD meetings on any emerging risks/issues that are material to delivery of the IMTP Routine/regular reporting against IMTP delivery		

material changes to your IMTP in year will require you to advise me of these changes through an Accountable Officer letter.	– which will be appropriately recorded in the minute. Strategic organisational risks identified/discussed via the Trust Board Assurance Framework at Strategic Planning Committee and Trust Board	Strategic organisational risks identified/discussed via the Trust Board Assurance Framework at Strategic Planning Committee and Trust Board Revised Performance Management framework to track expected outputs and benefits of the IMTP		
General requirement – 'five ways of working and sustainable development It is essential that your organisation continues to build on the progress made to utilise the five ways of working, sustainable development principles, to deliver your integrated plan. The organisation should ensure its well-being objectives are consistent with and continue to be supported by its planning arrangements.	The Well-being of Future Generations Act and 'Five Ways' are the 'golden threads' that run through the Trust's approach. Complete strategic refresh achieved and approved by Trust Board includes: Trust 10 year strategy 'Destination 2032' framed upon the WBFGA. Also includes new	Major service developments and infrastructure planned against the WBFGA and 5 ways of working. Significant examples e.g. Design of new Velindre Cancer Centre (electric hospital; enhanced bio-diversity) achieved through long-term; partnership working. Hefyd community benefits programme e.g. social prescribing		

	sustainability, digital, people and estates strategy	through partnership with Ray of Light; develop local arts strategy; local engagement of school children with tee pee etc Outline business case for refurbishment of Welsh Blood Service Llantrisant – built upon partnership; decarbonisation benefits. Research programme with local universities (PhDs; MSc) generating new evidence on sustainability in infrastructure/design; PROMs/PREMs; social value/prescribing etc		
General requirement – IMTP The IMTP must be published on public facing Trust website.	This action is included in the SOP for the Planning Team.	IMTP updated on website 22nd September		

General requirement – Quarterly progress report on IMTP Action plans to IQPD There should be reporting against the key milestones associated with that quarter, any slippage against the plan, next milestones and the mitigation of any new/emerging risks.	Process in place to provide quarterly updates to EMB and Trust Board which will include escalation of any emerging risks etc.	IMTP 2022/25 Quarterly Progress reports submitted to Welsh Government as part of the Integrated Quality Performance Delivery (IQPD) meetings Chaired by Nick Wood.	Upcoming IQPD meetings with Welsh Govt: • IQPD 4th October – Q1 progress plus early feedback on Q2	IQPD 7th December (TBC) – Q2 and Q3 progress reports
General requirement – Quarterly Minimum Data Set (MDS) refresh The MDS must be refreshed on a quarterly basis.	Dataset refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies	Dataset refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies	Dataset refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies	Dataset refreshed quarterly with narrative provided to SLT on any significant changes, discrepancies
Cancer Care Services				
a) Demonstrate how key attributes of the quality statement for cancer are being taken forward	D&C modelling undertaken for SACT and treatment planning taskforce established with Improvement plans developed for SACT and RT Constant review of quality of services (quality, safety, experience	Modelling complete SACT/RT initiatives commenced Audit of clinical Harm review SOP in place Contingency plan for Linac upgrade to be developed New linac procured and installation works commenced	RT back in balance Contingency plan in place to support Linac upgrade SACT back in balance	SACT position sustained & to be reflected in IMTP 2023-2026

b) Demonstrate how access to cancer treatment is contributing to achievement of the suspected cancer waiting time target for the region.	QA20 HB monthly ops meetings in place to monitor pathway issues and opportunities for improvement	Group established with CVUHB/CTMUHB to look at lung patient pathway in line with 62-day target. Terms of Ref agreed. Audit undertaken New linac procured and installation works commenced	Continue improvement actions review of lung pathway. Review referral pathway into VCC process to minimise delays for first appointment.	Implement improvements for Q3 review.
c) Demonstrate what mental health support is being provided to patients.	Psychology, Counselling and Supportive Care services already in existence. Health Needs Assessments undertaken. Services include programmes of care for self-management eg fatigue etc. Referral pathways and SOP's in place for referral to specialist services. Range of services to support children including visits to VCC to see treatment areas, bereavement support in conjunction with City Hospice and a range	Ongoing As Q1	Ongoing As Q1	Ongoing As Q1 & to be reflected in IMTP 2023-2026

	of books developed by VCC.			
Workforce				
a) Demonstrate workforce intelligence that has identified key workforce risks and workforce planning that includes actions to address these key risks.	Triangulation of workforce and finance risks approach Workforce risk review on risk register and Trust Assurance Framework risks.	Key workforce risks and issues identified and discussed. Programme of work underway including workforce shape/supply; retention/recruitment Development of OD change programme Building Our Future Together to support workforce well-being and change		
New Velindre Cancer Centre				
a) Demonstrate effective management oversight of the development and transition to the new Velindre Cancer Centre (nVCC), Radiotherapy Satellite Centre (RSC) and Integrated Radiotherapy Solution (IRS).	IRS procurement finalised and transition to implementation began. Transition programme and commenced Transforming Cancer Services Programme Board in place	**IRS** IRS business case awaiting Ministerial approval IRS monthly transition programme board in place **RSC** RSC business case awaiting Ministerial approval	IRS contract signed with successful provider finalised. Links provided to construction teams for nVCC and RSC to begin planning for phase 2 and 3 of IRS implementation. WG approval scheduled for IRS and RSC	Key deliverables and work streams of phase 1 IRS implementation in progress. Maintain links to programme leads of nVCC and RSC. Transforming Cancer Services Programme Board in place

	Transforming Cancer Services Sub-Committee in pace Monthly meetings with WG Health Strategy Board Quarterly reporting to the SE Wales Cancer Collaborative Leadership Group	Links with programme leads for nVCC and RSC. **nVCC** nVCC successful bidder identified – financial close target March 2023 Transforming Cancer Services Programme Board in place Transforming Cancer Services Sub-Committee in pace Monthly meetings with WG Health Strategy Board Quarterly reporting to the SE Wales Cancer Collaborative Leadership Group	Transforming Cancer Services Programme Board in place Transforming Cancer Services Sub-Committee in pace Monthly meetings with WG Health Strategy Board Quarterly reporting to the SE Wales Cancer Collaborative Leadership Group	Transforming Cancer Services Sub-Committee in pace Monthly meetings with WG Health Strategy Board Quarterly reporting to the SE Wales Cancer Collaborative Leadership Group

	Commissioning				
a)	Demonstrate leadership in the further development of the networked clinical model, including the Nuffield recommendations	Continuing to support/service the Cancer Collaborative Leadership Group (CCLG) Good progress made regionally on implementing the Nuffield Trust recommendations;- **Acute oncology** service: phase 1 being delivered. LHBs/Velindre recruitment of posts **V@UHW Research Hub**: initial infrastructure in place and research strategy approved **V@UHW unscheduled care:** pathways revised and various actions taken to enhance quality of delivery **V@outreach**: Operational plans in place to return services across LHBs post covid	Acute oncology service: phase 1 being delivered: launch of cancer of unknown primary (CUP) service and outreach oncology model **V@UHW Research Hub**: tender out to identify partner to develop investment strategy and identify research partners **V@outreach**: Re-scoping of requirements for outreach with CTM /Aneurin Bevan to align strategic cancer developments	CCLG: proposal developed for pilot of whole system approach across 3 tumor sites. On CCLG agenda Nov 2022 meeting	

b) Secure agreement to the new commissioning model for radiotherapy with partner organisations	Complete LHBs approved IRS and RSC business cases			
Finance				
a) Demonstrate action is being taken to mitigate exceptional costs throughout the year.	Finance reports to QSP and Trust Board Trust represented on Energy Price Risk Management Group led by NWSSP	Finance reports to QSP and Trust Board Trust represented on Energy Price Risk Management Group led by NWSSP		
b) Demonstrate action is being taken to mitigate COVID costs throughout the year as the pandemic response continues	Finance reports to QSP and Trust Board Regular divisional finance performance reviews to monitor and manage Covid costs.	Finance reports to QSP and Trust Board Reduction of £0.112m in forecast Covid costs reported in M5		
c) Risks to delivery of saving plan delivery must be reduced to increase confidence in the plan - to be monitored by FDU on a quarterly basis.	Finance reports to QSP and Trust Board Monthly reporting and meetings with FDU in place to review financial position and savings plan.	Finance reports to QSP and Trust Board Monthly reporting and meetings with FDU in place to review financial position and savings plan.		
d) Ensure clear agreements are in place with commissioners to support delivery of COVID recovery and required activity.	LTAs issued to LHBs Monthly meetings in place for Collective Commissioning Group to monitor financial performance of LTAs	LTAs signed by VUNHST and LHBs Monthly meetings in place for Collective Commissioning Group to monitor financial performance of LTAs		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**						
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
Strategic Priority 1: Access to equitable and consistent care, no matter where; To meet increasing demand	**1.** SACT Capacity Plan	Maintain high level of chair utilisation at VCC to support capacity growth. (see 2023/24)	Implement programme to attract and retain SACT trained staff, and increase nurse led 'protocol' clinics to shift to a greater nurse led are model for SACT	New nursing staff in post and trained	Commence booking service review.	Task and finish group established with work plan for short term options. Impact assessments undertaken and weekly tracking of data undertaken. Capacity review of bookings team complete, nursing team underway and review of pharmacy services to commence in September. Discussions ongoing with regard to where injectable treatments are best placed to be undertaken with a view to releasing SACT capacity.	Additional clinics commenced on 6th August and planned to mid October 2022. Plan under development to increase capacity within Macmillan Unit at PCH. Recruitment campaign has been successful. Discussions ongoing with Executive Director of Nursing and Chief Operating Officer regarding workforce plan.	
		Finalise interim facility plan at Neville Hall Hospital.	Work with ABUHB to identify appropriate	Review workforce requirements to support interim service	implement plan to support interim NHH model	Initial accommodation challenges at NHH resulted in a re-focus to expand capacity at PCH. NHH are continuing to explore options which VCC will	Data modelling of geographical flows underway to determine level of demand.	

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			accommodation	model across PCH and NHH		need to consider as fit for purpose. Expansion to either/both is subject to staffing capacity modelling and resourcing.		
		Commence contract with third party provider to deliver SACT chair capacity while Neville Hall is progressing	Implement staffing review agreed actions.	Develop business case for SACT Consultant Nurse/ Pharmacist.		Substantial readiness work undertaken throughout Q1. However, RCC went into liquidation June and therefore objective has to be withdrawn.		

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		Commence the SACT Improvement / Transformation programme to develop a robust service which is 'fit for the future' to include review staffing model and assess workforce options.	Review of booking clerk capacity to be undertaken	Review of nursing capacity to be undertaken review of pharmacy capacity to be undertaken	Review pharmacy capacity to be completed	Task and finish group established with workplan for short term options. Impact assessments undertaken and weekly tracking of data undertaken. Capacity review of bookings team complete, nursing team underway and review of pharmacy services to commence in September. Discussions ongoing with regard to where injectable treatments are best placed to be undertaken with a view to releasing SACT capacity.	Performance relative to key performance indicators improving during quarter 2. SACT task and finish group continue to meet, nurse modelling completed, pharmacy review commenced. Additional clinics commenced on 6th August and planned to mid October 2022. Plan under development to increase capacity within Macmillan Unit at PCH.	
	2. Radiation Services Capacity Plan	Maximise Rutherford contract – revised service	MRI refurbishment in radiology	Streamline plan complexity for certain		RCC has gone into liquidation therefore this option is withdrawn Discussions are currently underway with the new		

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
				palliative scenarios.		private provider around contrating options for RCC.		
		Begin project to increase Linac capacity to 80 hours (73 currently)	Implement 80 hours Linac capacity	Finalise proposals for capacity increase to 80 hours	Implement 80 hours Linac capacity	Capacity Planning meeting in place with RT treatment team – dependencies linked to recruitment start dates quarter 4	Linac capacity increased to 75 hours from July. Further expansion to 76 hours planned to take place at beginning of October. Capacity Planning meeting in place with RT treatment team – dependencies linked to recruitment start dates quarter 4.	

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		Complete Brachytherapy Peer Review and submit Business Case for additional planned capacity to meet demand.	Brachytherapy action plan delivery business case potentially here as will need to follow the action plan from the peer review and workforce review			Peer Review complete and action plan in development.	Engagement with WHSSC undertaken. Commitment secured to fund expansion of prostate service to a maximum of 78 patients per year. Following benchmarking exercise undertaken with the Clatterbridge Cancer Centre a capacity and workforce review and gap analysis of gynae service ahead of the development of a service development business case for submission to WHSSC in late 2022/23.	
		Review demand and capacity for clinical trials	Explore dose and fractionation schedules and alternative			Medical decision required on alternative treatment options trial capacity specifically		

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
			treatment approaches			detailed in service capacity plan		
		Review the Linac transition capacity for IRS implementation.	Agree the position on temporary/mobile/ fully commissioned leased bunkers while IRS process takes down fleet.				IRS updated paper approved by to Executive Management Board September with plan for first linac replacement. Radiotherapy recruitment complete, medical physics underway	
	3. Radiotherapy Pathway/COSC target achievement and radiotherapy clinical	Programme to review efficiency of existing pathways continues including	Develop standard operating procedures for pathway management, building on	Evaluate roles for advanced practice particularly Non-Medical Outliners in optimal	Implement agreed pathway and workforce models developed to meet COSC	Requires VCC wide response linked to demand profile and pathway development. Requires medical leadership and decision making to implement improved ways	Pathway and practice review on a site by site basis progressed (led by Dr Tom Rackley). Process intended to identified and scale good practice/learning, to	

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
	treatment developments	reduction in variation in ways of working /action plan developed.	those developed in Lung Pathways and emerging themes/challenges with SST leads.	pathways with SST leads.	target requirements.	of working identified from initial pathway work. This manual data capture to deliver gap analysis. Support commissioned through Improvement Cymru for pathway development/review. VCC actively involved in the Wales Cancer Network Lung cancer pathway review. All Site Specialist Teams (SST's) have now undertaken one deep dive session.	identify and address systemic issues via the Radiotherapy Management Group and other groups. Data analysis undertaken to identify trends in breaches, missed appointments and cancellations to determine areas for improvement. Further support commissioned through Improvement Cymru for pathway development/review. VCC actively involved in the Wales Cancer Network Lung cancer pathway review.	

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
							All Site Specialist Teams (SST's) have now undertaken one deep dive session.	
		Engage with WHSSC on PRRT service to deliver patient benefit (awaiting WHSSC decision)	Engage with WHSSC on PRRT service to deliver patient benefit	PRRT business case if able to progress	Finalise business case and Delivery of PRRT plan	Service specification required from WHSSC. Initial WHSSC response to open service Q1 2023.	WHSSC have established a national MRT programme board with Velindre input. Programme board will lead on the development of a service specification, in conjunction with clinical stakeholders. Work scheduled to begin in autumn 2022.	

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		Review proposed RT treatment developments including IMRT to establish capacity and commissioning approach	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners remains in place. Specific business cases to be provided to Commissioners, with a focus on the highest priority developments, inclusive of clinical benefits to patients and service benefits in terms of productivity. Radiotherapy developments prioritisation completed a number of years ago so needs to be reviewed radiotherapy	New quarterly meeting instituted between VCC and WHSSC to review specialist services and inform planning and development work. ToRs of VCC Collective Commissioning Group reviewed and governance and reporting links strengthened. Specific business cases to be provided to Commissioners, with a focus on the highest priority developments, inclusive of clinical benefits to patients and service benefits in terms of productivity. Radiotherapy	

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							developments prioritisation completed a number of years ago so needs to be reviewed.	
	4. Outpatient Services/Medical Directorate	SST and Outpatient Transformation programmes to commence building on pre-pandemic work. (interdependent with	The transformation objectives for the SSTs and Outpatient workforce will continue as previously	Deliver transformation programmes- estate, pathways and workforce	Deliver transformation programmes- estate, pathways and workforce	Transformation programme structure in place with reporting into Velindre Futures. A draft high level outpatient work programme has been developed has been discussed with further work progressing on providing more details	SST reviews commenced July and continuing into August 2022. Draft Outpatient Work Programme developed in collaboration with the Medical Directorate. This has been reviewed, feedback provided, plan	

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		radiotherapy projects)	described in quarter 1.			plans. The transformation programme is built upon the National aims and objectives. The programme is interdependent upon all other services.	to be adjusted and submitted for final approval. Performance Management Framework will include National tagrets regarding outpatient services.	
		Rolling programme of SST 'supportive reviews' to commence to work to ensure that pathways are effective, efficient and smooth, and to inform modernisation of the multidisciplinar						

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		y workforce model.						
		Commence workforce modelling and planning within the SSTs and Outpatient teams (and link to radiotherapy); maximising opportunities for enhancing skill mix and embracing more efficient				**OPD** capacity and demand plan under development. Nursing establishment review completed leading to a review of skill mix leading to advertisement of band 4 apprenticeship nursing roles which is the first of its type at VCC.	**RACH I THINK THIS IS AMBER/RED AS HAVENT SEEN MUCH EVIDENCE OF A ROBUST PLAN ACROSS THE SERVICE**	
						· Upskilling of HCSW's		
						· All trained nurses to complete SACT passport to support the demand for injectables		

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		ways of working						
		Maximise use of virtual consultations and embed into 'business as usual'. (50% at present).				Utilisation of virtual consultations has continued and is firmly embedded in to service, via telephone and video conferencing technology. Virtual group sessions have also been introduced and further extended within the Therapies service. Positive feedback received from Welsh Government on use of virtual technology. Usage data is monitored by the Outpatient Management Group.	Utilisation of virtual consultations has continued and is firmly embedded in to service. Welsh Government refers to Velindre Cancer Centre as an 'exemplar' due the rapid transformation and modernisation of outpatient appointments and group sessions.	

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						Phlebotomy services continues function at an activity rate of an average of 100 patients per day with activity aligned to an increase in SACT. Electronic test requests are completed and issued to patients (excluding patients under Cardiff and Vale University Health Board as Velindre Cancer Centre is contracted to undertake this service) to attend their local primary or secondary care service for pre clinic bloods, however, it is noted that a number of GP practices have refused to complete 'hospital bloods'. The scale of this is under review.	The ratio of face to face/virtual consultations is continually monitored by the Outpatient Management Group.	

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		Establish optimum levels of Phlebotomy provision and notify HBs of changes in access.				Outpatient Nursing Team and Reception Staff have implemented extended working hours from 08:00 to 18:00 hours to provide support to meet increased demand. Feedback from the SST deep dives and discussions with the Medical Directorate Manager are underway in respect of demand/request for evening/weekend working without the outpatient department. Weekend working is in place and fully established for phlebotomy during bank holidays. Opportunities to increase activity within the Outpatient Treatment Room are under discussion.	Opportunities to increase activity have been explored with further SACT injectable treatment delivered within the Department (within the Outpatient Treatment Room). Discussions remain on-going in relation to further opportunities.	
		Provide increased capacity incl. at evenings/week ends to meet demand initially while the more fundamental pathway changes and						

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		ways of working are introduced pending service improvement efficiency delivery.						
		Work to reduce demand within the Outpatient setting, including: review and streamlining of patient pathways and the implementation of the 'supported self-				Patient pathways under review by each SST and explored during deep dive sessions. The Cancer Centre has commenced a PSA self-management project with the view to extending self-management models across other sites.		

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		management' model						
		Re-commence the pre Covid Outreach Clinics	outreach project group to be reestablished outreach project manager to be appointed	review of data assumptions and workforce requirements to support outreach clinics identification of gaps to support service delivery		Most outreach clinics have been repatriated. The remaining clinics are mainly within Aneurin Bevan University Health Board and have been escalated for resolution.	Engagement with Aneurin Bevan UHB undertaken to address key challenges currently being worked through to progress the return the remaining oncology clinics to Neville Hall and Royal Gwent Hospitals.	

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Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments	5. Digital Health Care Record (CANISC Replacement)	Finalise development	Testing and training	Commence Go Live Phases– dry run	Review impact of implementation on operational delivery	DHCW have delivered much of the software as outlined in the re-profiled plan. There are elements of the individual developments that require further work. VCC along with colleagues from across the wider NHS Wales Oncology service are continuing to work closely with DHCW to resolve these issues and find a solution that aligned with both national and local requirements.		
		Functional testing	Operational Go Live planning	Dry run weekend planned Complete Go Live	Plan phase 2	All required functional testing has been completed and the data migration plan is on schedule to compete the final sign off in Q3. The		

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		User Acceptance Testing	Go Live readiness assessment	review impact on service delivery and lessons learned		training plan was completed in readiness for the operational review. Implementation and operational readiness planning commenced as planned, these will be refined as the organisation moves toward the go-live scheduled for November 2022.		
			Go Live run through					
		Data Migration	SOP development					
		Operational service change planning						
		Training sign off						
	6. Integrated Radiotherapy Solution	Complete Tender Evaluation and Identify Winning Bidder, issue standstill letter.	Complete hybrid OBC/FBC and submit to WG and await approval.	LA6 Bunker Decommissioning commences	LA6 Bunker Refurb complete.	Project team evaluations concluded in April 2022.	Engagement with Varian continued. Negotiation with Elekta to ensure ongoing maintainance of machines undertaken and commitment of expenditure papers developed for	
						Minimum Threshold Scored Questions (MTSQ) and Pricing clarifications		

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						developed by the team, were issued and responses received from bidders were subsequently reviews for final evaluation	consideration by the Trust Board.	
			Award IRS contract once approval of capital and revenue funding.		Service plans for second machine replacement confirmed.	Draft Procurement outcome report was developed for mid-April with a Legal review scheduled.		
			Receive vendors detailed implementation plans			Work was ongoing with the team for drafting approvals and to finalise OBC/FBC including agreement of resource for implementation, risk and benefit owners to ensure alignment and a smooth transition from procurement to implementation transition		

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					Initial scoping works on TPS/OIS replacement and Phase 1 additional functionality.	Multiple legal reviews for finalisation of the IRS Procurement Outcome Evaluation Report were scheduled and attended by the team. Development of Alcatel report with the legal team for issue to bidders on procurement award outcome was developed for Board approval		
						Issued to bidders following SRO approval in early June		
					Plans for Satellite and nVCC confirmed			
						June		
						IRS Contract development was ongoing with the support of Legal for finalisation of the contract. Meetings were scheduled throughout July & August		

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						to finalise the IRS contract with Varian		
		Appoint Radiation Services Programme Manager to lead implementation and commence design of 1st bunker.	Prepare recruitment of IRS implementation posts.	Recruit to IRS implementation posts		Actions on track managed through IRS Implementation programme Board	Actions on track managed through IRS implementation programme board.	
		Establish		Commence			The shadow IRS	

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		Shadow Implementation Board		formal IRS implementation – shadow implementation board stands up as a formal board.			implementation board continues to meet with good engagement between the procurement team and the implementation team.	
	7. Acute Oncology Service- local delivery	Recruit ANPs and other staff	Pathway design with region	Pathway implementation	Pathway implementation	ANP Lead Nurse has recently completed an Establishment Review of the ANP workforce to ensure appropriate staffing levels and skill mix for the AOS service going forward.	Ongoing recruitment within the ANP team to ensure appropriate staffing levels and skill mix. Dedicated ANP to provide outreach clinical support for teams.	
	8. Integrated care	Scope bed plans/model for assessment unit aligned to the VCC element of AOS.	Continue to review the unscheduled care patient pathway aligned to the VCC element of AOS.			Work continues with regional AOS teams to develop robust AOS model. Ongoing work to improve lunchtime AOS meetings with Health Boards. Work also ongoing with service leads to discuss the model for Unscheduled care and a	Work being progressed via the Clinical Model Review Group led by Annie Evans. Presentation to the Integrated Care Operational Group by Annie Evans to define next steps.	

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						VCC Clinical Model Review Group established and action plan developed.		
		Develop plans for delivering national projects e.g. Immuno Oncology (SDEC) Immunohematology Service – Recruit staff	Immunohematology Service Increase capacity	Immunohematology Service- further pathway work with HBs	Immunohematology Service- grow service delivery	Nursing team and administrator is in post (in line with funding), the 0.2 BI post remains outstanding and has been escalated to Cath O'Brien/Rachel Hennessy for decision.	Immunotherapy Toxicity Service launched early September. Draft SLA has been formulated for specialist endocrine sessions - awaiting instruction on signoff steps from VCC governance;	
						Modelling of the new service, Standard Operating Procedures, clinical guidelines and the patient IO pathway is under review;	An IO data application (with associated DPIA) has been developed by BI, this has been tested throughout September before handed to Digital;	

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						Draft SLA has been formulated for specialist endocrine sessions - awaiting instruction on signoff steps from VCC governance;	IO Intranet and Internet page have been set up and are in process of being populated in line with service developments/guidance document sign off;	
						An IO data application (with associated DPIA) has been developed by the Business Intelligence Team. This will be user acceptance tested via the pilot stage – awaiting confirmation that digital will support this App;	A suite of clinical guidelines/pathways has been issued to interested parties for feedback.	
						Scrutiny agreed in July to advertise 3 of the 7 funded Consultants sessions externally:		
						A pilot of the IO service will commence 16th August 2022 to test virtual		

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						scenarios in readiness for proposed launch of service early September 2022.		
		(SDEC) Ambulatory Care – finalise staff recruitment	Ambulatory Care- increase weekday opening	Ambulatory Care- weekend opening		Recruitment of nursing and therapies staff (bid funded) is complete. The Ambulatory Care Operational Policy and the Weekend Working Standard Operating Procedure have been finalised and proceeding through approval process. Patient Experiences (PREMS) and Patient Outcomes (PROMS) continue to be captured via the CIVICA Patient Experience system, following rollout of handheld devices and the App.	Excellent progress made as defined in quarter 1. All staff now in place and extended days implemented. Sunday opening commenced in July and is working well.	

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						An end-to-end process review of data capture within Integrated care is ongoing with service leads and service improvement to allow for more accurate, consistent and sustainable data capture. RD&I preparing to expedite a Head and Neck Patient Support Unit peer review; Sunday extended hours have commenced. Lessons learnt are being captured as a 'plan, do, study, act cycle in readiness for extension of Saturday hours from August 2022.		
			Deliver requirements of national projects e.g.			As above		

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			Immuno Oncology					
	9. Palliative Care	Review Cancer Associated Thrombosis clinic service: establish working SLA with Oncology	Undertake Peer Review as planned	Review of Chronic pain service.	Preparing the move from CANISC (No solution yet identified)	Review of Chronic pain service. Preparing the move from CANISC (no solution yet identified).	Initial meeting to re-establish Cancer and Hospital Acquired Thrombosis Group held. Draft terms of reference developed to progress the finding of the April 2022 All Wales HAT audit.. This will include review of the CAT clinic.	
	10. Key Treatment Development– IMN SABR Lutetium PSMA HDR Brachytherapy	Finalise the priority of implementation of key treatments where external funding is required and agree timescales.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Capacity paper to Executive Management Board in December 2021 confirmed no additional capacity available, and loss of capacity will occur during essential major change programme delivery - DHCR / IRS implementation / RSC / nVCC.	WHSSC have established a national MRT programme board with Velindre input. Programme board will lead on the development of a service specification, in conjunction with clinical stakeholders. Work scheduled to begin in autumn 2022.	

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						Risk and Harm impact assessments will be required when extra capacity above core commissioned activity is required to implement to change / amend pathways for new service provision.	Engagement with WHSSC undertaken. Commitment secured to fund expansion of prostate service to a putative maximum of 78 patients per year.	
	Clinical team priorities – gaps in servie therapies access to trials research MDT attendance/cover arrangements							
		Commence	Apply 'Just do	Apply 'Just do		Not applicable no		

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		business case developments for agreed treatments in phased approach according to priority and timetable agreed.	it' criteria where appropriate for clinical team	it' criteria where appropriate		extension / service changes yet agreed through triumvirate risk assessment		
		Finalise the priority of clinical team priorities.	Begin development of implementation plans for clinical team priorities requiring support/wider discussions.	Continue the development of implementation plans for clinical team priorities requiring support/wider discussions.		No response provided		

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	11. Radiotherapy Satellite Centre	Support Strategic case development and review of FBC.	FBC approval- WG implement Arts strategy for RSC operational model development aligned to IRS	Ongoing liaison with ABUHB regarding build, IRS alignment project board, project team meetings	operaitonal model delivery plan preparation	Managed through IRS Implementation Board	Managed through IRS Implementation Board	
		Workforce Plan.						
		Finance case.						
		IRS alignment and FBC.						
		FBC scrutiny and approval by service lead and through Boards						

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	12. Radiology	Commission reconditioned MRI scanner. Phase 1 capacity delivery	Review Radiology demand and align to capacity plan		Full additional capacity plan is delivered	Not started – interdependency required for radiology demand for pathway changes Treatment pathways requires completion and sign off to assess demand requirement	Commissioning of refurbished MR scanner completed. Fully operational.	

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	13. Patient treatment helpline	Implement new handover arrangement into SACT service.	Develop action plan to address issues identified and changes required.	Implement actions identified.	Implement associated workforce or training plans	No response provided	SACT Treatment Helpline handed over to SACT and MM Directorate. Review of why the helpline is currently being accessed towards near end of completion with view of Options appraisal being presented Autumn 2022. Initial work to stabilise the platform for recording calls completed. Further work to be considered in conjuntion with digital teams, including functionality of the telephony system	

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		Commence review of service functionality and fitness for purpose. Engage with digital team to explore system capability and options for future.	Engage with stakeholders at VCC and externally in developing plans to ensure all calls are appropriately directed from 1st contact.,	Implement any identified telephony systems to allow signposting to all areas.	Roll out new system and ways of working			
	14. Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners	Commence Patient panel	Commence establishment of Patient Engagement Hub and Patient Leadership Group	Patient Leadership Group recruitment and training	Continue to develop Group, staff team and patient engagement delivery. Includes underpinning nVCC.	New strategy approved Trust Board in May 2022. Final documentation and infographic have been finalised. Funding has been agreed for Patient Engagement Manager which is due to be advertised in late July 2022.	Pilot of new CIVICA engage platform to enable establishment of patient panel to commence autumn 2022.	

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		Implement patient panel management software programme	Establish initial Patient Engagement activity for Velindre Futures projects				Launch and recruitment plan also for early autumn 2022.	
	15. Establish Primary Care project under Velindre Futures					Task and finish group to be established to scope of project and associated actions. The original IMTP did not include any objectives so will be added retrospectively.		

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Strategic Priority 4: To be an international leader in research, development, innovation and education	16. R & D Hub (Development at UHW)	Progress the clinical scientist and clinical academic business cases.	Progress the clinical scientist and clinical academic business cases.	Business case and costs	Establish Governance Arrangements for the Hub.	**<u>Progress the clinical scientist and clinical academic business cases.</u>**	New south-east Wales Prehab2Rehab collaborative group formed. Inugral meeting of group, chaired by Suzanne Rankin (CEO C&VUHB) on behalf of the Cancer Collaborative Leadership Group (CCLG), held.	
						· Funding for 0.5FTE Clinical Academic post (an Early Phase Trialist) was recently approved at the Velindre Charitable Funds committee and the plan will be to secure match funding by Cardiff University. The business case is currently going through Cardiff University processes.		

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						· A number of posts are going through recruitment and selection; these include a Band 8a Senior Nurse (12 months secondment), a Band 6 nurse and a Clinical Research Fellow.	-	
						Business case costing and funding agreements in place.		
						· ECMC, Cardiff's 5year renewal bid to CRUK (2023-2028) was submitted on the 30th June. If successful, the ECMC bid includes some research nurse capacity that will support the research delivery within the Hub.		

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						· WCRC's bid was submitted to HCRW for the next 2 years (2023-2025). Included in the bid were Clinical Research Fellows that would support the Hub as well as undertake postgraduate training. Also included were other opportunities to build further collaboration with Cardiff University and VUNHST. WCRC is awaiting initial feedback from HCRW.	-	
						· An approach has been made to HCRW regarding the additional 3.6 WTE posts. Both VUNHST and CVUHB are supplying further information with regard to this request.		

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						Establish Governance Arrangements for the Hub.		

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						The Head of R&D and her team continue to work closely with the Joint Research Office (JRO) to ensure process is in place to efficiently and effectively deliver collaborative research studies that will be delivered through the Cardiff Cancer Research Hub. Areas of focus will be managing activity coming into the JRO that will be delivered through the hub. The Early project review process, which has been established to manage projects from CU and CV UHB, to undertake an early assessment of their projects by the JRO team to iron out any potential issues in setting up projects continues with		

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						VUNHST now contributing to the process development to ensure alignment. The intention is to ensure synergy in a streamlined process to speed up the setup process and expand capacity to deliver contracts more quickly. The Research Governance Groups will move to a joint Research Governance Group within the JRO with Velindre included as required, bringing organisational governance together. This work also includes the development and execution of a Heads of Terms agreement which will be at a high level as well as the inclusion of Velindre in a Memorandum of		

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						Understanding (MOU) between the three organisations. The JRO memorandum of understanding is currently still in draft and between C&VUHB and CU only. Work on this agreement has been on hold pending the appointment of the JRO's new Partnership and Business Development Manager who is expected to join the JRO soon. The Head of R&D and the Senior Research Contracts manager will work with the JRO to ensure that the further development of the MoU will include the Trust's requirements. Work on the Heads of Terms agreement has commenced and it was		

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						requested by the Cardiff Cancer Research Hub Project Board at their meeting of 6 July 2022 that this document should be finalised for their next meeting in October 2022.		

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						Project Board established to take place in September 2022. Awaiting further detail via the National TrAMS model to better inform potential impact on VCC.	-	
						VCC Therapies Team are working collaboratively with Health Board partners to progress prehabilitation programme. Participating in newly established South-East Wales Prehab 2 Rehab Collaborative which aims to support a system wide transformation, initiated and delivered closer to the patient's home. Participation within the collaborative will help define the service delivery need for VCC in conjunction with the work		

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						happening in our partner organisations.		
	17. TrAMS	Establish VCC programme board and supporting sub groups: - clinical serices model - clinical trials via Trams - workforce and staff impact - finance incl private pt impact	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	A strategic workforce programme group has been established, and this group will work to provide strategic direction to the VCC Senior Leadership Team regarding the workforce modernisation. Much of the initial phase of this work will involve benchmarking with other UK and International Cancer Centres to identify best practice models and ways of working	Project Board established September 2022. national TRAMS Service Model awaited.	

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	18. Therapies incl. collaborative work across region	Participate in regional Prehabilitation programme and scope development plan.	Review funding streams and commissioning models to facilitate prehabilitation service development.	Continue participation in regional service	Bring forward proposals for therapies development	Workforce planning owned by service leads review with Health Education Improvement Wales on 'route 2' role extension training planned for September 2022.	New south-east Wales Prehab2Rehab collaborative group formed. Inugral meeting of group, chaired by Suzanne Rankin (CEO C&VUHB) on behalf of the Cancer Collaborative Leadership Group (CCLG), held.	
	19. Workforce Modernisation:	Establish a workforce modernisation programme – with a 2 phased approach - 'Stabilise and Modernise' Finalise proposals for revised clinical	Align workforce plans for regional developments e.g. AOS, RSC. Advanced practice plan the potential for 'pump priming' advanced practice roles	Implement Physicians Associate posts. Prepare plan for advanced practice and non-medical Consultant level roles.	Workforce modernisation programme continues	Network SCP Project Manager leading review of referral pathways with lung cancer National project used as a pilot site.	Value business case to support development of new non-medical outliner roles developed.	

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		leadership arrangements.	to 'kick start' the workforce Advanced Practice Radiographers and Therapeutic Radiographers					
	20. Single Cancer Pathway	Focus on front end of the pathway for all tumour sites:	Develop dashboards and pathway data to make all patients' pathway points visible.	Focus on whole Breast Pathway:	Commence Action plan implementation.	SCP Project Manager requested to review data and current process with regard to referral management. Work programme and project plan awaited.	Work initaited to focus on earlier part of VCC pathways (MDT management, referrals, initial outpatient appoinments, etc). Work designed to identify and address issues and to inform future work to standardise working practices.	
		Aims to				Joint improvement project		

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		Standardise patient referrals to VCC.		Mapping of Breast Pathway from patient referral to service to treatment commenced.		agreed with CTUHB regarding referral management.		
		Timely receipt of all diagnostic test results and treatment pre-requisites prior to MDT.		Identify touch points along pathway and potential bottlenecks		Pathway development required to manage implementation of COSC measures.		
		Improve patient outcomes by early genomic testing where indicated.		Measure how currently delivering against the National Optimal		No response received with regard to genomic project.		

Velindre Cancer Centre IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022								
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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Progress Rating Q2**
		Develop training plans		Pathways (NOP)				
Strategic Priority 5: To work in partnership with stakeholders to improve prevention and early detection of cancer	21. Engagement with HB's	Agree terms of reference and priorities for joint working with each HB.	Share patient pathway challenges in developing improvement plans.				Monthly meetings established with Cwm Taf Morgannwg, Aneurin Bevan and Cardiff UHBs. Standardised agendas and datasets agreed. Regular discussions around outreach facilities	
		Commence meetings to deliver on these priorities.	Agree outreach plans for outpatients and SACT with all HBs.					

KEY:

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YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Welsh Blood Service IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
SP1: Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality and modern	**1.** Develop and introduce Plasma For Fractionation - Medicine Service Model for Wales.	Scope service need. Project group established.	Business case to Welsh Governmen t.	Develop draft service model.	Service model approved.	**Q1** Waiting for Welsh Government to set up program for Plasma for Medicines/Fractionation which will direct the WBS plans for collection. **Q2** UK wide MOU agreed with Welsh Govt - not yet received by Department of Health	
	2. Develop and implement Donor Strategy.	Scope service need. Project structure established. Draft strategy produced.	Consultatio n on strategy.	Implementatio n plan developed.	Implementation of eDRM phase 1 to support delivery of implementation plan.	**Q1** Scoping best practice, developing evidence to support strategy. **Q2** Strategy continues to be under development.	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	3. Develop and implement WBMDR strategy.	Scope service need project structure established draft strategy produced.	Consultation on strategy.	Implementation plan developed.	Implementation commence.	**Q1** Workshop completed, formal strategy for service being progressed. **Q2** Strategy for sustained growth and retention of the stem cell donor panel is being progressed. Recovery Plan being developed to support increased bone marrow volunteer recruitment.	
	4. Review blood collection clinic model in light of COVID changes to ensure the service model moving forward remains fit for purpose.	Establish project structure review service models to meet need & undertake service/data review in light of COVID and proposed contract variation.	Undertake service/data review in light of COVID and proposed contract variation.	Complete OCP process in relation to service model.	Complete OCP process in relation to service model.	**Q1** Project structure, data review & OCP not yet completed work is ongoing. **Q2** OCP concluded and agreed with union partners – implementation being phased.	
SP2: Meet the patient demand for	**5.** Introduction of 'live connectivity' to allow 'real-time' information	Scope opportunities for digital	Establish technology solutions.	Identify resources to support	Implementation commence.	**Q1** Health Technology Wales report in support of proposal. Business case submitted to WG	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
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blood and blood products through faciltiating the most appropriate use across Health organisations	to be shared WBS, laboratories and health board transfusion/clinical teams.	technology to support sharing real time data and transfer of goods between WBS and customers.		implementation.		awaiting final agreement. Will introduce in alignment with LINC programme 2023 – 24. **Q2** Ongoing project in collaboration with Cardiff & Vale HB leading on application to Welsh Government for funding to support electronic blood management system.	
SP3: Provide safe, high quality and the most advanced manufacturing, distrbution and testing laboratory services	**6.** Assess and implement SaBTO (guidelines 2021 release date) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.	Confirm role of WBS with Welsh Government establish project structure.	Complete OCP process in relation to service mode.	Establish workforce model.	Implementation.	**Q1** Project and T&F groups established and working towards implementation on 30/05/2022. Hep B core testing implemented on 30/05/22. Project group meetings and stock swap out ongoing. **Q2** Stock swap out completed, all blood components in WBS and Health Boards now Hep B core negative. This element of the Hep B Core project is now completed.	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
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		Q1	**Q2**	**Q3**	**Q4**		
						Lookback pathway for patients has been drafted -yet to be agreed at All Wales level	
SP4: Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services	**7.** Deliver WLIMS modules for Blood Transfusion (BT)	Scope service specification.	Undertake procurement.	Undertake procurement.	Complete USR procurement.	**Q1** URS in progress. First draft of business case complete and circulated for comment. **Q2** WBS Local Deployment Board established. 9-month delay in design phase of Citadel system. This will have significant impact on the national deployment timelines. Discussions ongoing.	
	8. Implementation of Foetal DNA typing.	Engage with Antenatal Screening services to develop implementation plan.	Agree implementation plan.	Take forward implementation.	Take forward implementation.	**Q1** Initial Programme Board meeting held 06/06/22, internal project group being formed. **Q2** Project groups in progress.	
SP5: Provide, services that are environmentally	**9.** Establish a quality assurance modernisation programme to develop and	Project to be scoped. Project structure established.	Develop implementation plan.	Take forward implementation.		**Q1** No formal project scope and structure developed to date. **Q2**	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
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sustainable and benefit our local communities and Wales	implement strategy which support more efficient and effective management of regulatory compliance and maximising digital technology.	Phased work plan.				Tender being prepared for the renewal of the WBS Quality Management System. SMT paper being prepared for the utilising of electronic signatures been approved. Preparation activities including trialling different formats taking place. Presentation made to SMT with a positive feedback, individual departments now being engaged. Formal project plan to be initiated in Q3/Q4.	
	10. Develop an estate and supporting infrastructure service model which delivers improved energy efficiency and reduction of carbon emissions.	Submit OBC for Talbot Green infrastructure Project	Procure support to develop FBC.	Appoint Healthcare planner to develop FBC.	FBC submitted to Welsh Government.	**Q1** OBC in development not yet approved. **Q2** Work underway to understand phasing in light of Laboratory Modernisation Programme and Plasma for Medicines and the impacts on this programme.	
SP6: Be a great organisation with great people	**11.** Develop a sustainable workforce model for WBS which provides leadership,	Engagement with teams in relation to review of Clinical	Developme nt of service model paper to be developed	Development of service model paper to be	Implementation plan developed.	**Q1** Delivery plan yet to be developed. SMT training need before creating their workforce plan. Initial plans to meet to be	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
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dedicated to improving outcomes for patients and donors.	resilience and succession planning.	Services. Review of Facilities model. Review of BI.	for approval.	developed for approval.		shaped & involve key stakeholders. Plan also dependent on resolving SMT structure, which relies on interim staff being resolved. **Q2** Discussions on this to take place during SMT Away Day. By Q3 a proposed SMT structure following consultation to be in place. New workforce model anticipated to be ready Q1/2 2023.	
	12. Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS.	Scope programme of work. Establish project structure.	Develop implementation plan.	Business case submitted to WHSSC to support implementation of new standards and guidance in component development lab.	Funding secured.	**Q1** Project structure in development. **Q2** Work underway to understand alignment of this programme and Talbot Green Infrastructure Programme.	
	13. Lead the All Wales approach to implementation of Welsh Government	Secure funding review structure and develop	Clinical lead appointed. Implementa	Implementation of work plan.	Implementation of work plan.	**Q1** Programme funding has been secured from Welsh Government until March	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
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	Statement of Intent for Advanced Therapies.	work plan 2022/23.	tion of work plan.			2023. The Programme's structure was reviewed, updated and implemented by the Advanced Therapies Programme Board with the introduction of a more streamlined governance process and two new working groups. **Q2** Advertisement for Clinical Lead took place in August, but the role was not recruited into. Options are being considered. Implementation of the new workplan is currently underway after Programme Board agreement in Q1.	
	14. Support UK Infected Blood Inquiry and delivery of its Terms of Reference.	IBI continues	IBI continues	IBI continues	IBI continues	**Q1** Work ongoing. **Q2** IBI is continuing to hear evidence, which will continue until the end of the year WBS is preparing a final written statement in relation to recommendations and conclusions they would like the Chair of the IBI to consider	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
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						WBS is working with the other UK Blood Services in relation to the final written statement and recommendations.	

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Trust-wide Programmes IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022

Clinical Quality & Safety Health and Social Care IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
Strategic Priority 1: Meeting requirements of the Quality & Engagement Act (2020)	1. Finalise and Implement the Trusts Quality Framework	Finalise the Trust Quality Framework & Gain Board approval. Develop clear implementation plan.	Commence implementation of the framework		Formally review framework implementation	Quality & Safety Framework approved by Board in July 2022. Implementation commenced	
	2. Develop integrated Quality Hubs – Trust wide Hub and two divisional Hubs	Commence Hub development	Establish integrated Quality & Safety Hubs – Corporate/ VCC & WBS Establish Operational Quality	Hubs to be fully operationalised & all Hub members to receive required training	Review formally the functioning of the Hubs & reporting lines	Quality Hub development underway – Corporately, within WBS & VCC	
	3. Establish Core Trust wide Quality & Safety Team that is 'fit to deliver' new legislation	Complete OCP & appoint into posts	Ensure all QS Team members received training & competency assessments	Review Team in line with Duty Quality & Duty Candour statutory guidance requirements		Quality & Safety Team OCP completed and recruitment into posts has commenced	

Clinical Quality & Safety Health and Social Care IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	4. Fully implement Duty of Quality requirements	Review Draft Duty of Quality guidance – develop Gap analysis plan	Develop clear Trust wide, divisional & hosted organisation implementation plan	Agree and commence implementing revised Duty of Quality reporting	Implement Duty of Quality requirements in shadow form Ensure all Trust Incident, concerns policies are revised	Quality & Safety Team OCP completed and recruitment into posts has commenced	
	5. Fully implement Duty of Candour requirements	Review Draft Duty of Candour guidance – develop Gap analysis plan	Develop clear Trust wide, divisional & hosted organisation implementation plan	Agree and commence implementing revised Duty of Candour reporting	Implement Duty of Candour requirements in shadow form Ensure all Trust Incident, concerns policies are revised	Quality & Safety Team OCP completed and recruitment into posts has commenced	
	6. Plan for & implement the new Quality Standards (replacing H&CS)			Review the proposed new Quality Standards and undertake a relevance & impact assessment	Develop a Duty of Quality standards implementation plan and reporting mechanism	There are national delays in drafting revised quality standards – alignment to 6 domains of quality and high level mapping only to date – Trust cannot currently plan due to delay	**National delay**

Clinical Quality & Safety Health and Social Care IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	7. There are clear service delivery to Board Quality metrics	Clinical quality metrics for the VCC to be determined incl. data definitions and sources to be agreed	How services will assess 'what good looks like' to be determined and required metrics agreed	Commence service level to Board hierarchy quality outcome reporting	Commence implementation of the new Duty of Quality & Candour quality metrics – through robust integrated business systems	Quality metrics for VCC still under development. SST reviews done across VCC to define 'what good looks like'	
Strategic Priority 2: Placing Quality & Experience at the Centre of the organisation	8. Real time patient / donor feedback is captured at source and used in all areas of the Trust	CIVICA to be rolled out within WBS Formal review of VCC implementation to date to be undertaken	Infrastructure to be in place for CIVICA outputs to be reviewed at all level of the Trust and used as an improvement tool	You Said …. We did…. In respect of patient / donor feedback to be in place across all parts of Trust	CIVICA patient engagement system to be implemented	CIVICA implemented within both VCC & WBS – the volume of feedback needs to considerably increase within VCC	
	9. Develop & Implement Trust Quality Management system with integrated learning & improvement	Formal review of Trust improvement capability Undertake targeted work across Divisions regarding the implementation of the learning & action modules in Datix	Plan to be agreed & implemented to address any improvement capability gaps identified	Establish meaningful automated mechanisms for sharing improvements and learning Audit the use of learning & action modules in Datix	Collate and review outcomes of all quality improvement activities	Trust engaging with Improvement Cymru to explore the feasibility of implementing Quality as an organisational design	

Clinical Quality & Safety Health and Social Care IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	10. Trust has robust mechanisms in place for capturing patient & Donor outcomes across all services , ensuring learning and improvement mechanisms are in place & appropriately reporting	Review systems and mechanisms in place across all services to capture patient / donor outcomes to develop baseline position. Including how outcomes are recorded, reported and used to inform service developments / changes.		Undertake service benchmarking and national / best practice standards in respect of patient / donor outcome measures.	Formal review of Outcome metrics and reporting to be undertaken. Any gaps across services to be identified and reported to EMB	Infrastructure for PROMS being taken forward through the Trusts Values Based Health Care work – digital solution procured	
Strategic Priority 3: Trust is clinically & scientifically led organisation	11. Robust multi-professional clinical leadership across all areas of the organisation	Review current multi- professional clinical leadership infrastructure make recommendations for any enhancements		Review current clinical leadership development opportunities and develop a clinical leadership pathway		Work well underway	

Clinical Quality & Safety Health and Social Care IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	12. Establish a Clinical & Scientific Strategic Board to drive the organisation, lead on values based healthcare, the national clinical plan requirements and the development of the Trust Clinical & Scientific Strategy	Establish Clinical & Scientific Strategy Board with external 'critical friend' support	Agree Values based healthcare priorities and agree implementation plan Agree clinical priorities aligned with national clinical plan		Finalise and have approved the Trust Clinical & Scientific Strategy	Release of resources to facilitate the establishment of the CSSB are under discussion	

Clinical Quality & Safety Health and Social Care IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	13. Top of license working with appropriate support & admin infrastructure	Undertake a comprehensive clinical workforce review – expanding on opportunities for enhancing non-registered workforce, clinical apprentices and top of license working within a robust framework of clinical competencies. Embedding workforce resilience across all clinical workforce reviews.					
	14.Optimisation of multi-professional advanced practice	Agree, in line with national advance practice framework a Trust Multi Professional Advanced Practice framework aligned across patient / donor pathways			Develop a clear advanced practice workforce plan (aligned with clinical workforce plan)		

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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Strategic Priority 1: Creating Wider Value: our organisational approach	1. Ensure sustainability is embedded into our organisational conscience and decision-making	Sustainability strategy	Engagement events				
		Partnerships with Future Generations Office		Best practice shared via attendance at All Wales Environmental Management Meetings	Partnerships with industry leads to deliver seminars to staff		
	2. Improve life for people who lives in the communities we serve	Regional Arts Partnership Launched	Inaugural Regional Arts Collaboration Event				
Strategic Priority 2: Sustainable Care Models	3. Improve the environment sustainability of our care pathways			Pharmaceutical packaging return initiatives			

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	4. Maximise the use of technology and digital services to reduce the environmental impact of care	Digital Strategy Launched	Continued use of Attend Anywhere		Addressing Digital Exclusion through outreach	Q1/2 Update. Digital Strategy approved and Digital Programme being established for delivery. Attend Anywhere needs further adoption and team are following up with TEC Cymru to explore additional support that can be put in place. On track for Digital Inclusion work in Q4 (Post DH&CR) with support from Digital Communities Wales.	
	5.Collaborate with patients, donors and our partners to deliver models of care that reduce site visits for the provision of care at home		Engagement events promoting our sustainable future		Promote benefits of digital appointments	Q1/2 Update. Digital Strategy approved and Digital Programme being established for delivery.	

Sustainability Programme IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	or closer to home						
Strategic Priority 3: Eliminating Carbon	6. Be a Net Zero carbon organisation by 2030	LED lighting upgrades at VCC		Upgrading emergency lighting systems to LED			
		Building Management System Upgrades for all sites	Metering Strategy implementation	Review site optimisation against metering strategy	Refine and review Metering Strategy against progress	Ongoing discussions and planning in line with Decarbonisation Action Plan	
Strategic Priority 4: Sustainable Infrastructure	7. Reduce environment impact of building works during design, refurbish construction,			Talbot Green Full Business Case developed	Talbot Green Full Business Case developed		
				Sustainability guidelines developed for all capital projects			

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	operation & decommissioning stages				Radiotherapy Satellite Centre construction		
Strategic Priority 5: Transiton to a Renewable Future	8. Reduce consumption of energy by 70% and reduce water usage year on year	Undertake site optimisation study of Building Management System	Metering Strategy	Target consumption 'hotspots' as identified in the site optimisation & metering strategy	Target consumption 'hotspots' as identified in the site optimisation & metering strategy	Ongoing discussions and planning in line with Decarbonisation Action Plan	
	9. Transition to purchasing 100% of our energy from renewable sources by 2027	Purchasing green electricity					
Strategic Priority 6: Sustainable Use of Resources	10. Reduce our waste by 26% by 2025 and 33% by 2030 aligning with the Welsh Government Beyond Recycling targets	Introduce reusable items in canteen (pending IP & C guidelines)		Review waste at donor clinics and source reusable alternatives			

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	11. Achieve 'zero waste to landfill' by 2025		Introduce recycling schemes for WEEE			Specific WEEE waste stream initiative not implemented in Q2, will be investigated in Q3/4	
	12. Have 70% of our waste recycled by 2025		Recycling campaigns		Recycling campaigns		
Strategic Priority 7: Connecting with Nature	13. Improve the well-being of our patients, donors and staff connection with the	Green Social Prescribing Collaboration	Green Social Prescribing Collaboration				

Sustainability Programme IMTP Strategic Priorities Service Delivery Framework 2022/23							
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	natural environment						
	14. Increase biodiversity by protecting and enhancing natural assets	Reduction of Mowing	Sewing wildflowers		Removal of invasive species		
	15. Maximise the quality and benefits from our green spaces	Install Nature Notices	Nature Walk at Talbot Green		External audit, 3 years after our baseline (as mandated in the Environment (Wales) Act 2015)		
Strategic Priority 8: Greening our Travel and Transport	16.Decarbonise our transport and travel operations	Launch Travel Plan across all sites	Events / Promotion of Travel Plan		All Wales Travel Charter		
			Pilot of Electric Vehicle Fleet at Welsh Blood Service	Electric Vehicle Charging Port at VCC			
	17.Encourage sustainable	Next Bike Reopening and	Cycle Confidence Events held in	Promotion of local cycle routes			

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	and active travel wherever possible seeking to reduce business mileage by 70%	promotional video / communication campaign to relaunch	partnership with Cardiff Council				
			Promotion of 'Park and Stride ,	Departmental competitions		Promotion not taken forward to date – other Travel related initiative introduced included Cycle Confidence / Cycle to Work scheme / Electric Vehicle Fleet Solutions	
	18. Provide more care and services at home or closer to home	Launch of Digital Strategy				Q1/2 Update. Digital Strategy approved and Digital Programme being established for delivery.	
Strategic Priority 9: Adapting to Climate Change	19. Assess and understand the impacts of climate change on our services		Create Climate Change Adaption Toolkit		Monitor risk of Climate Change	Research into industry leading Toolkits undertaken.	

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	and communities						
	20. Ensure infrastructure services, procurement activities and local communities are well prepared to mitigate and manage climate change						
Strategic Priority 10: Our people as Agents for Change	21. Support staff to develop the knowledge and skills to improve sustainability	Targeted Environmental Awareness training action plan	Event – NHS Sustainability Day for Action		Promotion of Agile Working and environmental benefits of digital working		

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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	at work and home.						
	22. Empower staff to make sustainable choices in the services we provide which improve their well-being	Review and refresh of Sustainability webpages to signpost	Promotional Campaigns	Creation of 'Green Champions'	Regular Communications		
			Well-being Sustainability Pop Up event at WBS	Well-being Sustainability Pop Up event at THQ			
Ministerial Priority - Emissions reported in line with the Welsh Public Sector Net Zero Carbon	23. 16% reduction in carbon emissions by 2025 against the 2018/19 NHS Wales				Monitoring return	Return submitted to Welsh Government for financial year 2021 -22	

Sustainability Programme **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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Reporting Approach	baseline position						
Ministerial Priority - Qualitative report detailing the progress of NHS Wales' contribution to decarbonisation as outlined in the organisation's plan	24. Evidence of improvement				Monitoring return	Return submitted to Welsh Government for April – September 2022.	

Value-based Healthcare IMTP Strategic Priorities Service Delivery Framework 2022/23							
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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
Strategic Priority 1: Culture, socialisation and education	1. Develop Strategy & Implementation Framework	• Complete Capacity & Maturity Self-Assessment process & evaluate to inform Strategic priorities & objectives • Engage with staff to understand what value means for them • Develop Communication engagement & training education plan (Velindre Futures & WBS Modernisation) • Patient Engagement policy implemented, for a co-design approach with future work streams	• Engage with staff to understand what value means for them • Use maturity self-assessment and engagement with staff to develop and agree Trust VBHC Strategy & Plans and integrate into Velindre Futures (VF) & WBS service modernisation • Agree strategic priorities & objectives			Actions completed: • VBHC Strategic priorities and implementation plan developed • Exec Directors have completed Capacity & Maturity Self- Assessment process which has been used to identify the strategic priorities & objectives • Initial engagement with Executive Management Board (EMB) and Velindre Futures Board around value • VBHC strategic priorities and objectives agreed by EMB and Board as part of IMTP Actions outstanding: • Wider staff engagement around value as part of the Building Our Future Together Programme • Development and roll out of a value communication and training & education plan	

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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	2. Implement Resources & Governance	• Develop & submit bid to WG VBHC fund identifying infrastructure (Project Management, Digital, BI etc) and key areas of value driven service improvement resource requirements				Actions completed: • Successful bid to WG VBHC Fund to establish a Value Intelligence Centre which will include implementation of a PROM collection system (using the National Framework) • Value Intelligence Centre resource to support provision of infrastructure across all SST's to provide a systematic trust wide approach to reviewing Trust clinical pathways against best practice to identify areas of improvement, provide clinical leadership time, provide data to identify unwarranted variation and waste, develop dashboards bringing together activity, clinical audit, resources, PLICS, PROMs data to support value improvement	
	3. People development	• Baseline assessment of capability & expertise and	• Key staff to attend VBHC courses, e.g. Executive	• Principles of VBHC to be communicated well and clearly		Actions completed: • Initial assessment of capability & expertise	

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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
		key posts identified to support work programme • Develop Communication engagement & training education plan (Velindre Futures & WBS Modernisation)	education, masterclasses or the Mid Wales Bringing Value to Life education course	across the Trust		identified that the Trust had no VBHC capability & expertise. A key aspect of the VBHC bid to WG Value Fund was to enable the Trust to recruit the capability & expertise • A number of Trust staff attended the Hywel Dda VBHC course • Executives have been informed of the availability of the Bringing Value to Life education courses. Two Executives have attended this course Actions outstanding: • Key posts identified to support work programme were included in the successful VBHC funding bid to WG. Recruitment to these posts will be progressed over Q3 & Q4 • A communication engagement & training education plan has not yet been developed. This will be one of the roles of the Head of VBHC post to be	

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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
						recruited from WG funding for infrastructure. JD developed and recruitment process to commence in Q3	
	4. Active membership of the Value in Health Strategy Group and implementation of key learning from National Programme	• Meet with National Team to discuss and agree Trust priorities and support required • Seek learning from HBs on their VBHC implementation to avoid mistakes / pitfalls how they have overcome data/info gaps • Continue partnership working across SE Wales region to develop whole system pathways, e.g. AOS, prehab				Actions completed: • DoF attends the Value in Health Strategy Group and shares learning within Trust to facilitate implementation where relevant • DDoF attends the Value in Health operational group for areas of learning and seek support from HBs / Trusts that have been implementing VBHC for many years • Trust Directors met with Value in Health Team in August to share its planned approach to VBHC, understand the National Value in Health Strategy around VBHC and agree approach to joint working and priorities for Velindre Trust • Trust has had further meetings and communication with	

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		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
		• Linking in with the Mid/North Wales Network to learn from them				National team seeking support to progress a number of objectives / actions in this plan	
	5. Integrate VBHC principles into existing governance structures internally & externally	• Build culture of Value in way Trust works • Raise awareness of VBHC / Prudent principles through Divisions e.g. Velindre Futures, TCS Programme, Clinical Advisory Group, WBS Lab Modernisation • Highlight VBHC central to recovery plan & National Clinical Framework	• Seek views on and agree strategic priorities & objectives • Through CCLG & HB Cancer Boards reinforce added value of AOS and explore further opportunities to add value across cancer pathways			Actions completed: • VBHC is included as one of the projects with the Trust "Building our Future Together" Programme led by the Chief Executive • The AOS service development agreed with HB's in SE Wales has been used as an example of delivering Value in practice across the cancer pathway • Initial awareness of VBHC / Prudent principles undertaken with EMB & Velindre Futures, but further work required to spread more widely • VBHC principles have been embedded in the ToR of the recently establish Trust Integrated Quality & Safety Group Actions outstanding:	

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		Q1	**Q2**	**Q3**	**Q4**		
						• Recruitment to the Head of VBHC and other infrastructure posts will commence in Q3 & Q4 enabling work to commence to build a culture of Value in way Trust works and carry out further work required to raise awareness of VBHC and prudent healthcare across the Trust to spread more widely	
Strategic Priority 2: Measurement of Outcomes & Cost in a meaningful way	6. VBHC Cancer SST Dashboard Development	• Commencement of the SST transformation programme, with an introduction to the VBHC approach to the SSTs (including 'supported self-management' and scrutiny around patient follow up pathways and review of data requirements,	• Review how the National Lung Dashboard can be used with the Trust	• Commence development of a Trust Lung dashboard bringing together clinical audit data, PROs / PREMs data and patient level cost data	• Commence development of Breast Dashboard	• All the actions to develop Cancer SST Dashboards to provide teams with data to highlight unwarranted clinical variation, waste, pathway inefficiencies etc have been delayed pending the establishment of the VBHC Intelligence Centre team. Recruitment to posts within this team has commenced with the Head of VBHC being a key role to provide the focussed leadership and management necessary to drive forward the VBHC objectives. Alongside recruitment of the posts that the WG VBHC	

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						funding will provide, support is being sought from HB VBHC teams and the National Team as well as consideration of procuring expert support to provide Business Intelligence input in the interim	
	7. Create and connect a digital cancer services community in South East Wales	• Baseline assessment: Survey staff who have direct patient contact to identify PROM & PREM data collection and assess the proportion of data that is patient identifiable • Ensure patient engagement plans include improving digital literacy, access and engagement on PROMs • Engaged in national	• Develop plan to digitise existing data collection into data Warehouse • Urology SST PROMs data which will be expanded and included in data Warehouse to enable use across the Trust on value assessment	• Implement pilot for patient portal included in IRS procurement (PROMs & PREMs data collection)	• Collection of PROMs & PREMs for Radiotherapy patients via IRS patient portal	Actions completed: • Shared specification for PROM software procured as part of the IRS with the Nation Value in Health Digital lead for assessment against National specification • PhD Student currently producing baseline of PROM collection across the Trust and assessment of proportion of patient identifiable data. Main area of collection is using My Health Record software in Urology SST for prostate patients as a pilot Actions outstanding: • Once the additional VBHC infrastructure staff are recruited into BI & Digital work to digitise existing	

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		procurement for Prom Collection				PROM collection into the Trust data warehouse can commence as well as roll out of the use of My Health Online into other SST's • Need to liaise with patient engagement leads to ensure plans include improving digital literacy, access and engagement on PROMs • The implementation of the patient portal pilot procured as part of the IRS are identified for Q3 & Q4, but this will be dependent on the available resources from Varian the IRS supplier according to the detailed implementation plan for the IRS and recruitment by the Trust into the VBHC infrastructure posts	
	8. Allocation and distribution of resources in order to maximise outcomes	Scope work required to map costs to pathways for each cancer area / SST	• Engage with clinical teams on cost - share patient level costing data with each SST • Develop a plan for integration of PLCS/New warehouse			• All the actions to review and realign the allocation and distribution of resources to maximise outcomes have been delayed pending the establishment of the VBHC Intelligence Centre team. Recruitment to posts within this team has commenced with the Head of VBHC	

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			costing system to automate costing of pathways against outcomes. • Develop plan for PROMS/PREMS to the whole costed pathway • Engagement with clinical teams where costs of pathways and treatments are not already available or require updating			being a key role to provide the focussed leadership and management necessary to drive forward the VBHC objectives.	
	10. Commissioning for outcomes	• Benchmark against the NHS England specialist commissioning outcomes for cancer for a baseline assessment and to identify early opportunities.	Working with National VBHC Programme Scope out project for planning and commissioning for cancer outcomes	Start work with clinicians & commissioners to develop a contracting framework that funds based on outcomes		Actions completed: • Fed into the National Funds Flow group about undertaking an assessment of approaches to inclusion of outcomes as part of the payments mechanism in LTAs between commissioners and providers. The National Group will consider commissioning for outcomes as part of their overall remit	

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		• Participate in procurement of an All Wales benchmarking tool to ensure it includes cancer services.				• Trust Cancer services are included in the benchmarking tool procured by the FDU from KPMG . Actions outstanding: • Work with clinicians to agree outcome measures for a contracting framework will commence once the VBHC infrastructure team is recruited and the work form the National Funds Flow Group has been shared	
Strategic Priority 3: Prudent Healthcare & Service Prioritisation	11. VCC: USC / Acute oncology service & outpatient improvement	• Commence On-site & virtual oncology support to HBs • Commence MUP/CUP clinic • Commence Toxicity Clinic (SDEC bid) • Finalise the Unscheduled Care pathways with the 3 LHB • Commence phase 2 of the 24/7 Helpline Transformation	• Develop plans to establish a 24/7 critical care outreach service at VCC to improve pathways and reduce need for urgent transfer of patients to HBs • Integration, enhancement & expansion of access to Ambulatory care services (SDEC bid)			Actions completed: • Enhanced AOS commenced with on-site & virtual oncology in HBs • MUP/CIP clinic commenced • Toxicity Clinic commenced • Integration, enhancement and expansion of the Ambulatory Care services has been commenced Actions outstanding: • USC pathway work with three main HBs remains ongoing • Phase 2 of helpline transformation not yet commenced as will require	

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		– triaging of patients to the 'right place. First time. • Continue with the Outpatient modernisation / Transformation programme, review of SST pathways, maximising digital opportunities				support from the VBHC team wants recruited • Review of SST clinical pathways has commenced as part of the SST Deep Dive reviews, however detailed work will commence once the VBHC Infrastructure team are recruited to support the work	
	12. VCC: Radiotherapy service improvement	• Submit business cases to Commissioners for investment in prioritised list of new RT techniques • Commence Radiotherapy workforce modernisation and 'fit for the future' planning	• Commence Implementation of new radiotherapy techniques as per prioritisation list (if funded)	• Increase proportions of IMRT/VMAT (3D Plans) • implementation of new IRS – equipment upgrades and new Software for existing fleet @ VCC • Working with IRS supplier commence changes to workflow, automated planning	Consider options for introduction of further accelerated pathways: ▪ trials with reduced fractionation ▪ treat patients with best practice waiting times	Actions completed: • Cases for RT priorities submitted to commissioners and are being discussed through commissioners group • Proportion of 3D planning has increased and implementation of the IRS will enable further opportunity for 3D planning • Hyperfractionation (reduced fractions at higher dose) has been implemented for breast and some prostate treatment Actions outstanding:	

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						• IRS implantation has been delayed since the actions within the IMTP were developed so the RT workflow work with the IRS supplier is now anticipated to commence in 23-24 •	
	13. VCC:SACT service improvement	• Review 3year capacity plans for best value options between internal & outsourced are maximised • Resource work to progress agreement on TCS outreach service model infrastructure • Evaluate options of a 'Velindre Medicines at Home' service model • Commence workforce planning and modernisation	• Review SACT treatment algorithms / pathways to ensure standardised approach audited against NICE recommendations & benchmarked with other cancer certes • Review how work Trust is involved in on Genomics can be used for new drugs.	• Review of the impact of immunotherapy agents on activity and patient flow and recommend pathways changes for improvement	• Develop a plan to produce a Genomics dataset to aid review of SACT NICE drug use and assist in clinical trial matching	Actions completed: • Work undertaken within SACT service to map out processes and available capacity based on staff time and skills to meet workload demand. This work has identified areas of improvement that will add value. • Outsourced capacity through the Rutherford Cancer Centre not an option since the company went into liquidation. Additional internal capacity has been created in Prince Charles Hospital outreach facility at significantly better value • Discussions ongoing with AB UHB around the re-establishment of outreach SACT capacity at Nevill Hall	

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		– includes links Cancer SST				• Discussions with HB's around longer term approach to TCS SACT outreach service model has recommenced Actions outstanding: • All the other actions identified are on hold pending the recruitment of the VBHC infrastructure team which will review and reset realistic timescales and prioritise areas of greatest value	
	14. WBS: Lab modernisation Programme	• Commence work to agree value adding outcomes of Lab Modernisation				• Laboratory Services Modernisation Programme established within WBS that has been established to review and develop service processes, practices, and workforce requirements to support an efficient and effective service model across all laboratories in WBS. • OBC for capital investment to improve the WBS estates infrastructure as an enabler to the service modernisation	

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						is being finalised for submission to WG.	
	15. Implement prudent healthcare principles	• Engage with clinical teams around prudent healthcare to reduce unwarranted variation, activity of limited value, and prioritise standardisation of best practice • Include this within the Cancer SST Transformation 'deep dives and opportunities for pathway refinement e.g. ceasing any follow up	Seek clinical agreement to adopt ICHOMs Standards for non-surgical oncology: Lung, Breast, Advanced & Localised Prostate, and Colorectal	• SSTs review & and formally adopt • SST develop plans for implementation of standard	SSTs commence implementation of standards	• This work has been delayed pending recruitment of the Head of VBHC and other posts that will create a Value Intelligence Centre to provide the information to clinical teams around unwarranted variation, activity of limited value and potential clinical pathway improvement to best practice	
	16. Implement a prioritisation process	• This will be included as part of the Cancer SST transformation programme	• Agree a robust, transparent and data driven prioritisation process to make it clear why choices are			• Initial work commenced to shape an invest / dis-investment prioritisation process based on data demonstrating value i.e. resources consumed relative to outcomes	

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		Q1	**Q2**	**Q3**	**Q4**		
		and the 'deep-dives'.	made across all levels in VUNHST				
Ministerial Priority - Report detailing evidence of NHS Wales embedding Value Based Health and Care within organisational strategic plans and decision making processes	17.Evidence of activity undertaken to embed a Value Based Health Care approach				Monitoring return	• Separate return provided on 20th Sep 2022 covering 1 Apr '22 – 31 Aug '22	
Ministerial Priority - Agency spend as a percentage of the total pay bill	18. 12 month reduction trend	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monitoring return	• Separate return provided on 20th Sep 2022 covering 1 Apr '22 – 31 Aug '22	

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Strategic Priority 1: ***The Trust will drive forward the implementation of its Cancer Research and Development Ambitions***	The implementation of immediate term plan for the Cardiff Cancer Research Hub (a tri-partite development between the Trust, Cardiff & Vale UHB and Cardiff University) to use existing Cardiff & Vale UHB facilities for intermediate to high-risk research studies that cannot be delivered at Velindre Cancer Centre.				Complete the implementation of the immediate term plan (first 18 months) for the Cardiff Cancer Research Hub that utilises existing C&V UHB facilities.	**Cardiff Cancer Research Hub** • The shared cancer research priorities have been agreed by all Tripartite partners. These priorities act as the building blocks of the Hub, providing a clear direction when applying for grants and developing further partnerships. • Delay in identifying the infrastructure requirements for the Hub which is being addressed with C&VUHB and VUNHST colleagues • A number of posts are going through recruitment and selection; these include a Band 8a Senior Nurse (12 months secondment) due to start November 2022, and a Band 6 nurse and a Clinical Research Fellow.	

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						Governance Arrangements for Cardiff Cancer Research Hub • The Head of R&D and the R&D team continue to work closely with the Joint Research Office (JRO) to ensure process is in place to efficiently and effectively deliver collaborative research studies that will be delivered through the Cardiff Cancer Research Hub. • Areas of focus are: 1. Managing activity coming into the JRO that will be delivered through the hub. 2. The development and execution of a Heads of Terms agreement which will be at a high level as well as the inclusion of Velindre in a Memorandum of Understanding (MOU) between the three organisations. 3. The Head of R&D and the Senior Research Contracts manager are working with the JRO to ensure that the further development of the MoU will include the Trust's requirements. Work on the Heads of Terms agreement		

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						has commenced is expected to be discussed at the next Cardiff Cancer Research Hub Project Board meeting.	
	The development and implementation of the intermediate term plan for the Cardiff Cancer Research Hub to provide a focal point and facility for delivering intermediate to high risk research studies, translational research and allow opportunities for education and training.					Expected to Complete the implementation of the intermediate term plan (following 30 months) for the Cardiff Cancer Research Hub, in 2024/25. The Trust has gone out to tender to commission and Investment Strategy for the Hub on behalf of the Tripartite partners. We are awaiting results of this tender	
	Establish Clinical Academic posts in cancer research to strengthen our			One post appointed		**Clinical Academic Post** • Funding for 0.5FTE Clinical Academic post (an Early Phase Trialist) was recently approved at the Velindre Charitable Funds committee	

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	links with Academic Partners and enable translational research					and the plan will be to secure match funding by Cardiff University. The business case is current going through Cardiff University processes. • Discussions are ongoing regarding additional Clinical academic posts in partnership with funding the Wales Cancer Research Centre and Cardiff University.	
	Maximise R&D&I opportunities in radiotherapy associated with the development of nVCC and the radiotherapy research bunker				Ongoing/ continuous	**IRS Radiotherapy Bunker** • A Radiotherapy R&D Group has been established to oversee activities and membership will include all key internal stakeholders. • The group will consider and prioritise all proposals for submission to the IRS Joint R&D Committee that will be formed, in partnership with Varian, post contract signature. **Radiotherapy Research** A group has been set-up to discuss capacity issues in the core Radiotherapy service and the impact on radiotherapy research. The aim is to define the issues and identify possible	

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						solutions. The group includes senior colleagues from medical physics, radiography, and medics	
	Further investment in the capacity and capability to support multi-disciplinary research to ensure that the Trust can grow its capacity to deliver clinical research to patients.		Identify the local clinical support services that require further investment in capacity and capability to support research	Develop a plan defining the future investment in capacity and capability to support research.	Initiate a programme of investment in capacity and capability of local clinical support services to provide resource to research studies.	**Nursing and Allied Health Professional & Clinical Scientist's Research** • RD&I Database under development, to capture all research and innovation conducted by Nurses, AHPs, and Clinical Scientists. • Aimed at Nurses, AHPs, and Clinical Scientists a RD&I staff survey is in development with the aim of ascertaining a baseline of the research and innovation projects that are being conducted across VUNHST, identifying RD&I understanding and educational needs. **Training and Education** • The team are developing a 'Dragons Den' workshop for an upcoming Velindre Nurse conference to be held in March 2023. The workshop will address a specific research proposal and the panel will raise questions to highlight areas	

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						researchers need to address such as governance and ethics.	
Strategic Priority 2: ***The Trust will maximise the RD&I ambitions of the Welsh Blood Service.***	WBS will continue to grow the RD&I opportunities partnerships to realise the significant potential of Component Development Lab.				Ongoing/ continuous		
Strategic Priority 3: ***The Trust will implement the Velindre Innovation Plan.***	©Velindre Innovation Plan will be Implemented	New RIIC guidelines implemented		Innovation MDT established and linked to the Cardiff MDT	Core Team Established	**Research, Innovation, Improvement and Coordination (RIIC)** • New guidelines for the RIIC hubs were published in March by the Welsh Government. The team at Welsh Government, after wide consultation changed the very broad focus of the RIIC hubs to clearly supporting innovation infrastructures. Also moving away from networking to delivering collaborative innovation projects with significant	

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						outcomes for patients. The new hubs would be Regional Innovation Coordination Hubs (RICH). The implementation has been completed after discussion across key areas of the service and within the RD&I team. This resulted in the submission of the RICH plan and funding of £75k for 2022/23, to the Innovation Team in the Welsh Government.	
Strategic Priority 4: *The Trust will maximise collaborative opportunities locally, nationally and internationall y*	Formalise the Cardiff Cancer Research Hub partnership					Expected to complete the establishment of an MOU/Heads of Terms arrangement with partners to facilitate partnership working in the Tripartite Cardiff Cancer Research Hub in 2023/24. Current progress is described in "Governance Arrangements for Cardiff Cancer Research Hub" under **Strategic Priority 1: *The Trust will drive forward the implementation of its Cancer Research and Development Ambitions***	

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	Maximise R&D opportunities at the Velindre satellite unit at Nevill Hall Hospital				Ongoing/ continuous	Expected to complete the development of a plan to maximise research, development & innovation opportunities in radiotherapy associated with the radiotherapy satellite unit at Nevill Hall Hospital in 2023/24.	
	Development & implementation of “Velindre@” Programme, with research facilities at Aneurin Bevan UHB, Cwm Taf Morgannwg UHB, as well as within the Cardiff Cancer Research Hub at CV UHB, forming a South East Wales research network increasing opportunities for donors/patients to access research studies across the region.				Complete the development of “Velindre@” Programme implementation plan.	**Velindre @ Programme** Dialogue around building on research opportunities continues between VUNHST and ABUHB with a key meeting scheduled on November 2022, where increasing trial activity and developing collaborative working will be discussed.	

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		Q1	**Q2**	**Q3**	**Q4**		
Cross-cutting themes across Strategic Priorities 1-4 above	Implementation of programmes, complementing existing training opportunities that enable and support Trust staff to develop, deliver and manage research portfolios.			Review of existing training opportunities to develop an implementation plan for a complementary programme Trust staff to develop & deliver research		**Training Programme & Opportunities** Work continues to identify existing training and develop an implementation plan to ensure the Trust can provide/promote a staff training programme for research & development	
	Further investment in the research delivery and governance teams to make sure that studies are optimised to facilitate effective and timely recruitment and delivery.	Continue the development and implementation of staffing plans for the research delivery and governance teams (identified in 2021/22) to facilitate timely recruitment	Complete the appointment of senior staff in the research delivery team and to support the delivery of the Cardiff Cancer Research Hub	Complete the implementation of changes to the structure of the research delivery team administrative structure.		**Reorganisation of Trust Research Delivery team** • Work continues on plans to improve/change the administrative structure, roles and responsibilities of the research delivery team is ongoing with support from Trust Workforce & Organisational Development, as appropriate.	
	The development and implementation of clinical information systems to identify donors/patients eligible to take		Complete the R&D contribution to the Trust's implementation of the Digital Health & Care Record in line with the Trust's project schedule.		Complete a review of clinical information systems available (in conjunction with partner stakeholders, i.e. DHCW and HCRW)	**Delivery of the Digital Health and Care Record system** • The R&D delivery staff continue to support the Trust's Digital Health and Care Record development programme. Although delayed the system is expected to go live in November 2022. Staff	

Research Development & Innovation **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	part in research studies.				to identify research study participants.	continue to contribute to the design of the dataset for the capture of research study data in line with regulatory body and study Sponsor requirements.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022 - 2025	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
Implementation of an Enhanced Acute Oncology Service in South East Wales	Implementation of MUO/CUP Service	Recruitment process for MUO/CUP nurse and AOS Co-ordinator MUO/CUP service governance and SOP structures developed	MUO/CUP nurse and AOS Co-ordinator in post MUO/CUP clinic and MDT to commence	MDT Service Review	MDT Service Review	MUO /CUP nurse appointed and in post. AOS co-ordinator due to be appointed in quarter 4. MUO / CUP service to open for referrals on 7th November 2022. First MUO / COP scheduled for 17th November 2022. First MUO / CUP service scheduled for 21st November 2022.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022 - 2025	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	Enhanced Digital Services to Support AOS	Recruitment of Regional posts	Regional development of data capture t	Ongoing Digital Developments		Recruitment of regional digital posts completed and due to start in quarter 3. Data capture moved to quarter 3.	
	Specialist Oncology Support Within Health Boards	Task & Finish Group implemented to support the PSDA pilot of virtual morning support for LHB's.	Ongoing review of virtual support via T&F group			Task and finish group established and meeting on a regular basis. Enhanced virtual lunchtime sessions implemented. Full implementation now planned for quarter 4.	
	AB & CTM Specialist Oncology/Recruitment	AB to support the development of 7 specialist oncology sessions (2/7 to be filled) AB CNS Recruitment process to start CTM Implementation plan to commence	3/7 of AB specialist oncology sessions to be filled AB CNS recruitment to be completed 2/6 of CTM specialist oncology sessions to be filled	5/7 of AB specialist oncology sessions to be filled 4/6 of CTM specialist oncology sessions to be filled	7/7 of AB specialist oncology sessions to be filled 6/6 of CTM specialist oncology sessions to be filled	ABUHB have requested a revised model, which prioritises virtual support due to the number of sites from which they operate. These will commence in quarter 3. Implementation at CTMUHB has been delayed. However, joint meetings have been implementation to develop mitigating actions and a revised plan.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022 - 2025	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
	CAV Specialist Oncology	2/5 of specialist oncology sessions to be filled	3/5 of specialist oncology sessions to be filled	4/5 of specialist oncology sessions to be filled	5/5 of specialist oncology sessions to be filled	1 additional oncology session has been filled. A plan has been developed to provide 2 more additional oncology sessions in December 2022. A plan has been developed to provide the final 2 additional oncology sessions.	
	Recruitment – CAV	All local CAV positions fully recruited and in post (CNS, AHP's, Admin) Confirmation of AOS clinical sessions in CAV being secured	CAV clinical sessions to be in post.			AHPs (excl 0.5 WTE) in post. CNS to be in post during quarter 3. Clinical sessions recruited.	
	Hot Clinic - CAV	Twice weekly Hot Clinics held at UHW and UHL to commence.	Review of hot clinics and development as per available outpatient space	Ongoing service review and development	Ongoing service review and development	Review currently being undertaken in line with agreed actions.	
	AB Ambulatory Clinics	Planning for AB ambulatory hot clinics to commence	Local ambulatory clinics to commence at Royal Gwent	Ongoing service review and development	Ongoing service review and development	An Implementation Board has been established. However, there have been challenges in recruitment	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022 - 2025	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
						which has resulted in delays to full implementation.	
Implementation of an Enhanced Unscheduled Care Service in South East Wales	Agreed model of care for acutely unwell patients and those requiring unscheduled care	Agreed model of care including pathways, acceptance criteria, facilities and workforce model for acutely unwell patients and those requiring unscheduled care		Joint operational clinical guideline for unscheduled care	Agreed shared key performance metrics to monitor and manage the quality of the service	A model of care has been developed. However, it has yet to be agreed and approved by both organisations. This is now planned for quarter 3.	
		Finalisation implementation guidance	Service review	Service review	Service Audit	As the model of care has yet to be agreed it has not been possible to proceed with this action.	
	Shared key performance metrics to monitor and manage the quality of the service	Finalisation and implementation of performance metrics	Service review	Service review	Service Audit	As the model of care has yet to be agreed it has not been possible to proceed with this action.	
	Patient experience survey	Patient focus group	Ongoing collection of data	Ongoing collection of data	Ongoing collection of data	It has been agreed between C&VUHB and VUNHST to revise this action.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022 - 2025	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						A joint meeting has been held and it has been agreed to collect data from quarter 4.	
Implementation of a Tripartite Cancer Research Hub	Implement Phase 1 of the Clinical Service Model	Clinical Model and Service Specification approved by tripartite partners	Funding strategy developed & approved by tripartite partners	Full implementation of Phase 1 completed	Benefits realised for South East Wales Cancer patients	Clinical Model and Service Specification approved by tripartite partners. Funding strategy initiated and seeking external support to complete. This will mean that this action will not be completed until quarter 3. In parallel a business case to support the required investment will be developed in quarter 3.	
	Implementation of Phase 2 of the Clinical Service Model			Phase 2 capital and revenue requirements agreed with tripartite partners	Phase 2 Business Case approved by tripartite partners	Phase 2 business case cannot be completed until phase 1 business case has been implemented. Phase 2 business case re-profiled for submission in quarter 1 2023 / 2024.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022 - 2025	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	Implement Phase 3 of the Clinical Service Model					Not applicable – no actions required during 2022 / 2023.	
Development of Enhances Haemato-oncology Services in South-East Wales	Implement agreed Haemato-oncology Service Model in South-East Wales	Agree shared pathways for Haemato-oncology patients in South East Wales	Development of acceptance criteria and clinical pathways	Agreed performance metrics to monitor quality of the service Agreed workforce and operational model across South East Wales	Implementation of agreed Haemato-oncology service in South East Wales	Model yet to be agreed between Velindre and Health Boards. In response joint workshops have been organised between all parties with a revised action plan due to be agreed in quarter 3.	
Ministerial Priority - Qualitative report detailing evidence of NHS Wales advancing its understanding and role within the foundational economy via the delivery of the Foundational	Delivery of Foundational Economy initiatives and/or evidence of improvements in decision making process				Monitoring return	Not applicable – no action required until quarter 4.	

System Leadership & Regional Partnership Working IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022 - 2025	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q1 &2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
Economy in Health and Social Services 2021-22 Programme							

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Support Services Functions IMTP Quarterly Progress Report 2022/23 for Quarters 1 and 2 as at 21/10/2022

Digital IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	Utilise digital technology to reduce unnecessary workload and risk through improving efficiency and reducing waste (transition to cloud-hosted services).				Scoping exercise to identify potential candidates for transition to cloud platform.	Digital Strategy approved and Digital Programme being established for delivery. Cloud-first is now the assumption for new digital systems. On track to identify candidates in Q4.	

Digital IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	Enhance existing Trust-wide telephony infrastructure to support current and emerging service needs, to include replacement of existing call centre software.				Scoping Procurement Deployment	On track with plans for Q4 to introduce SIP Telephony into VCC, and a common call recording platform Trust wide.	
	Explore opportunities to utilise AI / machine / automation learning to support business processes.				Establishment of PoCs / pilots. Commence set up of RPA service.	Robotic Process Automation pilot is being scoped and looking to re-use examples from other HBs with Finance being the pilot area. AI / Machine learning will follow in Q4 as part of the Digital programme following the DH&CR rollout in Q3.	

Digital **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	Develop 'digital first' culture across VUNHST, through development of workforce capability and digital literacy.					Digital Strategy approved and Digital Programme being established for delivery, including the Digital Organisation theme. Delivery approach and timescales needs to be agreed alongside other Trust priorities. Continued engagement with Digital Communities Wales for digital inclusion activities.	

Digital IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	Deploy a range of preventative cyber security tools and services, including staff education programme, to reduce likelihood of cyber breach.					Staff education programme is in place as part of mandatory training plans. Phishing simulation is actively used and results reported as Trust KPI. Cyber Security technical controls continue to be strengthened although technical debt will still be present in the infrastructure for a considerable period. Global supply chain is currently impacted for security devices (e.g. firewalls) causing delays in introducing technical controls.	

Digital **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	Establish a platform, through which Velindre staff and patient/donor-facing services can be accessed.				Establish development platform / approach.	Digital Strategy approved and Digital Programme being established for delivery which includes patient/donor apps. We are contributing to the Digital Services for Patients and Public (DSPP) programme as the entry point for Donors and Patients. Commitment for our services to be available needs to be established with the programme. PSA tracker app to be launched in Q3	

Digital **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	Create income-generation opportunities through the deployment of VUNHST-developed applications / digital services to other organisations.		WBS Appts. System (NIBTS, HCRW).		Explore other income-generation options.	Proposal for providing the WBS Appointments system for NIBTS has been scoped and planned for Q3. On track for wider review in Q4.	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
Wellbeing	Empower staff to maintain their physical and mental wellbeing in line with an agreed Health and Wellbeing Framework as developed by the Healthy and Engaged Steering Group	Review/renew information available supporting mental and physical health and wellbeing Provide information and training in holding wellbeing and attendance conversations Incorporate HEIW health and wellbeing framework into VUNHST approach and agree framework for 2022-23	Involve staff in developing peer support network, building on Mental Health First Aid skills Involve staff in the agile working project to achieve relevant work/life balance arrangements	Offer flexible career opportunities to meet changing needs Review usage of VCC and WBS wellbeing rooms and resources	Measure progress with health and wellbeing using NHS Staff Survey and listening events	New pages launched on the intranet setting out information to support mental and physical health and wellbeing. Information issued on holding wellbeing and attendance conversations. Training being developed for delivery in Autumn 2022. HEIW HWB website is embedded in VUNHST approach. Mental Health First Aiders meet regularly as a network and are working with the Staff Psychologist to develop peer support. Agile Working Project has two staff engagement session in October 2022.	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
	VUNHST develops its compassionate, values-led culture where staff are empowered, involved and engaged.	Embark on a 12 month project refreshing and embedding a positive and relevant code of values for the Trust.	Continue with Values project	Continue with Values project	Measure progress with Values project and move to next stage	The Values project has been approved by EMB and is now part of the Building our Future Together work. Culture and Values interviews have taken place with Board members. Staff surveys to be launched. Summary report due in December	
	Promote a culture of true inclusivity, fairness and equity across the workforce.	Agree an Equality, Diversity and Inclusion plan and a Welsh Language Plan for 2022-23 Develop metrics to track progress of plans. Develop a plan to ensure compliance with Welsh Government Race Equality Action and LGBTQ+ Action Plans	Focus on addressing pay gaps across protected characteristics Establish mechanisms for staff to speak up and be heard	Grow networks and groups for staff to be actively involved in develop an inclusive, bi-lingual culture	Reflect on feedback from staff survey and ask staff what is important for 2023-24	Plan for ED&I is part of the agenda for the Healthy and Engaged Steering Group. This needs to be drawn out as a standalone document. Plan for Welsh Language is drawn from the Quarterly RAG rating against the Welsh Language Standard. Actions are taken by WBS, VCC and Corporate into three individual action plans. The Trust has established a steering group to develop the action plan for Anti-racist Wales which will be submitted in December 2022. Guidance has not yet emerged from Welsh Government	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						regarding the LGBTQ+ action plan. The Gender Pay Gap for 2022 has been measured and discussed at EMB and LPF. A more detailed action plan is currently in development, including the use of staff networks. Work in Confidence has been re-launched and advertised as a means of speaking up. The Trust is working with partners on devising an All Wales approach to Speaking Up.	
Supply and Shape/Attraction and Retention	Develop effective people plans having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence	Further embed our workforce planning process and toolkit Review hard to fill roles ensuring robust recruitment and retention plans	MDT training pathways mapped to maximise opportunities for transformation Ongoing management of Apprenticeships, Graduate trainees	Introduction of Physicians Associate roles Introduction of the Delegation Frameworks	Review and evaluate plans to ensure delivery	MDT Deep dives have been undertaken in Divisional areas to assess service models. Workforce modelling tool purchased to model future workforce – example workforce models to be discussed in October. Apprenticeship strategy agreed and active promotion of apprenticeship in place and targeted at hotspot areas of	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		Q1	**Q2**	**Q3**	**Q4**		
	based care and support patient and donor wellbeing					recruitments. Linking with University and HEIW to support graduate training schemes	
Education and Learning	Develop a competent, capable and caring workforce	Assurance of safety through 85% compliance on Statutory and Mandatory Training Refocus the Education and Training Steering Group to promote the objectives of the People Strategy and launch a Training and Development	Working with HEIW, maintain provision of the Trust Inspire Management Programme. Further develop follow-on activities that are flexible and support 'just for me, just in time' development	Utilise the NHS Staff Survey to improve digital literacy across the workforce. Re-launch the Virtual Reality education projects, in collaboration with Swansea University to provide virtual reality fire training to improve compliance	Conduct evaluation of the Training and Development plan including satisfaction, learning and application to the workplace.	Stat and Mandatory training is closely monitored and action taken where figures dip below 85%. The Education and Training Steering Group has been refocused around the Education Strategy and the People Strategy. The Training Plan has been drafted. Inspire has continued to be offered in line with demand (now in its 5th cohort). Other development options are regularly discussed on a 'just for me, just in time' basis	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		plan owned by stakeholders throughout the Trust					
Leadership and Succession	Provide effective leadership development	Undertake a baseline review and evaluation of current leadership offers Ongoing provision of bespoke offers, in liaison with HEIW	Produce an options appraisal on leadership development for the Trust	Build on our partnerships in academia and Health Education and Improvement Wales to ensure the best leadership and management offers are provided for staff including coaching, mentoring and provision of masterclasses		An evaluation of Inspire is underway and a review of leadership development is taking place as part of Building our Future Together. This will outline the leadership development options for the Trust.	
	Promote a coaching culture at all levels to encourage compassionate leadership behaviour	Undertake a baseline review of skills, capabilities and activity across the Trust	Develop a coaching and mentoring network in the Trust Deliver skills development for potential coaches and mentors, line managers and all staff	Link the Trust network with All Wales networks and external bodies, as relevant. Create culture of continuous learning.		Data relating to coaches and mentors is being collated to understand the skills and capabilities we hold. Links have been made with other Health Boards for reciprocal coaching as and when required	
	Establish a Talent Management process to spot and	Contribute to the HEIW Talent Management Programme, April to July 2022	Apply next steps in HEIW programme	Review appraisal and recruitment to make space for talent management discussions	Encourage staff to identify their personal and professional aspirations and	VUNHST fully participated in the HEIW Talent Management Programme. The learning from this programme is being	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		Q1	**Q2**	**Q3**	**Q4**		
	manage talent at all levels	Undertake HEIW diagnostic of organisation readiness for Talent Management process			take control of their careers	reviewed for applying to Trust practices.	
Ministerial Priority - Overall staff engagement score	Annual improvement				Monitoring return	• The Healthy and Engaged Steering Group has been established with an Executive Lead to drive improvements in health, wellbeing and inclusion. This brings together Divisional and professional leads to develop strategies to improve working lives. There is an annual work plan	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
						linked to the People Strategy. • The values and culture of the organisation are being reviewed within the Building Our Future Together work to create positive and constructive working conditions for all. • A new Wellbeing Hub opened in Velindre Cancer Centre in May 2022 offering support to staff from all areas of the Trust. • A Staff Psychologist is coming into post	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
						in September 2022 to develop a culture of psychological health and wellbeing across the Trust. • The Work in Confidence platform is in place for staff to raise concerns anonymously. • Staff communications have improved with the weekly newsletter being supplemented by News and Events on the new intranet from June 2022. • An Agile Working Group has	

Workforce and Organisational **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
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		Q1	**Q2**	**Q3**	**Q4**		
						developed principles for Hybrid Working and will be establishing processes and practices that balance employee and service requirements. This group has undertaken a number of wellbeing engagement sessions to understand the impact of home working on individuals. • Executive Equality Ambassadors established for all	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
						protected characteristics.	
Ministerial Priority - Percentage of staff who report that their line manager takes a positive interest in their health and well-being	Annual improvement				Monitoring return	• Listening events with leadership and management teams have taken place regarding health and wellbeing. • The wellbeing focus within our leadership and management development programme has been increased.	
Ministerial Priority - Percentage compliance for all completed level 1 competencies of the Core Skills and	Target 85%	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monitoring return	Compliance met Monthly reporting and assurance via Executive Management Board	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
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		Q1	**Q2**	**Q3**	**Q4**		
Training Framework by organisation							
Ministerial Priority - Percentage of sickness absence rate of staff	12 Month Reduction Trend	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monitoring return	Sickness rates above 6% A range of health and wellbeing interventions in place and promoted through the Trust and in areas of high sickness Data triangulation utilised to understand reason for low compliance WOD working with management to establish an improvement trajectory in areas on high absence	
Ministerial Priority - Percentage headcount by organisation who have had a Personal Appraisal	Target 85%	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monthly monitoring report to EMB	Monitoring return	Compliance circa 65% Plans in place in areas of low compliance Data triangulation utilised to understand reason for low compliance WOD working with management to establish an	

Workforce and Organisational IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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Development Review (PADR)/medical appraisal previous 12 months (including doctors and dentists in training						improvement trajectory in areas on non-compliance	

Estates IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
Safe and High Quality Estate	Address IP&C Related Concerns raised through Audit.	Prioritise Action Plan	Tender Works	Delivery	Delivery	Closed out.	

Estates IMTP Strategic Priorities Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		2022/23					
		Q1	**Q2**	**Q3**	**Q4**		
	Maintain compliance with HTM and legislation, Estates Action Plan	Prioritise Action Plan	Tender Works	Delivery	Delivery	Action Plan complete, a high percentages of actions have been closed out. Change is approach to manage these outputs through the various Safety Groups (Vent, Water, Electric, IP&C, Med gas). Reports issued to Quarterly H&S Board	
	Complete works identified under fire safety	Commence PFP Works Continue with Fire door replacement Continue Emergency Lighting Installation Conduct fire damper tender	Complete Fire door replacement Complete Emergency lighting Complete works	Complete PFP Works	Review	Compartmentation remedial works at VCC commenced in September 2022 with scheduled completion by December 2022. Compartmentation works for WBS HQ will follow with scheduled completion by March 2023. Fire door replacement work at VCC underway with scheduled completion by March 2023. Fire door replacement works at WBS to commence and continue in tandem with scheduled completion by March 2023.	

Estates **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						Emergency lighting has been procured with installation programme due to commence all works to be completed by end of January	
Healthy Buildings and Healthier People	Deploy new technologies working with SES to improve air quality	Research	Trail	Evaluate	Issue paper to EMB	This work has stalled due to resource requirements to manage works. Estates Recruitment to be completed Q3, this will be picked up and actioned.	
	FF Ward Ventilation	Develop Board paper	Commence Design	Complete Design	Tender	Paper to be submitted to September Board. Recommendation to proceed with a revised solution.	
	Decoration Plan to address areas below cat B	Compile prioritised List of Area	Tender works 2022/23	Delivery	Delivery	Plan complete, finance required to support	
Minimise our Impact	Target reduction in Utility	Develop metering strategy	Metering Strategy implementation	Review site optimisation against metering strategy	Refine and review Metering Strategy against progress	Application for funding to WG BMS Metering almost complete	
	Be a Net Zero carbon	LED lighting upgrades at VCC		Upgrading emergency lighting systems to LED	insert text	Slight delay to project due to funding reallocation to	

Estates **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	organisation by 2030	Building Management System Upgrades for all sites				support IRS. Construction due to commence Q3 Building Management System Upgrades complete optimisation of controls ongoing to be completed end Q3	
	Reduce the environmental impact of building works during design, refurbish construction, operation and decommissioning stages	Update standard tender small works documentation to include sustainable option appraisal	Implement and monitor	Talbot Green Full Business Case developed Sustainability guidelines developed for all capital projects	Talbot Green Full Business Case developed	Estates annex complete. This process has highlighted the need to revisit delivery of works as outlined in the PBC works underway to update documentation All tendered works both major and minor include a 15 % weighting to assess sustainability as standard	
Using our Estate to Deliver the Maximum Benefit and Social Value	Achieved through new build programme						

Estates **IMTP Strategic Priorities Service Delivery Framework 2022/23**							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables /Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**Quarterly Progress Update for Q 1 & 2**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
to the Community							

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

TRUST BOARD

PRIORITISATION FRAMEWORK AND TRANSFORMATION ROADMAP

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Carl James, Acting CEO Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Carl James, Acting CEO Lauren Fear, Director of Corporate Governance & Chief of Staff
REPORT PURPOSE	FOR DISCUSSION

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
Executive Management Board	Various	Discussed
Strategic Development Committee	13/10/22	Discussed

ACRONYMS	

1. SITUATION/BACKGROUND

1.1. The Executive Management Team have been working with Q5 over the summer on a number of pieces of work. Two of these were to design a prioritisation framework to capture organisational priorities, both to deliver on requirements of core service delivery and service improvements in this respect, together with transformational priorities. Secondly to use this exercise to populate a Transformation Roadmap, which would also be used to inform Integrated Medium Term Planning.

1.2. Input was gathered by Q5 from the wider Trust Board, Executive Management Board, the Divisional Leadership Teams and the Extended Leadership Team.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1. The attached presentation provides an opportunity for the Trust Board to note the outputs of this work to date. A final draft version had been discussed at the October Strategic Development Committee. A summary of the discussion from the Committee included on slide 5.

2.2. To also note that in further discussions with the Executive and Extended Leadership Team, it was emphasised that in presenting the outputs of the work to stakeholders, including staff, that the approach of the scope of priorities is based on our Trust Strategy – the focus of which is delivery of core service excellence, with the golden thread being quality and safety.

2.3 Following discussion at the Trust Board, the priorities will form part of the Integrated Medium Term Plan guidance for the organisation – to ensure that our one-to-three year plans appropriately reflect these aspects.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	The driver of prioritisation is the Trust Strategy, which has quality and safety as it's golden thread.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Priorities impact across the standards.
EQUALITY IMPACT ASSESSMENT COMPLETED	Each of the priorities will require appropriate EQIA
LEGAL IMPLICATIONS / IMPACT	Each of the priorities will have respective legal implications
FINANCIAL IMPLICATIONS / IMPACT	Each of the priorities will have respective financial implications

4. RECOMMENDATION

The Board is asked to **NOTE** the content of attached presentation and **NOTE** that the programmes of work will feed into the Integrated Medium Term Planning guidance.

Prioritisation Framework and Transformation Roadmap

Trust Board

24 November 2022

Carl James, Acting CEO & Lauren Fear, Director Corporate Governance & Chief of Staff, obo

Steve Ham, CEO

Context

- Busy operating environment with competing pressures and priorities

- Our strategies were coming to an end

- Significant changes and expectations in health services from WG Policy, e.g. prevention, intervention and broader social value

- What was the problem statement?, e.g. What is our purpose?, Where do we want to be in 2032?, and How do we get there?

What did we do

- Step 1 – Purpose & Vision
- Step 2 – Strategic intent – Destination 2032, Enabling Strategies and 5 year Blood and Cancer Service plans
- Step 3 – Prioritisation – what do we do and why
- Step 4 - and in what order (i.e. the IMTP planning process)
- Step 5 – Strategic roadmap – simple story for stakeholders and management tool
- Step 6 – Delivery & Benefits realisation

Trust Board Discussion Today

- We have now discussed this version with WBS SLT, ELT and Strategic Development Committee. To discuss:

1. Note slide 6 as an appropriate overview of organisational priorities which we want to pursue over the next 3 years, recognising that prioritisation was done against our Trust Strategy, which has the excellence in service delivery and quality and safety as the golden threads
2. Note that elements of those programmes of work will be in years 1, 2 and 3 for IMTP
3. Note that IMTP being developed in order to represent an integrated and resourced plan to achieve these ambitions together with core service delivery

Strategic Development Committee Discussion

- No further amendments to slide 6 suggested

- Context discussed at the Committee:
  - All of these 37 are a priority – that's why they are on the list
  - Only one – Employee Value Proposition – dropped off – difference to the 54 is the way in which we have now grouped them
  - Some value in collating into one place but real value in how we us this going forwards, including:
    - Fulfilling the Trust Board's role in setting and shaping the strategic priorities for the organisation. This includes the on-going role of Strategic Development Committee in providing this strategic direction shaping and oversight.
    - Executive Management Board Shape has a key role in phasing, progress reporting, dependency mapping, resource allocation etc
    - Communication to staff and other stakeholders is key regarding the roadmap for the coming years in working towards Destination 2032
    - Frame the development of the IMTP – for 23-26 and ongoing

#	Programme of Work	#	Programme of Work	#	Programme of Work	#	Programme of Work	#	Programme of Work	#	Programme of Work	#	Programme of Work	#	Programme of Work
1	**Staff Wellbeing Programme –** ***Work programme overseen by Health & Well-being Group***	6	**Research Hub @UHW** *Deliver multi-phased clinical research1 in partnership with CAV and CU*	11	**BOFT: Quality Framework**	16	**Workforce Redesign** ***To be specific as to purpose and proposed outcomes – e.g. a workforce plan fit for 2027***	*21*	**SACT Service Transformation** ***VF Defined Scope***	26	**BOFT: Value Based Healthcare**	31	**HEP B Testing** ***Delivery of retrospective testing programme and changes to collection model going forwards***	36	**Transforming Access to Medicines Programme** ***VCS responsibilities for implementation of national model***
2	**Enabling Works & nVCC** ***Delivery of Projects 1 and 2***	7	**BOFT: Clinical & Scientific Arrangements**	12	**BOFT: Leadership Development**	17	**BOFT: Management Quality System**	22	**Outpatient Transformation Programme** ***VF Defined Scope***	27	**Digital Health & Care Record** ***Implementation of first phase by Nov 22, further phases tbd subject to funding***	32	**BOFT: Internal Staff communication & staff engagement**	*37*	Private Patients Strategic Development *Work to develop strategic options, decisions made, implementation programme of change as required*
3	**TCS Digital and Equipment** ***Delivery of Project 3***	~~8~~	Implementation of Patient Engagement strategy *As agreed at Trust Board (& Including Civica implementation and embedding)*	13	**Implementation of Duty of Quality**	18	**Sustainability Implementation of Sustainability Enabling Strategy** ***Priority of Wales Decarbonisation target***	*23*	**Acute Oncology Service Development** ***VCS responsibilities for implementation of regional model funded by business cases (by 24/25)***	*28*	**BOFT: Values & Culture**	*33*	**BOFT: Ways of Working**	38	*Added post WBS SLT discussion (not prioritised)* **Laboratory Services Modernisation Programme**
4	**Talbot Green Infrastructure** ***Refurbish the Talbot Green building to deliver operational resilience and reduce carbon by up to 70%***	9	**Quality Hub Implementation** ***Implement new approach, framework, ways of working and function***	14	**Plasma for Medicines Programme** *Develop a new service offering Plasma products for NHS and other use*	19	**Implementation of Duty of Candour**	24	**Service Delivery & Transition** ***Projects 6a,b and c – a. and b are VF design and delivery of Clinical model, c is Transition Project***	29	**Outreach services development** ***Delivery of Project 5***	34	**BOFT: Performance Management**	39	*Added post WBS SLT discussion (not prioritised)* **Collections Modernisation Programme**
5	Delivery of University Status Strategic Pillar, including various linked programmes of work: - Collation of Research, Innovation, Education, Leadership & Partnerships • *Delivery of* VCS/WBS *the Cancer and Blood Research Strategies* • *Implementation of* 7-P Innovation Framework • *Embedding of relationship with Faculty Medical Leadership & Management* • School of Oncology • Collaborative Centre for Learning, Technology and Innovation model • University Partnership Work	10	**Radiotherapy Satellite Centre** ***Delivery of Project 4***	15	Digital Programme Scope to be developed, including both platforms and ways of working: • SMART Tech & Internet of Things • Integrated Platform Development • National Data Resource Programme • Digital Literacy Programme • SMART Tech partnerships • Digital Inclusion & Communities development • National Systems Implementation • Digital Cloud Infrastructure	20	**Welsh Bone Marrow Donor Registry Programme** *Implementation of Donor Registry Module and strategic direction of model*	25	**BOFT: Governance, Risk & Assurance**	30	**Integrated Radiotherapy Solution Implementation** ***Project 3a implementation***	35	Advanced Welsh Medical Genetics *Trust role in Advanced Therapies to be clarified*		

Summary to Date

1

PRIORITISATION FRAMEWORK

1. Review in EMB Shape 26th September

2. Discussions with ELT, WBS SMT and EMB – further engagement required with VCC SLT.

2

TRANSFORMATION ROADMAP

3. Strategic Development Committee – 13th October – Part B as draft

4. Trust Board – Part A – 25th November

TRUST BOARD

Anti-Racist Wales Trust Action Plan

DATE OF MEETING	24th November 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Budgen: Head of Organisational Development,
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	21/11/22	PENDING ENDORSEMENT

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Welsh Government published the Anti-racist Wales Action Plan in June 2022. The Trust is required to publish its own action plan supporting this national initiative in December 2022. The action plan is included at Appendix 1.

1.2 Anti-racism is one aspect of the broader approach to equality, diversity and inclusion. The specific actions in the attached plan relating to race fit within a broader programme of work aligned to the Trust's Strategic Equality Plan.

1.4 This report provides background information and an action plan for Board approval.

1.3 The Trust Action Plan was presented to the Executive Management Board on the 21st November 2022, comments from that meeting will be provided verbally on the presentation of this paper.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Trust is committed to becoming anti-racist in all its activities, specifically those involving staff, patients and donors. The Trust has adopted the Welsh Government action plan and developed tailored actions to meet the objectives set nationally. In addition, the Trust has taken account of the Equality and Human Rights Commission report of June 2022 *Experiences from health and social care: treatment of lower paid ethnic minority workers* and the Public Health Wales/Diverse Matters focus group report of September 2022 *Experiences of Black, Asian and Racially Minoritised employees*.

2.2 More broadly, this work is being developed within the context of a review of the Workforce Strategy for Health and Social Care in Wales and the proposed review of the Public Sector Equality Duty in Wales. The Trust will engage with these reviews and reflect new requirements into the Anti-racist programme as they emerge.

2.3 This action plan will be owned by the Trust's Healthy and Engaged Steering Group. Progress will be reported to this Group at its quarterly meetings from December 2022. However, success with becoming anti-racist depends on commitment from all staff, from the Board, through senior management and at every level of the organisation. We all play a part in creating an environment where no-one feels limited or disadvantaged due to their race.

2.4 There are actions here relating specifically to the Board and Very Senior Managers as they are responsible for leading the tone and culture in the organisation, however the majority of the

actions we need to take belong to everyone within the Trust. In addition, engagement with patients, donors and people who work at the Trust needs to be done at the earliest opportunity so that we listen to what will make a difference and that other actions can be developed and flow throughout 2023.

2.5 Following the engagement and listening exercise described in the plan the Trust will build on the actions below to move further than the explicit challenges currently set out within the national action plan.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The EQIA showed an expected positive impact on people in relation to Race and this will support A More Equal Wales. This action plan will assist the Trust in progressing their Public Sector Equality Duty and have a long term positive impact on recruitment, retention and service delivery. Calculating the Race Pay Gap as part of the WRES in 2023 will pinpoint issues relating to low pay. The next step highlighted by the EQIA is to bring staff into the conversation about race and anti-racism through forums and networks.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Requirement to complete by December 2022

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There may be an impact on resources as further details of the interventions required to support the plan become clear.

4. RECOMMENDATION

The Board is asked to **APPROVE** the Anti-Racist Wales Trust Action Plan.

Appendix 1

Velindre University NHS Trust

Anti-Racist Trust Action Plan 2022-23

Aim

This plan aims to create an organisational culture in which all members of staff are able to enjoy working free from discrimination and where ethnic background is a source of strength, not a barrier. The plan aims to ensure that anyone who interacts with our blood or cancer services can be confident that they will be treated without any form of discrimination related to their race or ethnic background. It also aims to reduce differential outcomes for patients relating to their ethnic group and to ensure a wide cross-section of ethnic groups are actively engaged in being blood and bone marrow donors.

Ref	National Actions	Date	Trust Actions
1	Trust Chair's objective to be set in support of this anti-racism work, to be discussed by relevant stakeholder groups and agreed by Ministers or Welsh Government Senior officials.	September 2023	• Share the Chair's objectives with all Board members to highlight Anti-racism commitments
2	Trust to develop anti-racism action plans; for both employment and service delivery as a specific part of their wider approach to equality, inclusion and diversity.	December 2022 December 2022 March 2023 March 2023 December 2022 and ongoing	• Map Anti-racist goals against the goals of the Strategic Equality Plan and set out how the two work together • Include Anti-racism within the IMTP process using the Equality Impact Assessment. • Consult with staff, patients and donors to test what their experience is and what needs to change • Establish a current baseline set of data relating to staff, patients and donors in respect of race. Compare this data with local demographic data relating to racial diversity. • Develop, implement and monitor the plan through the Healthy and Engaged Steering Group.

3	All NHS Board members will begin anti-racist development in 2022 and undertake an anti-racist education programme	Summer 2023 December 2023	• Deliver Board Development awareness session on importance of cultural competence • Deliver Board development programme during 2023 commissioned by Public Bodies Unit, WG
4	All NHS Board members will have and report progress against personal objectives to meet vision of an anti-racist Wales.	December 2022 December 2022 and ongoing December 2023	• Establish personal objective in support of Anti-racist Wales for each Board member • Board members will role model anti-racist practices by challenging discrimination, listening to lived experiences and considering racial perspectives when making decisions. • Anti-racist objectives to be cascaded through every level of the organisation and made relevant to each job role.
5	Staff, volunteers and students to complete redesigned anti-racist education programmes to bring enhanced awareness of race, racism, micro behaviours, microagressions at all levels of the organisation.	December 2023 June 2023 June 2023 June 2023	• Implement programme when available • Embed anti-racism into management and leadership development activities • Offer coaching to support leaders implement and enhance practice in supporting their Black, Asian and racially minoritised colleagues • Embed anti-racism into staff induction by developing a welcome programme of activities for staff joining the organisation via international recruitment activities. This may involve establishing a buddying / support network for staff and drawing on experience of other Health organisations who have established such an approach.

6	Appointing 'Executive Equality Champions' and 'Cultural Ambassadors	September 2023 September 2023	• Build on existing role of Executive Equality Ambassador • Develop Cultural Ambassador role once role profile is available
7	Implementing a leadership and progression pipeline plan for Black, Asian and Minority Ethnic staff	September 2023 September 2023	• Establish a pipeline for Black, Asian and Minority Ethnic staff as part of Trust talent management approach • Review promotion and development process to ensure there is no bias or bias is mitigated
8	Review People policies to ensure they fully support all employees	December 2023 December 2023 December 2023	• Support All Wales programme of review of national policies • Review Trust level policies through active use of an Equality Impact Assessment for each policy • Examine all Trust recruitment processes through an anti-racist lens
9	Implement an anti-racist communication plan and create forums for Black, Asian and Minority Ethnic staff to communicate their experiences and ideas. Providing Ethnic Minority Networks appropriate levels of resource and access to the Board.	September 2023 September 2023	• Re-Establish Black and Ethnic Minority staff group. Terms of Reference to set out how they have access to the Board and that they are a resource for consultation and communication. • Standardise the consideration of staff, patient and donor stories setting out the lived experience of people from different racial backgrounds.
10	Improve workforce data quality and introduce a Workforce Race Equality Standard (WRES)	September 2023 September 2023 September 2023 September 2023	• Request all staff to update their demographic information on ESR • Work with NHS colleagues in adopting the WRES, ensuring ESR is able to produce the reports • Use WRES to understand the experience of ethnic minority staff in relation to pay and treatment • Ensure monitoring is in place and includes Leavers, Promotions, Training Opportunities, Grievances, Complaints, recruitment applications v shortlisted v successful and staff engagement surveys

11	Implement systemic monitoring of concerns of workforce discrimination and bullying raised by staff through the Joint Executive Team process. Review and scrutinise reporting processes for reporting racism, discrimination, inappropriate behaviours.	December 2023 December 2023 December 2022 and ongoing December 2023	• Capture and include discrimination and bullying data within Workforce Reports. • Develop clear robust processes and provide sufficient channels for staff to record and report racial discrimination and for the Trust to take action • Issue regular communications regarding zero tolerance of inappropriate behaviour • Work with Trades Unions to find ways for lower paid workers from ethnic minorities to raise concerns such as Speak Up initiatives, surveys and networks. Monitor uptake and remove barriers to access.
12	Ensure our COVID-19 recovery plans are fully inclusive and targeted to address known health inequalities in access to care and service provision.	September 2023	• Apply Equality Impact Assessment to COVID 19 recovery plans and link to known health inequalities.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

BUSINESS CASE FOR REPLACEMENT LABORATORY INFORMATION MANAGEMENT SYSTEM (LIMS) FOR THE WELSH HISTOCOMPATIBILITY & IMMUNOGENETICS SERVICE (WHAIS)

DATE OF MEETING	24/11/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Felicity May, Clinical Specialist H&I Digital Lead David Mason-Hawes, Head of Digital Delivery
PRESENTED BY	Alan Prosser, Director of Welsh Blood
EXECUTIVE SPONSOR APPROVED	Alan Prosser, Director of Welsh Blood

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS Laboratories Digital Transformation Board	14/06/2022	IN SUPPORT
WBS Senior Management Team	13/07/2022 10/08/2022	IN SUPPORT
Executive Management Board	03/10/2022	ENDORSED
Strategic Development Committee	13/10/2022	ENDOSED FOR BOARD APPROVAL
Trust Board	24/11/2022	

ACRONYMS	
H&I	Histocompatibility and Immunogenetics
LIMS	Laboratory Information Management System
LINC	Laboratory Information Network Cymru
WHAIS	Welsh Histocompatibility and Immunogenetics Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WBMDR	Welsh Bone Marrow Donor Registry

1. SITUATION/BACKGROUND

1.1 The purpose of this business case is to seek approval to procure a replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics (H&I) Service (WHAIS).

1.2 WHAIS is part of the Welsh Transplantation and Immunogenetics Laboratory (WTAIL) and provides laboratory results and clinical advice to support kidney, pancreas and stem cell transplantation, selected platelet transfusion and some genetic disease diagnosis.

1.3 The current WHAIS IT system was developed in-house in the early 90s. The system has therefore been in operational use for around 30 years, is no longer fit for purpose and confers a significant risk to the organisation (see quality / safety implications below). This is reflected on the Divisional and Trust risk registers.

1.4 A previous project to replace WHAIS LIMS (LIMS1) was unsuccessful due to a failure of the company to meet the specified requirements. However, there are key differences between LIMS1 and this proposal:

1.4.1 LIMS1 sought a solution for all WTAIL (which includes the WBMDR). This case seeks only a solution for WHAIS, recognising the different requirements for each system and how that points to different IT solutions for each area.

1.4.2 H&I requirements are not supported by the majority of standard LIMS. 10 years ago there were no viable commercial options available on the market so the only option for LIMS1 was to develop a system with the supplier. There are now off-the-shelf commercial systems specifically designed for H&I laboratories.

1.4.3 WHAIS issued a Prior Information Notice to the marketplace and saw demonstrations of at least 5 solutions deemed to be suitable. WHAIS intends to tender for the most appropriate system and adapt our workflows around it rather than extensively develop a system around us.

1.5 Due to the commercially sensitive nature of the information captured within the complete 5-model business case the Trust Board are asked to **APPROVE** the Strategic Case, attached as Appendix 1.

1.6 All other cases, including full details of all projected financial costs etc., are included in the complete 5-model business case.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 We seek support for this business case to progress to Trust Board for final approval.

2.2 Although the WHAIS system was 'decoupled' from the national procurement of the all-Wales LINC solution, the entirety of the WTAIL IT / LIMS requirements remained in scope of the LINC programme. It is recognised within the scoping documents of LINC that the delivery of WTAIL (including WHAIS) IT requirements would be delivered via a separate procurement to the national (pathology) "core" LIMS.

2.3 The intention is to seek financial support from Welsh Government via the LINC programme for the stated staffing, implementation and contract costs.

2.4 The attached document – Appendix 1 – sets out the Strategic Case section from the complete 5-model business case for the review of the Trust Board.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	• Existing system is built on obsolete/unsupported technology which puts our patient data at increasing risk in terms of stability and security. • WBS only has a single member of staff in the Digital Services team who has the appropriate programming expertise to deal with the system. • The system has had very little development and poorly supports WHAIS operations and requires multiple manual workarounds. • Limitations of the IT system leading to incidents/risk of error with the potential to impact patient care. Only extensive manual checks and staff diligence are currently mitigating this risk. • The limitations of the IT system were attributed to at least three findings in the most recent UKAS (ISO 15189) inspection and the recommendation was to implement a new LIMS
RELATED HEALTHCARE STANDARD	Effective Care
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	See Appendix 1 – Business Justification Case

4. RECOMMENDATION

4.1 The Trust Board are asked to **APPROVE** the Strategic Case, attached as Appendix 1, for the procurement and implementation of a commercial “off-the-shelf” H&I-specific LIMS solution for the WTAIL WHAIS laboratory in the Welsh Blood Service.

Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS)

SINGLE-STAGE BUSINESS CASE - MEDIUM VALUE AND RISK

SRO:	**Alan Prosser – Director, WBS**
Project Manager:	**Jon Norman – Portfolio Project Manager**
Organisation:	**Welsh Blood Service, Velindre University NHS Trust**

	Name	Signature	Date
Prepared by:	Felicity May Clinical Specialist H&I Digital Lead, WBS		15/07/2022
Reviewed by:	Deborah Prichard WTAIL Laboratory Services Manager, WBS		26/08/2022
	David Mason-Hawes Head of Digital Delivery, VUNHST		26/08/2022
Approved by:	Welsh Blood Service Senior Management Team	n/a	13/07/2022 10/08/2022
	VUNHST Executive Management Board	n/a	03/10/2022
	Strategic Development Committee	n/a	13/10/2022
	VUNHST Board		

Contents

Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS)

1. INTRODUCTION

The purpose of this business case is to seek approval to procure a replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics (H&I) Service (WHAIS).

This proposal is a strategic priority for the Welsh Blood Service and Velindre University NHS Trust.

WHAIS requires replacement of its existing 'end of life' legacy IT applications / infrastructure to enable the laboratory to modernise its services and improve quality and efficiency.

The national all-Wales WLIMS project (LIMS1) aimed to deliver a replacement LIMS for WHAIS. However, the intended system failed to meet the specialist H&I requirements. Therefore, the legacy IT systems continue their operational use and represent a critical risk for the Service, requiring urgent replacement.

Procurement and implementation of a commercial "off-the-shelf" H&I-specific LIMS solution is the recommended option of this proposal to enable the laboratory to continue to modernise its workflows and comply with data security requirements and quality standards.

IMPORTANT:

This version of the business case sets out the strategic case only. The complete 5-model business justification case is available separately on request.

2. STRATEGIC CASE

2.1 Context

2.1.1 Operational Context of the Welsh Histocompatibility and Immunogenetics Service

The Welsh Blood Service (WBS) is a division of Velindre University NHS Trust (VUNHST) which operates national services supporting the whole population of Wales. WBS is responsible for a range of essential and highly specialised services, including the collection and distribution of blood products and support of national and international transplantation programmes through its Welsh Transplantation and Immunogenetics Laboratory (WTAIL) services.

WTAIL operates the Welsh Histocompatibility and Immunogenetics Service (WHAIS), which provides scientific advice, results and expertise for a range of NHS Wales organisations, including hospitals, transfusion centres and General Practitioners. The services provided by WHAIS include patient/donor compatibility testing for solid organ and stem cell transplantation, testing for genetic disease markers, investigation of transfusion reactions and selected platelet transfusion support. As such, it has a critical role in supporting the matching of solid organ and stem cell donors to Welsh, UK and international patients. WHAIS is the only Histocompatibility & Immunogenetics (H&I) laboratory in Wales.

WHAIS currently manages its services using a bespoke IT platform developed in-house, which has been in operational use for approximately 30 years. This platform – in effect, a series of bespoke, integrated applications – is built on 'end of life' (unsupported) technology and needs to be replaced, to ensure the WHAIS service can continue to meet changing customer and regulatory demands and to ensure appropriate IT and information security of the data it uses to run its day-to-day operations.

2.1.2 Policy Environment

Digital transformation in healthcare is essential for improving access to patient data, reducing errors and improving patient outcomes. The new VUNHST strategy – "Destination 2032" – was developed in recognition of the continuing challenges faced across the health and care system, including the need to adapt services for an aging population and technological innovations. The VUNHST Digital Strategy includes the objective to empower staff to have access to high quality information, equipment and technology to deliver high quality and safe services and maintain resilient hardware and software across the organisation – a central tenet of the "Ensuring Our Foundations" pillar of the strategy.

Replacement of the IT systems in WHAIS with a modern, supported platform is crucial for WHAIS to continue to deliver and modernise its services, meet user needs and align with the Future Wellbeing and Generations Act 2015, A Healthier Wales) and the Welsh Government Digital Strategy.

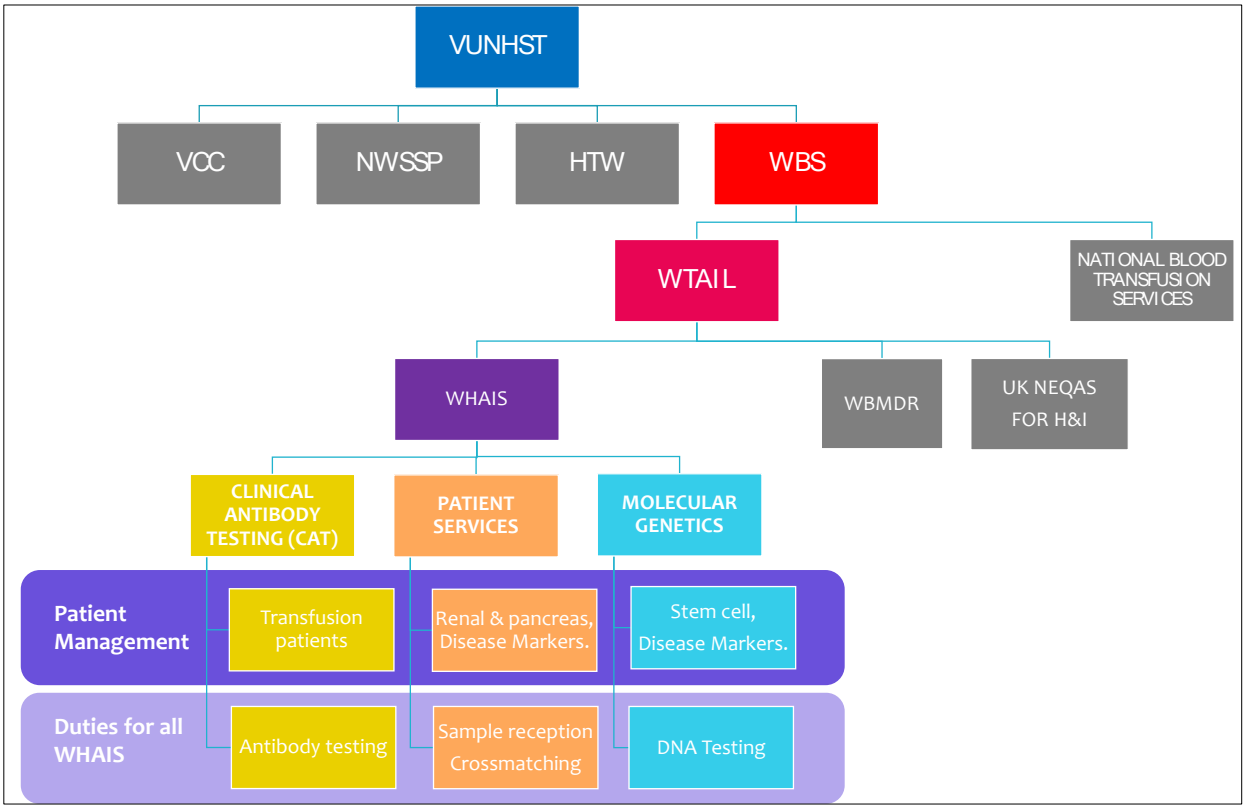


Figure 1: Chart showing the organisational context and duties of the Welsh Histocompatibility and Immunogenetics Service (WHAIS).

Velindre University NHS Trust (VUNHST) operates national (all Wales) services including Velindre Cancer Centre (VCC), NHS Wales Shared Services Partnership (NWSSP), Health Technology Wales (HTW) and the Welsh Blood Service (WBS).

WTAIL is a department of WBS which operates national and international services including the Welsh Bone Marrow Donor Registry (WBMDR), the United Kingdom National External Quality Assessment Service for Histocompatibility and Immunogenetics (UK NEQAS for H&I) and the Welsh Histocompatibility and Immunogenetics Service (WHAIS).

WHAIS is divided into three main laboratory sections: Clinical Antibody Testing, Patient Services and Molecular Genetics. Each section is responsible for management of a distinct group of patients (i.e. platelet transfusion patients, renal and pancreas transplant patients, stem cells transplant patients and patients requiring disease marker testing) and distinct types of H&I testing on behalf of other sections (e.g. a renal transplant patient requires antibody testing, crossmatching and DNA testing, however the Patient Services department is responsible for arranging the testing from each section and reporting the results). Therefore, exchange of information and samples between WHAIS sections is frequent and crucial.

The proposed investment also supports the following Welsh Blood Service Integrated Medium Term Plan (IMTP) objectives:

- Strategic Priority 1: Outstanding for quality, safety and experience
- Strategic Priority 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations
- Strategic Priority 3: A beacon for research, development and innovation in our stated areas of priority
- Strategic Priority 5: A sustainable organisation that plays a part in creating a better future for people across the globe

2.1.3 Laboratory Information Management Systems

A laboratory information management system (LIMS) is software designed to support laboratory operations, including sample registration, workflow management, analysis and reporting of results. A standard LIMS operates on the premise of a sample being received, tested, analysed and reported in a linear process (i.e. sample → test → report). However, histocompatibility and immunogenetics (H&I) laboratories are distinct from many other specialities in terms of workflows and LIMS requirements:

- H&I laboratories perform testing on donor, as well as patient, samples and must be able to 'link' associated patient/donor records in order to assess compatibility.
- H&I patients require a repertoire of tests combined and interpreted within a single report.
- H&I laboratories receive multiple samples from the same patient, often over the course of several years, while awaiting a suitable donor to be identified. This requires the software to associate multiple sample test requests with a single patient.
- H&I laboratories are frequently required to access and report historic test results. Therefore, migration of historical data from the legacy IT system to the new LIMS is critical.

The original Wales LIMS project (LIMS1, commencing in 2004) aimed to deliver a LIMS for all clinical laboratories in Wales. The user requirement specification (URS) for WTAIL (encompassing both WHAIS and the Welsh Bone Marrow Donor Registry (WBMDR)) was finalised in 2011. However, due to the specialist nature of H&I services, the company awarded the national LIMS contract was unable to deliver an H&I system, and sub-contracted the work to a 3rd party, who developed two systems – one to support WHAIS and the other to replace an element of the WBMDR external communication system.

Work is ongoing to deploy the application that was procured for the WBMDR as part of the contract, with plans being revised to go-live in 2022. However, the application does not cover all aspects of WBMDR requirements and the system intended for WHAIS required a significant amount of development to satisfy the URS which, after 6 years of working with the company, failed to deliver a system that met the requirements of the service. Therefore in 2020, the decision was made to not proceed with implementation of the WHAIS system, and the WHAIS solution was de-scoped from the national LIMS

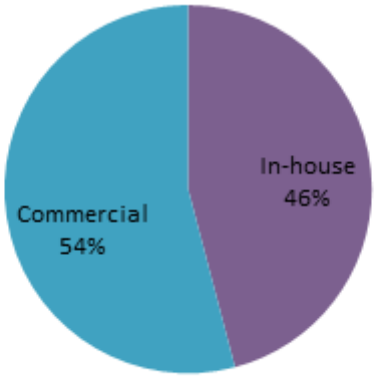
contract (owned by Digital Health & Care Wales). A lessons learnt exercise was completed to identify how a new project may be organised/resourced following the failed implementation.

2.2 Case for Change

The national Laboratory Information Network Cymru (LINC) programme commenced in 2019, with the remit to take forward the procurement of an all-Wales LIMS solution from 2025 onwards. Whilst WBMDR / WHAIS systems are in the scope of the LINC programme, due to lessons learned from the original LIMS1 procurement, any re-procurement activity associated with either service was de-coupled from the 'core LIMS' procurement. This allowed the WTAIL to assess the ongoing feasibility of its WTAIL (WBMDR and WHAIS) implementations, to inform how any further procurement activity could be undertaken as part of LINC.

At the time of the awarding of the LIMS1 contract a market assessment failed to identify any viable commercially available IT systems that would meet the requirements of WTAIL. However, in the 10 years since several H&I-specific LIMS solutions have emerged onto the market and have been successfully implemented in national and international H&I laboratories. A survey issued to H&I laboratories by UK NEQAS for H&I, an international external quality assessment service operated by WTAIL, requested information on their LIMS (Figure 2). 74 laboratories responded, identifying a total of 23 potential commercial LIMS solutions.

Figure 2: Response to the UK NEQAS for H&I Survey question: What Laboratory Information Management System (LIMS) do you currently use? (n=74 responding UK and international H&I laboratories))

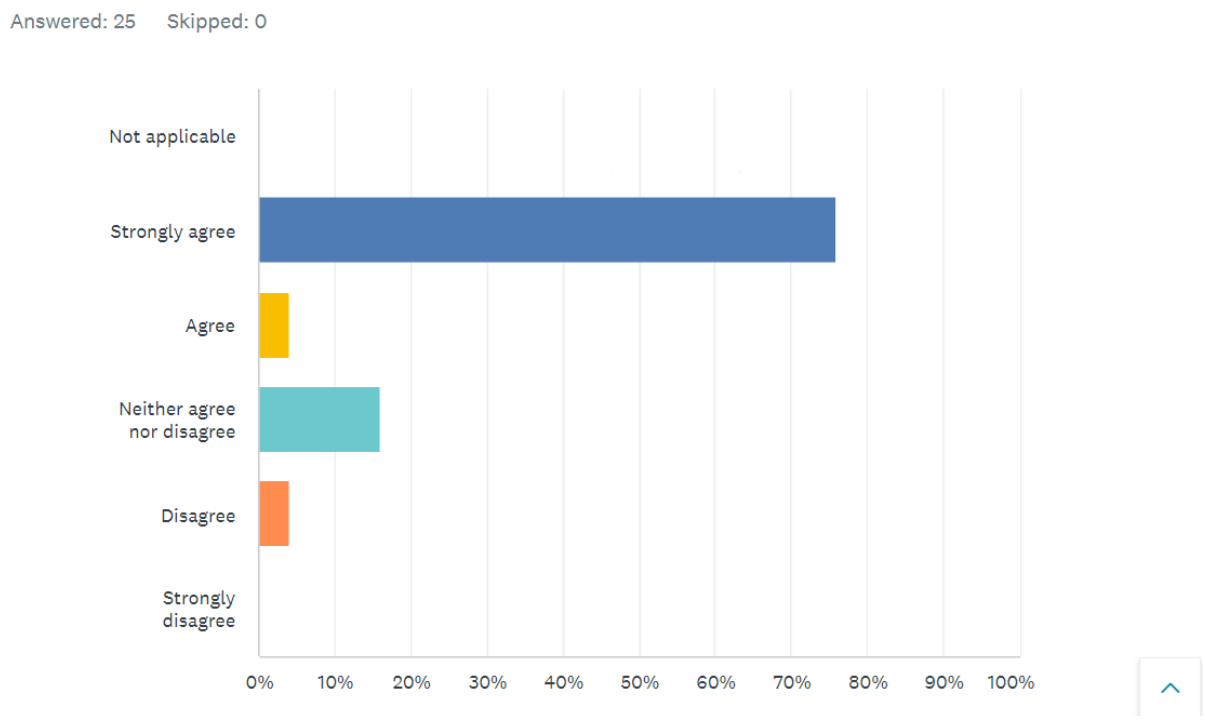


The approach for WBMDR and WHAIS have been separated because WBMDR has specific IT system requirements that are not currently available on the market. This business case seeks to confirm the approach for WHAIS and seeks support – via LINC – for the associated costs of that implementation. The procurement of a WBMDR solution is outside the scope of this case and will be sought separately. However, an interface between the WHAIS and WBMDR solutions will be required to enable transfer of information between the two systems.

In December 2021, WBS created a dedicated project group (the WHAISIT Project Group) to support the procurement and implementation of a WHAIS replacement LIMS. The group supported the publication of a Prior Information Notice in February 2022 and arranged demonstrations with eight responding suppliers. It was evident from the demonstrations that a commercial "off-the-shelf" H&I-specific LIMS was now a viable option for WHAIS.

In January 2022, a stakeholder survey was circulated by the WHAISIT project group to gauge attitudes of WHAIS staff to plans for introduction of a replacement LIMS. The survey results were discussed with staff in a follow-up workshop session. 73.5% (n=25/34) of staff completed the survey, generating useful insights that have informed this business case. For example, "reduction in workarounds", "improved efficiency of working practices" and "reduction in manual transcription and checks" received the highest number of votes as potential benefits of a new LIMS. The vast majority of staff (80%, n=20) support the need for a replacement LIMS (Figure 3).

Figure 3: Response to the WHAISIT Project survey question: "I fully support the requirement for a new LIMS in WHAIS" from n=25 responding WHAIS staff.



2.2.1 Existing Arrangements

WHAIS operates a legacy IT system developed in-house in the 1990s by a dedicated team of WBS IT developers. The system is comprised of multiple applications maintained in-house by WBS-based Application Services staff. As such, there are no associated contract, licencing or maintenance costs. The software was written in a language called Visual Fox Pro (VFP). The last iteration of VFP was released in

2004 (version 9) and received its final update in 2007. Microsoft officially ceased supporting VFP in 2015 meaning that no further support, such as software patches and security updates will be supplied for the software and Microsoft relinquishes all responsibility for any issues / incidents that are associated with the VFP platform.

During the LIMS1 project, development of the legacy WHAIS IT systems was mostly placed on hold, with only urgent fixes to the system being actioned. This has resulted in a system that reflects WHAIS tests and processes from over 14 years ago that is poorly suited to the services' evolving complexity and current changing customer demands. As a result, multiple workarounds (e.g. spreadsheets, paper forms) have gradually been incorporated into routine use to track testing and record data where the legacy system is unable to digitally support local operational workflows.

The following WHAIS activities are supported by the legacy IT system:

- Sample Registration *(approximately 5,000 samples registered p.a.)*
- Patient/donor DNA testing *(approximately 1,000 tests p.a.)*
- Patient/donor antibody testing *(approximately 4,000 tests p.a.)*
- Genetic disease marker testing *(approximately 2,500 tests p.a.)*
- Patient/donor crossmatch testing *(approximately 500 crossmatch tests p.a.)*
- Sample filing/inventory
- Reagent tracking (logging of a reagent lot number against a specific test result)

The legacy system also supports management of following services:

- Specialist platelet/transfusion support patients *(approximately 100 patients per year)*
- Haemopoietic Stem Cell Transplant management *(management of approximately 30 'active' patient cases at any one time, total of approximately 150 patient cases per year)*
- Potential kidney and pancreas transplantation management *(management of a waiting list of approximately 300 patients, support for approximately 100 transplants per year)*

The following aspects of WHAIS Services have significantly changed following the initial development of the legacy IT system:

- Antibody testing

    - Antibody testing is an H&I lab test that has increased in complexity since the legacy system was developed.
    - In the 1990s, WHAIS used simplistic in-house methods to perform antibody testing and interpretation of results was a predominantly manual process, recorded on paper forms.
    - WHAIS has now discontinued in-house antibody testing and uses a technology called 'Luminex' with commercial assays and associated software.

- There are no interfaces between commercial analysis software and the legacy IT system. Therefore, the results need to be printed off and manually entered into the legacy IT system by WHAIS staff, requiring either double entry or verification by a 2nd scientist to ensure quality of results.
- The legacy IT system is not able to capture all the clinically relevant information that the Luminex test generates. Therefore, WHAIS staff frequently need to refer back to the original test results on paper/PDF records in order to view all the relevant information.

- DNA testing

  - As per antibody testing, DNA testing has also increased in complexity since the legacy system was developed.
  - In the 1990s there were ~500 known H&I 'types' (genetic variants) and WHAIS used simplistic in-house methods to perform DNA testing and manual interpretation of results on paper forms.
  - There are now over 30,000 known H&I types, and new variants continue to be discovered by the H&I community on a daily basis.
  - WHAIS has now discontinued all in-house DNA testing and uses a repertoire of commercial DNA testing methodologies with associated analysis software (Next Generation Sequencing, Realtime PCR and Luminex).
  - There are no interfaces between the analysis software and the legacy IT system. Therefore, all DNA test results need to be printed from the analysis software and manually entered into the legacy IT system by WHAIS staff, requiring either double entry or verification by a 2nd scientist to ensure quality of results.
  - The legacy IT system is poorly suited to the frequent discovery of new genetic variants. A written request must be submitted to the Application Services department each time a novel result is identified for a sample, to enable data entry into the legacy system.

- Patient/donor crossmatching

  - Crossmatching is an established assay used to determine patient and donor compatibility, using various methodologies.
  - During the LIMS1 project, WHAIS used two methodologies for crossmatching, flow cytometry and CDC, the latter of which was in declining use in H&I labs and would have required a significant amount of development work from most LIMS suppliers to accommodate it.
  - WHAIS discontinued all CDC testing in 2021 and now uses a combination of flow cytometry and a paper-based methodology known as 'virtual' crossmatching, both of which are in common use by other H&I labs and supported by existing LIMS.

- Workflow management

    - The legacy system was designed to support simplistic workflows and predominantly manual/in-house testing.
    - All new samples are booked into on the legacy system by manually entering the details from paper request forms onto the legacy IT system. However, there is limited functionality for the system to track testing and generate worklists for the analysers. There is some limited functionality to generate audit lists of samples requiring testing. However, these lists do not capture all the required details and WHAIS staff are required to hand-write worklists onto paper forms.
    - The legacy system has some basic functionality to support 'reflex' testing (e.g it is able to generate an audit list for antibody reflex testing on the basis of a positive screening result). However, this functionality is limited and does not cover all WHAIS requirements. WHAIS staff use manual processes (white boards, spreadsheets and paper forms) to ensure the right samples receive the right tests and arrange any required reflex testing.
    - There are no interfaces between the legacy IT system and the analysers, therefore all patient worklists must be manually typed into the analyser software for each test run.

- Reporting

    - Some basic reports can be automatically generated by the IT system (e.g. genetic marker testing). However, the vast majority of H&I reports have increased in complexity and can no longer be supported by the legacy system. These reports need to be manually typed on a Microsoft Word document using version-controlled templates designed by WHAIS staff.
    - Manually generated reports require manual transcription of patient information and complex clinical data, which then needs to be carefully verified by another scientist to ensure patient safety.

- Patient Management

    - Certain information (for example clinical notes, email communications, results from certain H&I tests) cannot be recorded in the system. This information needs to be kept on paper copies, in patient files or in Excel spreadsheets (see Figure 4).
    - There is limited functionality for users to query/extract data from the system (e.g. for monitoring of key performance indicators, clinical audit or RD&I activities). Therefore, manual workarounds or IT helpdesk requests are generally required.

Figure 4: (LEFT) the 152 files required to store paper-based results for just one H&I lab test (Luminex antibody testing), for 'active' patients waiting for a kidney/pancreas transplant. (RIGHT) The patient files used to store results, reports, correspondence etc. that cannot be stored in the legacy IT system.

2.2.2 Business Needs

The legacy IT system is not user friendly when compared to the standards of most modern-day digital applications. It does not hold all required information and there is limited interoperability between applications. This has resulted in time consuming and non-streamlined workflows where multiple programmes and manual steps are required to complete a single task. Furthermore, searching through different applications, patient files and paper copies of results to find crucial information is time consuming and frustrating for staff and service users who may be waiting for answers to queries. A replacement LIMS would improve accessibility of information, enable storage of all relevant information including notes, communications and attachments, streamlining accessibility of data and eliminating requirement for storage of information in paper records or spreadsheets.

The legacy systems are slow to open and run operations, wasting staff time. This is compounded by the number of different applications, and the frequent requirement to access multiple applications for a single task. Furthermore, some WTAIL systems cannot be accessed at the same time, causing further delays for staff waiting for systems to become available. The applications have known errors/bugs, have had limited development since their initial creation. Microsoft no longer supports VFP and, as such, the programming expertise is becoming extinct. Only one current member of the WBS Digital Services team has the appropriate level of expertise in VFP programming to address application development and troubleshooting. Implementation of a commercial LIMS would mean that support and maintenance of the software would be handled by a 3rd party.

There are many examples where the legacy system does not support effective service delivery or has not kept pace with the scientific, technical and clinical developments in H&I/transplantation. In response, WHAIS have been forced to implement manual, time-consuming workarounds to support the shortfall (e.g. spreadsheets, manual checks, paper forms described in section 2.2.2). A replacement LIMS would provide comprehensive sample tracking and automated generation of worklists, reducing the requirement for manual workarounds. Furthermore, a commercial LIMS solution would be regularly updated and upgraded by the supplier in line with WHAIS requirement and those of national and international H&I laboratory clients.

The legacy IT system cannot support upstream and downstream interfacing. The reliance on manual transcription and transfer of information have introduced risks of error. This risk is currently mitigated by staff diligence and built-in resilience steps to detect failures in manual workarounds (e.g. verification steps, checklists etc.). However, the additional checks are resource heavy and time consuming (but generally efficient as they detect errors prior to result release). A replacement LIMS would support interfaces, reduce reliance on manual transcription of information.

An interface between the WHAIS IT system and the Welsh Clinical Portal (WCP) has been requested on several occasions by service users but cannot be achieved with the legacy system. As WHAIS are unable to report results to the WCP, this results in service users being unable to locate paper-based copies of clinical reports. This leads to increased workload for WHAIS staff to answer queries/re-send reports or

deal with unnecessary repeat requests. For example, in 2019-20 repeat sample requests for one of our H&I tests (HLA-B27, a genetic test for which the result does not alter and repeat testing offers no clinical benefit) found that 235 (7%) of samples were repeat requests. Although the samples were not retested, there is a waste of resource for the patient, requester and the H&I lab with samples being taken, and letters sent to the requester with a copy of the original report. A replacement LIMS would enable development of an interface with WCP, which would enable test results to be available to GP practices/hospitals.

The pandemic hastened a rise in remote working, which has continued in WHAIS due to the significant benefits for staff and the organisation. Although remote access to the legacy WTAIL IT System is possible, the functionality and reliability is limited due to the capability of the aging systems and reliance on manual workarounds. Furthermore, there is a potential cyber risk using current methods of access. A replacement LIMS would support delivery of a hybrid working model, enabling highly skilled individuals to work in a flexible and agile fashion with secure remote access.

WHAIS is a UKAS (United Kingdom Accreditation Service) accredited medical laboratory (ISO 15189:2012). The limitations of the legacy IT system were attributed to at least three findings in the most recent UKAS inspection (20/07/2021), notably in the following finding: (220592-03-01-E01629-005) *"The laboratory LIMS is outdated and does not fully meet the needs of the clinical service; the existing systems in use require a significant amount of manual transcription, double entry checking & the use of multiple different Excel worksheets and paper records. The laboratory may wish to consider prioritising obtaining funding for and implementation of a more comprehensive LIMS system better suited to their clinical requirements; this would help to reduce manual transcription & thereby reduce the potential for error*.". Failure to act on this recommendation risks the service losing its accreditation and, consequently, its reputation and the confidence of its service users.

Where we are now	**Where we want to be**
Use of legacy systems which no longer meet the requirements of H&I services.	Use of a modern, commercially supported LIMS that meets the requirements of H&I services.
Increasing reliance of manual workarounds to compensate for deficiencies in IT systems.	A comprehensive LIMS that covers a broad range of WHAIS activities, automates processes and reduces or eliminates the need for workarounds.
Complete reliance on manual transcriptions or test results (absence of any interfaces with laboratory analysers).	Interfaces between the LIMS and relevant analysers and software to enable automated transfer of information and minimise reliance of manual transcription.
Lack of resilience within WBS Digital Systems team in respect of staff with the required VFP expertise to develop existing WTAIL IT systems (single point of failure). Difficulty sourcing expertise for 'end of life' (unsupported) VFP technology due to rarity of resource and high associated costs.	A commercial LIMS based on a supported platform, maintained by a third-party supplier with appropriate staffing and business continuity measures. No requirement for VFP expertise once legacy data has been migrated.

Unable to meet external service specifications and interfaces which impacts on our service provision (e.g. WCP interface).	Use of a modern, commercially supported LIMS that enables interfacing, is regularly updates/upgraded and is flexible to future needs of the service.
Unable to query/extract data which severely limits support for evidenced based decision making/business intelligence.	Use of a modern commercial LIMS with in-built functionality for data mining and generation of statistics.
Ability to improve processes and introduce new laboratory tests is severely limited due to constraints of IT system and limited capacity to support existing number of manual workaround processes in place.	Use of a modern, commercially supported LIMS that is flexible to current and future needs of the service.

2.2.3 Main Benefits

Benefit ID	Benefit Type	Benefit	Beneficiary
B001	Efficiency (Time Saving)	Simplified workflows, faster retrieval of information.	Organisation, Service Users, Patients
B002	Efficiency (Time Saving)	Release of staff time to focus on value-added tasks.	Organisation, Service Users, Patients
B003	Performance Improvement	Increased productivity through improvement of workflows (transfer of data from analysis software, production of reports etc.) and elimination of wasteful steps (duplication, manual transcription etc.)	Organisation, Service Users, Patients
B004	Performance Improvement	Ability to be responsive to future changes to the regulatory and scientific environment in which WHAIS operates	Organisation, Service Users, Patients
B005	Quality & Safety	Improved traceability of samples and workflows	Organisation, Service Users, Patients
B006	Quality & Safety	Reduced error due to automation of processes	Organisation, Service Users, Patients
B007	Donor / Hospital Experience	Greater capacity to meet service user	Organisation, Service Users, Patients

		needs/requests (electronic reporting, generating bespoke reports for complex patients etc.)	
B008	Donor / Hospital Experience	Reduced turnaround times	Organisation, Service Users, Patients
B009	Donor / Hospital Experience	Improved patient experience as clinicians will have access to most up to date information.	Service Users, Patients
B010	Human Resources	Improvement in staff morale and retention	Organisation

2.2.4 Main Risks

Risk ID	Risks	Countermeasures
R001	WBS staff resource for procurement and implementation of the replacement LIMS due to demands on time and priorities of other work	Creation of the WHAISIT Project team including a dedicated Subject Matter Expert (SME) Lead (Clinical Specialist H&I Digital Lead) and Validation Lead, each appointed for a 2 year secondment.
R002	Only one member of staff in Digital Systems with Visual Fox Pro (VFP) programming expertise	Recruitment of additional Digital Services resources to support planning and implementation of a new LIMS: a Business Systems Analyst and an Integration Specialist.
R003	Loss of legacy data or inability to successfully migrate/access data due to data being stored in outdated legacy systems	Migration of legacy data will be a critical aspect of the User Requirement Specification and will be carefully tested and validated.
R004	Failure to identify a suitable LIMS solution, or delays to implementation due to extensive software development, and the impact this will have on WHAIS, service users and patients.	WHAIS has made changes to its services making it better suited to a commercial LIMS (e.g. discontinuing CDC). Research into existing H&I-specific LIMS systems (via supplier demonstrations and engagement with other UK H&I labs) indicates that suitable solutions are available. A new URS is planned, which will be appropriate to current supplier capabilities with an expectation that WHAIS

		will adapt workflows to accommodate an existing solution to minimise requirements for software development.
R005	Service downtime/disruption during implementation and the downstream impact on service users/patients.	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. A Service Level Agreement with LIMS supplier will be implemented to ensure appropriate support and system availability.
R006	Failure to secure funding.	Explore funding options via LINC, Welsh Government and/or internal funding opportunities (e.g. Trust discretionary or a combination of sources). If all funding sources are exhausted, this will relate to the suspension of project and a failure to address the issues with the existing systems as described above.

2.2.5 Constraints

Resources:	• Availability of WHAISIT project group members and other relevant WBS staff and their ability to have allocated time to complete required work. • Supply chain issues in respect of provision of required IT infrastructure may impact on delivery timelines. This is likely to be mitigated should a cloud option be selected. • Supplier capacity to support proposed WBS implementation timelines; however, none of the suppliers engaged as part of the initial supplier engagement days flagged this as a concern.
Budget:	• Ability to secure appropriate funding.
Timescales:	• 2-year contracts for dedicated members of the WHAISIT project group, expiring 2023 Q4 (Validation Lead and Clinical Specialist Histocompatibility & Immunogenetics Digital Lead).

2.2.6 Dependencies

The investment proposal is dependent on successful delivery of the following:

Project Name	Details	Start Date	End Date
Laboratory Information Network Cymru (LINC)	Dependency on support of funding application to Welsh Government.	December 2017	March 2025
Welsh Bone Marrow Donor Registry (WBMDR) IT System	Dependency on interface between WBMDR and WHAIS IT solutions to enable transfer of data.	April 2023	March 2024

3. GLOSSARY

CSFs	Critical Success Factors
H&I	Histocompatibility & Immunogenetics
IMTP	Integrated Medium Term Plan
LDTB	Laboratories Digital Transformation Board.
LIMS	Laboratory Information Management System
LIMS1	National all-Wales (W)LIMS project
LINC	Laboratory Information Network Cymru
MHRA	Medicines and Healthcare products Regulatory Agency
PIN	Prior Information Notice
SME	Subject Matter Expert
UAT	User Acceptance Testing
UKAS	United Kingdom Accreditation Service
UK NEQAS	United Kingdom National External Quality Assessment Service
URS	User Requirements Specification
VFP	Visual Fox Pro
VUNHST	Velindre University NHS Trust
WBMDR	Welsh Bone Marrow Donor Registry
WBS	Welsh Blood Service
WHAIS	Welsh Histocompatibility & Immunogenetics Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory