Bundle Public Trust Board Meeting - Velindre University NHS Trust 26 May 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
Apologies received:
Martin Veale
Vicky Morris
Cath O'Brien MBE

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 10:05 - MATTERS ARISING

Led by Prof Donna Mead OBE, Chair

1.4.1 Action Log

Led by Prof Donna Mead OBE, Chair

1.4.1 PUBLIC TRUST BOARD ACTION LOGv2-LF.docx

2.0.0 CONSENT ITEMS

Led by Prof Donna Mead OBE, Chair

2.1.0 10:15 - For Approval

Led by Prof Donna Mead OBE, Chair

2.1.1 Minutes from the Public Trust Board meeting held on 31 March 2022

Led by Prof Donna Mead OBE, Chair

2.1.1 Minutes Public Trust Board 31.03.2022 Final Approved.docx

2.1.2 Commitment of Expenditure Exceeding Chief Executives Limit

Led by Matthew Bunce, Executive Director of Finance

2.1.2 May Trust Board Commitment of Expenditure Cover Paper.docx

2.1.2a Annex 1 Commitment of Expendature Fire Doors_.docx

2.1.2b Annex 2 Commitment of Expenditure Exceeding Chief Executive's Limit Compartmentation.docx

2.1.2c Annex 3 Laundry Detergent - Commitment of Expenditure Over Chief Exec Limit_Template and Guidance Final Draft (004).docx

2.2.0 10:25 - For Noting

Led by Prof Donna Mead OBE, Chair

2.2.1 Remuneration Committee Highlight Report

Led by Prof Donna Mead OBE, Chair

Draft Rem Comm Highlight Report - 28.04.2022 v1.docx

2.2.2 Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report - 4 May 2022

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

PUBLIC TCS Programme Scrutiny Committee Highlight Report 04-05-2022 v1-LF-SH.docx

2.2.3 Transforming Cancer Services Communication and Engagement Update

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

2.2.3 TCS Comms April 2022 - Trust Board.docx

2.2.4 Welsh Health Specialised Services Committee Joint Committee Briefing - 10 May 2022

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

2.2.4 WHSSC Joint Committee Briefing (Public) 10 May 2022.pdf

2.2.5 Shared Services Partnership Committee Assurance Report - 24 March 2022

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

2.2.5 SSPC Assurance Report 24 March 2022.doc

2.2.6 Policies Approval Report

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

2.2.6 Approved Policies Update - May 2022.docx

2.2.6a Appendix 1_ IPC07 MRSA Policy.docx

3.0.0 PRESENTATIONS AND GUEST ATTENDEES

Led by Prof Donna Mead OBE, Chair
Nil presentations

4.0.0 KEY REPORTS

4.1.0 10:35 - Chair's Update

Led by Prof Donna Mead OBE, Chair

4.1.0 Chair Update Report 26.5.22 - Final Approved.docx

4.2.0 10:40 - CEO's Update

Led by Steve Ham, Chief Executive

4.2.0 Chief Execs Update Report 26.05.2022 -Final2.docx

Attachment 1 - NHS Executive - NHS CEOs - english.pdf

5.0.0 10:45 - BREAK (10:50-11:00)

6.0.0 STRATEGIC DEVELOPMENT

6.1.0 10:55 - Trust Enabling Strategies for Approval

Led by Carl James Director of Strategic Transformation, Planning and Digital and Susan Thomas, Deputy Director of Organisational Development and Workforce

6.1.0 Trust Board strategy enablers approval 26 may 2022 FINAL VERSION (1) 19 may 2022 cj-TC-FINAL.docx

6.1.0a Sustainability Strategy v15 FINAL BOARD VERSION 19 MAY 2022.pdf

6.1.0b People Strategy final draft May 2022.pdf

6.1.0c Digital Strategy v0.9 17 May 2022 FINAL BOARD VERSION.pdf

6.1.0d Estates Strategy version 14 FINAL BOARD VERSION 19 MAY 2022.pdf

6.2.0 11:15 - Patient Engagement Strategy

Led by Non Gwilym, Assistant Director Communications and Engagement, supported by:
• Annamarie Jones, Business Support Manager
• Sarah Evans, Commercial Director, Cwmpas
• Hilary Jones, Independent Member
• David Cogan, Chairman Velindre Patient Liason Group

6.2.0 Trust Board Patient Engagement Cover paper FINAL 19.5.22- FINAL2.docx

6.2.0a DRAFT Patient Engagement Strategy TRUST BOARD May 2022 19.5.22.pdf

6.2.0b VELINDRE INFOGRAPHIC final 17.5.22.pdf

6.2.0c Trust Board Patient Engagement Presentation 24.5.22 FINAL.pptx

7.0.0 QUALITY, SAFETY & PERFORMANCE

7.1.0 11:25 - Quality, Safety & Performance Committee Highlight Report - 12 May 2022

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professions and Health Science

7.1.0 Public Quality Safety Performance Committee Highlight Report 12.5.22 (v5approved).docx

7.2.0 11:35 - Delivering Excellence Performance Report for the Period Ended March 2022

Led by Rachel Hennessy Acting Director Velindre Cancer Centre and Alan Prosser Director Welsh Blood Service

7.2.0 VUNHST MARCH PERFORMANCE COVER PAPER FOR MAY TRUST BOARD 12.5.22.docx

7.2.0 Appendix 1 - VCC Performance Report (March 2022) FINAL 3.5.22.docx

7.2.0 Appendix 2 - SMT March 2022 PMF.pdf

7.2.0 Appendix 3 - Trust-wide WOD Performance Report - Feb 2022.pdf

7.3.0 11:55 - Financial Report for the Period Ended March 2022

Led by Matthew Bunce, Executive Director of Finance

7.3.0 Month 12 Finance Report Cover Paper.docx

7.3.0a M12 VELINDRE NHS TRUST FINANCIAL POSITION TO MARCH 2022.docx

7.4.0 12:05 - Audit Committee Highlight Report - 3 May 2022 **to follow**

Led by Matthew Bunce, Executive Director of Finance

7.5.0 12:10 - VUNHST Risk Register

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

7.5.0 Trust Board Risk Paper April 2022- Public- FINAL.pdf

7.6.0 12:20 - Trust Assurance Framework

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

7.6.0 Trust Assurance Framework -Trust Board - 26.05.2022 -FINAL.docx

7.6.0a TAF DASHBOARD - 11.05.22 -LF.pdf

7.7.0 12:30 - Annual Equalities Report

Led by Susan Thomas, Deputy Director of Organisational Development and Workforce

7.7.0 Board Cover Paper Equality Monitoring Report 31.3.21.st updated.docx

7.7.0a VUNHST Equality Monitoring Report 31.3.21.st updated.docx

8.0.0 TRANSFORMING CANCER SERVICES

8.1.0 12:35 - Integrated Radiotherapy Solution Outline/Full Business Case

Led by Huw Llewellyn, Director and Gavin Bryce Associate Director of Programmes

8.1.0 IRS OBC FBC Trust Board - Public - Final.docx

8.1.0a Appendix A IRS Strategic Case_Trust Board.docx

8.2.0 12:50 - Radiotherapy Satellite Centre Full Business Case

Led by Andrea Hague, Director Cancer Services

8.2.0 Cover Paper_Trust Board (PUBLIC) RSC FBC May 2022 FINAL2.docx

8.2.0a Pages from SRU FBC V 5 16.5.22 p3-35 - Public Meeting.pdf

9.0.0 ANY OTHER BUSINESS

Prior Approval by the Chair Required

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).

11.0.0 DATE AND TIME OF THE NEXT MEETING

Thursday 28th July 2022

12.0.0 13:05 - LUNCH (13:05-13:50)

VELINDRE UNIVERSITY NHS TRUST

PUBLIC TRUST BOARD MEETING 26 MAY 2022
ACTION LOG

ACTIONS ARISING FROM 27/01/2022					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
4.1.0	**Annual Audit Report 2021 – Velindre University NHS Trust** Kate Febry to revise the Audit Wales Report to ensure it is clear that the report is written in the first person by the Auditor General.	**Kate Febry**			**OPEN**
7.2.0	**Cardiff Cancer Research Hub, Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust** The next phase of development to include agreement to key principles that will go on to establish a formal Heads of Terms for the model going forwards.	**ME/LB/PH**	**28 October 2022**	All have agreed there is a requirement to develop a commercial and investment strategy (including Heads of Terms). This work will be supported by an external consultant. Update will be provided to the Board in the November meeting.	**OPEN**

ACTIONS ARISING FROM 31/03/2022					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
2.1.1	**Minutes from the Public Trust Board meeting held on 27 January 2022** The Chair and Lauren Fear agreed to review the level of detail captured in relation to the input of Independent Members and how this is articulated going forward.	**Lauren Fear**	**28 July 2022**	This feedback has been reflected in the draft minutes for the March meeting. A review and agreement of the approach to the style for minutes will be captured as part of the June Board Development Assurance Session.	**OPEN**
2.1.3	**MAK Contract – Commitment of Expenditure** Procurement advice regarding the contract extension for MAK-System to be circulated to the Board prior to issuing the VEAT and the Commitment of Expenditure to then be administered via Chair's Urgent Action Approval.	**Matthew Bunce**		Procurement advice has been circulated to the Board together with the Commitment of Expenditure via Chairs Urgent Action.	**CLOSED**
2.1.4	**All Wales Laundry – Transfer of Llansamlet Laundry Asset** The name of the Trust to be amended to read Velindre **University** NHS Trust.	**Secretariat**		The contract paperwork has been amended accordingly.	**CLOSED**
2.2.3	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report** A meeting to be arranged with the Community Health Council to discuss communications and engagement in relation to the programme.	**Carl James/ Lauren Fear**	**30 May 2022**	A meeting is in the process of being arranged	**OPEN**

No.	Action	Owner	Target Date	Progress to date	Status (Open / Closed)
7.1.0	**Board Committee Structure** The report narrative to be revised to reflect the current position in relation to the hosted organisations work programme.	**Lauren Fear**		The report has been updated accordingly.	**CLOSED**
7.1.0	**Board Committee Structure** Quality, Safety and Performance Committee Annual Report to be updated to include reference to the attendance of wider independent input.	**Lauren Fear**		The report has been updated accordingly.	**CLOSED**
8.2.0	**Integrated Medium Term Plan 2021-2022 Quarter 3 Update** An explanation for red, amber green to be incorporated into future reporting.	**Cath O'Brien/ Phil Hodson**	**28 July 2022**	The below will be added to all future reporting: • Red=challenges causing problems • Amber=issues have been identified • Green=satisfactory progress is being made Change will be included in next reporting cycle for Trust Board.	**OPEN**

MINUTES PUBLIC TRUST BOARD MEETING – PART A

VELINDRE UNIVERSITY NHS TRUST HOLIDAY INN / LIVE STREAMED
31 MARCH 2022 at 10:00AM

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

1.0.0	STANDARD BUSINESS	ACTION LEAD
	The Chair opened the meeting and welcomed everyone, in particular noting this was the first meeting of the Trust Board since the onset of the COVID pandemic, where some of the Board members have been able to meet together in person. The Chair also confirmed that the meeting was to be livestreamed for those joining the meeting remotely and would be made available on the Trust Website.	
1.1.0	**Apologies** The Chair noted apologies from Dr Jacinta Abraham, Executive Medical Director.	
1.2.0	**In Attendance** The Chair welcomed the regular attendees of the Public Trust Board and additional attendees joining for today's meeting: • Katrina Febry, Audit Wales Lead • Stephen Allen, Chief Officer, South Glamorgan Community Health Council	

	• Daniel Price, South Glamorgan Community Health Council • Peter Groves, Chair, Health Technology Wales (for item 3.1.0) • Mick Button, Consultant Clinical Oncologist (on behalf of Dr Jacinta Abraham, *in part*)	
1.3.0	**Declarations of Interest** There were no Declarations of Interest for any agenda items.	
1.4.0	**MATTERS ARISING**	
1.4.1	**Action Log** The Chair took the Board through the action log and noted that **11** of the **12** items had been completed with recommendation to **CLOSE**. Gareth Jones highlighted that action **4.1.0** needed to be amended to reflect that the action captured needed to be revised to confirm whether the Auditor General's name should appear on the report, as opposed to his signature. It was agreed that this will be amended in the action log and remain on the log for the next meeting. The Trust Board **APPROVED** the Action Log with the above amendment.	
2.0.0	**CONSENT ITEMS**	
2.1.0	**FOR APPROVAL**	
2.1.1	**Minutes from the Public Trust Board meeting held on 27 January 2022** Gareth Jones raised the level of detail captured regarding Independent Members input and whether that required further consideration in how that is articulated going forward, for example under item 7. The Chair and Lauren Fear agreed to review this aspect for future minutes and a suitable approach. The Trust Board **CONFIRMED** the Minutes of the meeting held on 27th January 2022 were an accurate and true reflection.	**DM/LF**
2.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **RATIFIED** the Chairs urgent actions taken between the **15th January 2022 to 17th March 2022** as outlined in **Appendix 1** of the report.	
2.1.3	**Commitment of Expenditure Exceeding Chief Executives Limit** Gareth Jones raised it would be helpful for the Board to see the procurement advice regarding the contract extension for MAK-System to ensure compliance with procurement regulations. It was agreed that the procurement advice regarding the contract extension for MAK-System to be circulated to the Board prior to issuing the VEAT and the Commitment of Expenditure to then be administered via Chair's Urgent Action Approval.	**MB/LF**
2.1.4	**All Wales Laundry – Transfer of Llansamlet Laundry Asset**	

	Gareth Jones raised the name of the Trust needed to be amended to read Velindre **University** NHS Trust under **2.1.4c**. The Board **APPROVED** the All-Wales Laundry Transfer of Llansamlet Laundry Asset to allow execution of the TR1 documentation in line with existing SSPC Standing orders for operation, with the above amendment to the documentation.	**LW**
2.1.5	**Documents 'Sealed' Report** The Trust Board **APPROVED** the contents of the Trust Board Seal Register included in **Appendix 1**.	
2.1.6	**Policies for Approval** The Trust Board **APPROVED** the Pensions Flexibilities Policy.	
2.1.7	**Gender Pay Gap** The Chair highlighted that the Gender Pay Report is a factual report and recommended that some of the actions listed should be included for discussions at a Board Development Session. Sarah Morley agreed and added that work is currently progressing with new data which will support building on the information in the report. The Trust Board **APPROVED** the Gender Pay Gap report.	
2.2.0	**FOR NOTING**	
2.2.1	**Remuneration Committee Highlight Report (24th Feb)** The Trust Board **NOTED** the contents of the report and actions being taken.	
2.2.2	**Local Partnership Forum Highlight Report (2nd March)** The Trust Board **NOTED** the contents of the report and actions being taken.	
2.2.3	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports (21st Dec 21, 19th Jan 22, 22 Feb 22 and 22nd March 22)** Stephen Harries advised the Board that a new programme risk was added regarding the interdependency of projects aligned to the Outreach Project. Carl James provided assurance that work is progressing and Nicola Williams added that prior to pausing the Outreach programme, significant work has been undertaken where agreement was reached around the principles for Outreach leading into the new build. Capacity issues have impacted on Outreach however resources are now being utilised differently to re-energise this work. Stephen Allen raised concern that there is a lack of engagement with the Community Health Council (CHC) regarding Transforming Cancer Services (TCS). Carl James apologised if communication was insufficient noting that there has been good engagement from the outset. A discussion will be held to look into how communication can be further strengthened. The Trust Board **NOTED** the contents of the highlight reports and actions.	**CJ/LF**

2.2.4	**Transforming Cancer Services Communication & Engagement Update** At the request of the Chair, Lauren Fear provided the Board with a brief update on the status of two Petitions following the Petitions Committee of the Senedd meeting in March. The Petitions Committee had formally closed the matter. The Trust Board **NOTED** the contents of the paper.	
2.2.5	**Charitable Funds Committee Highlight Report** The Chair invited Matthew Bunce to provide the Board with a brief overview of the Charity's position with regards to any investments with Russian Companies in light of the situation in the Ukraine. Matthew Bunce advised the Board that as part of the review by the Charity's investment advisors, confirmation can be given that there is no direct exposure to Russian Securities. A small number of indirect investments with exposure was identified. Instructions were given to remove the exposure. Assurance was given to the Board that there is zero exposure currently with investments with Russian Companies. The Trust Board **NOTED** the contents of the Charitable Funds Committee Highlight Report.	
2.2.6	**Strategic Development Committee Highlight Report** The Trust Board **NOTED** the contents of the report and actions being taken.	
2.2.7	**Public Quality, Safety and Performance Committee Highlight Report** The Trust Board **NOTED** the key deliberations and highlights from the Quality, Safety & Performance Committee.	
2.2.8	**Welsh Health Specialised Services Committee Joint Committee Briefing** The Trust Board **NOTED** the contents of the Joint Committee Meeting held on 15 March 2022.	
2.2.9	**NHS Wales Shared Services Partnership Committee Assurance Report** The Trust Board **NOTED** the contents of the Assurance Report	
2.2.10	**Approved Policies Update** The Trust Board **NOTED** the list of approved policies as outlined in the paper.	
3.1.0	**Health Technology Wales Annual Report** The Chair welcomed Peter Groves, Chair of Health Technology Wales who had been invited to present HTW's Annual Report and highlighted that there are regular meetings and engagement between the Trust and HTW. Peter Groves thanked the Chair for the opportunity and took the Board through a detailed presentation highlighting the following: • The Annual Report covers the calendar year 2021. • Health Technology Wales provides a coordinated and streamlined approach to medical technology.	

- The vision of the organisation is to deliver improved health outcomes and value for the people of Wales.
- The report covers the way in which priorities were met for COVID-19. This undertaking included an Evidence Centre with a number of Collaborating Partners.
- HTW has contributed to research and analytical expertise, a series of rapid evidence reviews on COVID-19 related topics and continues to support Welsh Government COVID-19 decision making groups.
- The following objectives have been identified for 2022/23:
    - Expand HTW's topic identification, prioritisation and selection efforts especially to include social care.
    - Develop and promote direct topic referrals from Local Health Boards and other organisations.
    - Digital Topic Call.
- The HTW Strategic Plan for 2021-2025 sets out the immediate, medium and long term strategic goals and objectives. The plan is a living document which will be refined to reflect the changing health and social care priorities and demands on HTW resources.

Following the presentation, the Chair invited comments/questions from the Board.

In response to a query from Nicola Williams, Peter Groves confirmed the engagement links with the Trust and other Partners. The Pilot referred to in the report included Local Health Boards which will be extended to include Special Health Authorities and Trusts in future reporting. The Chair noted that there has been increased collaboration with Velindre over the past year.

Andrew Westwell requested information about engagement with Partners in the wider United Kingdom and internationally and adoption of change in practice. Peter Groves advised that the formal approach from Welsh Government is that HTW guidance should be adopted and where this doesn't occur there should be a clear rationale / justification. It was noted that HTW does not duplicate the work of the National Institute for Health and Care Excellence (NICE).

Carl James noted the importance of aligning the strategic appraisal process with key policies and enablers e.g. long term systems change and queried if there is adequate room for innovation. Peter Groves advised that engagement is key and HTW regularly connect with key stakeholders to ensure openness to receive requests. The work of HTW is fundamentally based around evidence. Steve Ham added that the foundations built over the past years will support the system in the future. The approach has allowed for different participants to consider the importance of evidence based research, an understanding that has increased over time.

Peter Groves thanked the Velindre Board and Steve Ham in his role as Chief Executive for the work and interaction for the research function of HTW.

The Board thanked Peter Groves for the report and informative discussions. The Chair also congratulated Peter Groves and the HTW Team on being

	awarded the David Haley Award and Peter himself for his recent appointment by the Westminster Secretary of State for Health and Social Care, as NHS Chair on the NICE Appeals Panel. Finally, the Chair highlighted at a meeting held regarding the Public Inquiry into COVID-19, the Appraisal work undertaken by HTW will need to be included as part of the evidence submitted. The Trust Board **NOTED** the contents of the HTW Annual Report.	
4.1.0	**Chair's Update Report** The Chair highlighted an additional matter to the report, that at a Senedd meeting, one of the Senedd Members praised and commended the excellent work done by Velindre University NHS Trust. The Trust Board **NOTED** the contents of the Chair's Update Report.	
4.2.0	**CEO Update** Steve Ham highlighted to the Board the contribution of the Trust in responding to the humanitarian crisis in Ukraine. The Trust, via NHS Wales Shared Service Partnership, has supported the supply of medical supplies to Ukraine from Wales. The Trust Board **NOTED** the content of the Chief Executive's Update	
5.1.0	**Delivering Excellence Performance Report Period January 2022** The Chair highlighted to the Board that the Performance Report has been scrutinised and received prior to today's meeting by the Quality, Safety and Performance Committee and that the individual reports speak to the cover report. Cath O'Brien presented the cover report encompassing both the Velindre Cancer Service and the Welsh Blood Service and noted how both divisions have worked to sustain performance in difficult times. The following matters were highlighted: <u>Velindre Cancer Service</u> • The Monthly Performance Report includes a dashboard and provides a summary of performance. • Core service areas Systemic Anticancer Therapy (SACT) and Radiotherapy have experienced pressure in terms of delivery due to an increase in volume. In response, there has been maximum use of staff whilst ensuring safety standards. • A Task and Finish Group has been established to review SACT provision, including examining space utilisation, recruitment, training and workforce alignment. • The Trust is also looking to increase provision with the Rutherford Cancer Centre.	

Stephen Allen raised it may be helpful to advise the public with ongoing communication on SACT progress. The Chair advised that the information shared by Cath O'Brien is contained in the papers that are made available to the public. Steve Ham added that more information on this topic is also discussed under the Trust Integrated Medium Term Plan (IMTP).

Cath O'Brien referred the Board to the supporting Appendix for details on patients who waited in excess of 50 days. More information on planning particularly with SACT will be shared at the Board Development Session in April 2022.

Mick Button welcomed the work being undertaken to explore pathways for SACT and Radiotherapy and assured the Board that patients were regularly communicated with when changes were made.

Carl James added that workforce issues are a broader national problem, noting that this is not expected to change in the short term. Improvements are expected with the solutions coming forward by Health Education and Improvement Wales (HEIW) which includes additional methodologies such as automation and artificial intelligence.

The Chair highlighted the continuous, excellent performance regarding healthcare acquired infections and that that it has been eight years for the Trust with no Methicillin-resistant Staphylococcus aureus (MRSA) infection. The Trust has scrutinised matters that give concern and have taken actions where necessary. There has also been an improvement in audits around infection control. Nicola Williams added that audits reflect the Service is fully compliant with regard to infection control practices.

Welsh Blood Service

- There has been some variation in blood stock levels in recent months and the service relies on Donors and Partners to effectively manage blood stocks. A blue alert was issued in January however stocks have built up again in February.
- There are challenges achieving Red Cell Immunohematology (RCI) performance levels resulting from an increase in demand from the Health Boards, this is being reviewed. RCI tests have been categorised and prioritised in accordance with time critical testing to provide assurance that these are undertaken within the required timeframes. This work will be supported by new automated machinery that will make testing more efficient.
- There is a new piece of work underway to increase Bone Marrow Donors.

Mick Button left the meeting at 12:07

Workforce and Organisational Development

Sarah Morley summarised the Workforce and Organisational Development (WOD) report and highlighted the following key points:

- Performance Achievement and Development Review (PADR) compliance levels are low. However, there are ongoing discussions and support to

	managers to ensure performance and development discussions are taking place. • Sickness levels have increased from 5.6% to 6.01% in March 2022. This was expected and has been impacted by special leave taken by staff due to isolating with regard to COVID-19. • There is a focus on ensuring the health, safety and wellbeing of staff through engagement events, offering support, steering group meetings and training for managers. • Communication goes out regularly through Trust and Divisional Communication channels. Staff have also been communicated with individual letters posted to them with *"Its okay not to be okay"* message. The Chair noted the good performance for statutory and mandatory compliance by comparison with other organisations. Matthew Bunce highlighted that the increase in sickness is an important point. A letter by the Director General was received for additional cover around the COVID-19 response which will support staffing and other matters. Martin Veale welcomed the report and noted that there is still some work required in identifying what a statutory target is against a 'stretched' target. Nicola Williams clarified the position on staff isolation. Frontline staff who have had direct exposure to COVID-19 are removed from direct patient facing roles and redeployed to other roles or asked to work from home. Gareth Jones noted that Corporate Services appears to have the lowest performance in terms of PADR compliance querying why this is the case. Sarah Morley added that there is no specific reason but discussions are being held with the Executive Teams to ensure these dates are diarised to hold formal PADR sessions. The Trust Board **NOTED** the contents of the performance reports and the following Appendices: • VCC December PMF Report • WBS December PMF Report • Workforce KPI data • Rutherford information	
5.2.0	**Financial Report Period for the period ended February 2022** Matthew Bunce highlighted that the key performance indicators (KPIs) have been agreed in February 2022. The month 12 position will be closed in the coming week. An opportunity for questions or queries on the report was provided. Martin Veale noted that given the extraordinary circumstances such as staff absences and the COVID-19 impact, financial performance against the KPIs is good. Matthew Bunce agreed to pass on this message to the Finance Team who have been working tirelessly.	

	Vicky Morris noted the progress that Matthew Bunce and Sarah Morley have made in the development of the triangulation of the finance and workforce data and insight. A triangulated report is currently being worked on via the Quality, Safety & Performance Committee which will be shared with the Board in due course. The Trust Board **NOTED** the contents of the February 2022 financial report, in particular the financial performance to date, and the year-end forecast to achieve financial break-even.	
5.3.0	**VUNHST Risk Register** Lauren Fear took the Board through the Trust Risk Register and highlighted the following key points: • The next phase of focus for Velindre Cancer Service and Corporate risks is to ensure risks are clear, owned and timebound. It was noted that risks are clear in the reporting for the Welsh Blood Service and Transforming Cancer Services. • The Digital Health and Care Record Project Team will review the calibration of the level of granularity and the scoring of the project risk profile. • Risk Profile in Section 3 on Page 12 describes some of the actions taken based on feedback from the Trust Board and other Committee meetings. Gareth Jones queried the risks on Page 9 where the current and target risk ratings are both recorded as 16. Lauren Fear advised that this is the information in the Datix system and that the question was also raised via the Quality Safety and Performance Committee. It will form part of the review process that the project team will undertake. Martin Veale added that it is good to see the risks level 20 and 16 are included in the report and raised more detail on controls in terms of what will be done to decrease risk ratings is required. Lauren Fear confirmed this work is forming part of the further risk development work underway. Martin Veale also noted that the risk identification process should be both top down as well as bottom up. Lauren Fear advised that this is discussed in Executive Management Board meetings will continue to be reflected in the reports. The Trust Board: • **NOTED** the risks level 20 and 16 reported in the Trust Risk Register and highlighted in this cover paper. • **NOTED** the on-going developments of the Trust's Risk Framework.	
5.4.0	**Trust Assurance Framework** Lauren Fear took the Board through the following key points in the Trust Assurance Framework (TAF). • The 10 risks in the report have continued to be developed by each of the owners, a summary of which is provided in the Cover Paper.	

	• The report outlines discussions held at the March Strategic Development Committee. The concept of "issues" was discussed as events which are/have already occurred, that may have an adverse consequence. These would be reflected in the Trust Assurance Framework through sources of assurance. • As noted in the Risk Register paper in this meeting, the link between the risk register and the TAF is to be developed further to link relevant risks on the register to strategic risks in the TAF. Martin Veale added that some organisations have both an issues log and a risk register. Regardless of whether it is a risk or an issue, both require resolution. Hillary Jones queried when information will be provided on the links between the TAF and risks that may impede the organisation reaching its strategic objectives. Lauren Fear outlined the methodology that identified the Trust's nine principal risks using this approach, and following a review of this a tenth risk was added. A review of the TAF Strategic Risks will be aligned to follow the IMTP development process. Steve Ham added that the Board Development Sessions will be used to continue to link together the various important framework developments. These discussions will make clear how it all works alongside the TAF. Vicky Morris added that the Risk Descriptors are very helpful, however, the strategic objective and the risk against that objective will make things clearer to the Board. This will also support discussions around the IMTP. Carl James added that the Trust has sight of the five strategic goals and broadly speaking, there are similar strategic risks for most organisations which can also be useful insight when considering the next review of strategic risk. The Trust Board: • **DISCUSSED AND REVIEWED** the update to the Trust Assurance Framework Dashboard, Included at Appendix 1. • **NOTED** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework.	
7.1.0	**Board Committee Structure** Lauren Fear introduced the report and explained that this was the first formal review of the new Board Committee Structure following its first year of operation. The review was informed by a number of key internal and external sources of assurance provided through the course of the year that have been collated and analysed via a desktop exercise, augmented with key input during the course of the year from Trust officers, and a recent review of the new Board Committee Structure presented to the Trust Audit Committee in January 2022 by NWSSP Internal Audit. Following discussion with the Chair and Chief Executive it is proposed that the new Board Committee Structure is reviewed in another year's time given that the last year has been unusual due to the impact of COVID-19, along with different demands and challenges. There are ongoing conversations and information gathering in terms of how we work as a Board sharing views and opinions to inform decisions on the Trust Board Committee Structure.	

	In response to a query raised by Gareth Jones, Lauren Fear confirmed that Paragraph 3.6.3 will be amended to reflect conversations are underway as opposed to concluded and will continue over the coming year to develop the hosing organisations reporting arrangements, for example with the NHS Wales Shared Service Partnership. The Chair noted the point on too much detail contained in Board Committee reports raised by Vicky Morris, and highlighted that work has been initiated to address this with further opportunity for Independent Members to input into this process. The Chair also noted the point raised by Martin Veale, and that further consideration would be given as part of the ongoing review as to whether Committee highlight reports are received under the consent or main agenda. Stephen Allen referred the Board to one of the reports supporting appendices, the Quality, Safety and Performance Committee Annual Report, and highlighted that it would be beneficial for the Public to indicate within this that the Committee is supported by wider independent input e.g. Audit Wales and the Community Health Council. Lauren Fear advised that this will be incorporated going forward. Kate Febry raised that Audit Wales have provided input on Committee Effectiveness and wider intelligence for Structured Assessment toward the end of the year. Some of this information has been shared with Independent Members and further discussions are welcomed. Steve Ham added that these discussions are important over and above the report. Martin Veale wanted to contextualise the comments and added that the Audit Wales Structured Assessment Report, received in January 2022, states the Trust is well governed. The comments made are part of the continuous improvement to the Board Committee Structures. The Trust Board: • **DISCUSSED and REVIEWED** the findings of the new Board Committee Structure following its inaugural year of operation. • **NOTED** the progress made to date in continuing to strengthen and develop its operating arrangements. • **ENDORSED** next steps to support recommended actions and key areas of focus identified for the 2022 – 2023 reporting period.	**LF** **LF**
8.1.0	**Integrated Medium Term Plan 2022-2025** Donna Mead noted that the Integrated Medium Term Plan (2022-2025) has been discussed and scrutinised at various Committees and meetings and invited Steve Ham to lead this item, followed by Carl James, Cath O'Brien and Matthew Bunce. Steve Ham first wished to thank the team who have worked well to develop this piece of work. This has been a complex plan to put together in terms of framing and structure of the plan given that there is the unknown in terms of COVID-19 and other challenges in the coming months. These challenges were noted by Welsh Government. The way in which the Trust now implements the plan on a	

month by month basis links in with earlier discussions regarding operational issues.

Carl James highlighted the following salient points:

- The plan is a statutory requirement.
- It's a three year plan with a focus primarily on the coming year.
- In terms of process, there was a baseline assessment in terms of what the Trust set out to do. This was followed by various Board Development Sessions to ascertain what the expectations were of the Board. Thereafter input was gathered from our Partners. A number of conversations have also been held with the Community Health Council. Input was obtained from staff and also importantly from patients and donors. The plan was also submitted to the Executive Management Board and Commissioners.
- The plan is framed on the strategic picture. The strategic goals form the golden thread through everything we do.
- It articulates the work of VCC and WBS and their plans.
- This plan sets out the following:
    - Excellence in our core functions, which refers to our ambition and how we intend to operationalise that.
    - Our broader role in the system into the Leadership space.
    - Demonstrating our next steps toward maturity of the organisation. This would mean, transitioning from Healthcare Services (making people better), to contributing to the wellbeing of people. This would mean moving a step further toward prevention. This forms part of wider policy matters such as decarbonisation, to stop people from becoming ill.

Vicky Morris commented that the document is accurately structured based on what Carl James has shared, and the narrative is supported by good visual information which made it easy to read. Donna Mead added that there is an intention to develop a three to five page easy read version of the document. The document will likely be digitised as well.

Cath O'Brien noted that what is included in the plan is a continuation of work that has already started. The challenge is maintaining flexibility and agility with safe service delivery. Workforce planning recognises the best use of the medical and clinical workforce. Cath O'Brien highlighted the following points on operational delivery of the plan for WBS and VCC:

<u>Welsh Blood Service</u>

- The focus for the first year of the three year plan will be:
    - Plasma Fractionation
    - Laboratory Modernisation Programme
    - Bone Marrow Donor Registry
- Ongoing cycles of service improvement will be monitored.
- Sourcing larger clinic venues for collections.

The Chair queried the timeframes for Plasma Fractionation. Cath O'Brien advised that there are National discussions taking place. Information will be brought back to future meetings. Preparatory work has been done while clarification is awaited.

Velindre Cancer Centre

There are large pieces of work including the following:

- Outreach Services
- Velindre Futures which includes the replacement of the CANISC system.
- Implementation of Radiotherapy solutions.
- Implementation of joint pieces of work with other Health boards including Nuffield Trust.
- A myriad of other pieces of work including primary care aspirations and workforce planning.

Martin Veale queried what the assumptions about Accident and Emergency detailed on (page 4) are based on. Cath O'Brien advised that the process entailed working across patient pathways, gathering data from primary care all the way through to Velindre Cancer Service. Once the information was gathered, assumptions were checked with other Health boards. This information was also shared at Commissioner meetings for validation. Going forward the data will be continuously updated as new data sets are received.

Steve Ham added that staff discussions are important. The Trust needs to be agile and obtaining external capacity is one approach. It was noted that the increase in demand will not be one of a straight line scenario, but that demands vary at different points in time. Carl James added that s workforce challenges are national issues.

In terms of discharge challenges, the Trust mainly responds to ambulatory care. Nicola Williams added that there is a small number of discharge challenges, including End of Life and pathways back into Health boards where transport and bed availability continues to be a challenge. The VCC have worked tirelessly in the past year with Health boards to improve pathways. Therefore, the delay in discharge is negligible compared to previous time periods.

Vicky Morris added that year to date data will provide a better picture rather than month to month, noting that from other discussions there is the intention to provide this information.

Stephen Allen thanked Carl James and his team for the involvement of the CHC with the IMTP. Information was requested on how the Trust will engage with the wider Community. Carl James responded that further engagement with the wider Community is planned, for example engagement with young people using Minecraft. Nicola Williams added that patient engagement will be strengthened through the Patient Engagement Framework. A patient engagement module will be included as part of the patient experience software. This will allow the Trust to capture pertinent information and work better with the Public on the matter of engagement and patient experience. Future updates on this will be presented to the Board. Lauren Fear highlighted that the Patient Engagement Framework will be submitted to the Strategic Development Committee in May and will thereafter be shared with the Board.

	Stephen Harries noted the importance of the Outreach Services. Due to capacity and demand pressures, services may need to be increasingly delivered through Outreach Services. Matthew Bunce outlined the financial components of the plan: • Early iterations set out to achieve a balanced financial plan. This was impacted on by cost pressures as a result of COVID-19 and other extraordinary cost pressures. As a result of these pressures, a letter from the Director General has been received setting out the aim by Welsh Government to underwrite the financial risks. Therefore, the financial narrative of the plan was amended to reflect this. • It should be noted that Welsh Government are managing the distribution of funding centrally. • The Demand Modelling has been fundamental to the financial plan. • It was confirmed that a risk analysis has been conducted. • A new funding mechanism has been agreed Nationally in recent days. Steve Ham noted that this is not a risk-free plan and as per earlier discussions in the meeting, there are significant financial risks which the Trust needs to manage with Partners. It was also noted that the plan incorporated the feedback received from Board and Trust officers throughout the development pathway. a) The Trust Board **APPROVED** the Integrated Medium Term Plan (2022-2025) for submission to Welsh Government on 31st March 2022. b) The Trust Board **NOTED** the next steps / actions: • The submission of the IMTP (2022 - 2025) to the Welsh Government on 31st March 2022. • Receipt and response to any feedback from the Welsh Government in relation to the IMTP (2022 - 2025). • Development of an 'easy read' version (3-5 pages only) of the IMTP (2022 - 2025). • The continuous work with our key Partners and Stakeholders to support the implementation of our IMTP (2022 – 2025) and the successful delivery of the key actions and priorities identified. • Reporting on progress against the implementation of the key actions identified in the IMTP (2022 - 2025) in line with existing governance arrangements.	
8.2.0	**Integrated Medium Term Plan 2021-2022 Quarter 3 Update** Cath O'Brien highlighted that the Service has been able to deliver against almost all goals and objectives in the midst of extreme pressure and challenge. The Board discussed the progress report. In response to queries/comments raised Cath O'Brien confirmed: • an update on virtual appointments will be provided and whether this includes family members and the wider groups. This is based on a wider piece of work with Welsh Government and will be shared once information is received.	

	• The explanation for red, amber and green will be included in future documents. • The year to date performance reporting was emphasised with an example that Quarter three performance has to be signed off at the end of March with very little time to meet deadlines. Carl James added that this is an important point which will be looked into further, adding that consideration has to be given to lag time and real time. • Learning information has been gathered by the CHC with feedback from the Public on Digital appointments which will be shared with Cath O'Brien. **ACTION:** An explanation for red, amber, green to be incorporated into future reporting. The Trust Board **NOTED** the content of this report.	**COB**
9.0.0	**ANY OTHER BUSINESS** There was no other business to note.	
10.0.0	**CLOSE** The Chair closed the meeting.	
11.0.0	**DATE AND TIME OF THE NEXT MEETING** Thursday, 26th May 2022 at 10:00	

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 26 May 2022 to 28 July 2022

DATE OF MEETING	26 May 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**
Capital Planning Group	15/03/2022	Supported
Executive Management Board	11/05/2022	Endorsed for Board Approval

ACRONYMS	
SFIs	Standing Financial Instructions
VUNHST	Velindre University NHS Trust
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

1.1 Velindre University NHS Trust (VUNHST) has a Scheme of Delegation, as set out in its Standing Orders, together with its Standing Financial Instructions (SFIs), which ensures that there are effective governance arrangements in place for the delegation of financial authority.

1.2 Financial limits apply to the commitment of expenditure. If expenditure is greater than an individual's financial limit, and is more than the limit delegated to the VUNHST Chief Executive, the planned expenditure will require VUNHST Board approval. For extensions of existing contracts in place, this only applies if the provision for extension was not included in the original approval granted by the Trust Board.

1.3 The decisions expected during the period **26 May 2022 to 28 July 2022** 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 1-3** 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 £k (Inc. VAT)
Appendix 1	Corporate Estates, Environment and Capital	Fire Door Replacement	Start: 01/05/2022 End: 31/07/2022	£ 374.4
Appendix 2	Corporate Estates, Environment and Capital	Compartmentation	Start: 01/05/2022 End: 31/08/2022 Option to extend: Two months	£ 265,548
Appendix 3	NWSSP	Laundry Services Detergent Tender Request	Start: 01/09/2022 End: 31/08/2022 Option to extend: 24 months (12+12)	£3360

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 1of this report.

4. RECOMMENDATION

4.1 The Board is requested to **AUTHROISE** 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.

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

SCHEME TITLE	VELINDRE UNHS TRUST - FIRE DOOR REPLACEMENT
DIVISION / HOST ORGANISATION	Corporate Estates, Environment and Capital
DATE PREPARED	25/04/2022
PREPARED BY	Jason Hoskins Assistant Director Estates, Environment and Capital
SCHEME SPONSOR	Carl James Director of Strategic Transformation, Planning, and Digital

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

- **Replacement of Fire doors Trust wide:**
  - The works are to replace all defective fire doors, including replacement of door liners and architrave where necessary, complete with any works associated with making good.
- **Background:**
  - Assessment of the Trust Estates has highlighted a number of issues that present a risk from a fire safety perspective.
  - A business case has been presented to Welsh Government outlining funding requirements to address concerns raised
  - Welsh Government have endorsed the proposal providing £1.1M of funding staged over a number of years in support rectification of the identified issues. £600K allocated in 2021/22 with a further allocation of £500K to complete works during 2022/23.
  - An external consultancy firm was commissioned to carry out an assessment of the condition of fire doors across the trust which has informed the approach adopted by the Trust
  - A work package to address issues that exist across the Trust relating to Fire Doors has been compiled in preparation to go to tender.
  - All works have been reviewed and signed off internally by the Trust Fire Safety Manager, and external consultant
  - A paper was taken to Trust Board in November 2021 requesting permission to progress this scheme against rough order costs of £180K, which was approved.

• A tendering Exercise has been concluded with costs to carry out full scope of works being returned at £374,415 inclusive of VAT and contingency sum • All fire Doors were purchased last year in line with financial approvals at a cost of £140K inclusive of VAT • Remaining works cost £234,415 which requires approval of uplift against the previous project budget request submitted in to Trust Board November 2021 of £190K						
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	01/05/2022					
Expected End Date of Contract	31/07/2022					
Contract Extension Options **(E.g. maximum term in 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 scheme has been identified as part of the Estates Compliance Capital works 2021 – 2023. Funding has been secured through Welsh Government.		

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 with the exception of *Option 1 - Do Nothing – presents ongoing H&S risks associated with the non-compliance – Fire Safety legislation and H&S legislation breach*

Option 2 - Supply and install new fire door to replace existing doors that are beyond economic repair, In doing so making the Trust compliant with WHTM and H&S Legislation *Preferred Option – This options provides a compliant solution reducing risk of fire to life and limb, and property. Underpinned by a full assessment of each door listed for replacement.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• Provides a fully auditable compliant solution to asset level including update of the Trust Fire Safety Management documentation, and Bolster system allowing ongoing management of each asset. • Removes all identified risk presented by fire doors listed as requiring attention detailed within the commissioned survey and provides a benchmark for future management.

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**
• Non compliance with WHTM firecode • Non compliance with H&S Legislation • Non compliance with building documentation - The Fire Strategy for building.	• Risks cannot be fully mitigated

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	
Formal procurement exercise to be undertaken via issue of specification through external consultant (Gleeds)	
6.3 What is the approximate time line for procurement?	
4 weeks (complete)	

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:	25/04/2022

7. FINANCIAL ANALYSIS

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

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	**Year 1 (exc. VAT) 2021/22 £k**	**Year 2 (exc. VAT) 2022/23 £k**	**Year 3 (exc. VAT) £k**	**Total Future Years (exc. VAT) £k**	**Total (exc.VAT) £k**	**Total (inc. VAT) £k**
Fire Door Replacement purchase of doors (2021/22)	£116.66				£116.66	£139.99
Installation of fire doors and making good (2022/23)		£195.34			£195.34	£234.41

Overall Total	£116.66	£195.34			£312	£374.4

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*This project will be managed against organisational SFI's and the estates project management process.*

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:	Jason Hoskins
Signature:	J.D.Hoskins
Service Area:	Estates, Environment and Capital
Date:	25/04/2022

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	15/03/2022
Divisional Senior Management Team	N/A
Executive Management Board	12/05/2022

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	VELINDRE UNHS TRUST - COMPARTMENTATION
DIVISION / HOST ORGANISATION	Corporate Estates, Environment and Capital
DATE PREPARED	25/04/2022
PREPARED BY	Jason Hoskins Assistant Director Estates, Environment and Capital
SCHEME SPONSOR	Carl James Director of Strategic Transformation, Planning, and Digital

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Fire Stopping Works (Compartmentation):

- To address all know compartmentation issues at VCC and WBS HQ as listed in the detailed survey as completed by independent consultant commissioned by the Trust.

Background

- Assessment of the Trust Estate has highlighted a number of issues that present a risk from a fire safety perspective
- A business case has been presented to Welsh Government outlining funding requirements to address concerns raised
- Welsh Government have endorsed the proposal providing £1.1M of funding staged over a number of years in support rectification of the identified issues with £500K allocated for 2022/23
- An external consultancy firm was commissioned to carry out an assessment of the condition of compartmentation across which has informed the approach adopted by the Trust
- A work package to address issues that exist across the Trust relating to compartmentation has been compiled in preparation to go to tender.
- The works outlined in the documentation details areas of concern which require address through this work package
- All works have been reviewed and signed off internally by the Trust Fire Safety Manager, and an external independent consultant.

• Tendered costs have been returned at £265,548 inc of VAT and contingency • A detailed review of the tender documentation has been concluded.						
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	01/05/2022
Expected End Date of Contract	31/08/2022
Contract Extension Options **(E.g. maximum term in months)**	Two 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 scheme has been identified as part of the Estates Compliance Capital works 2021 – 2023. Funding has been secured through Welsh Government.		
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 with the exception of *Option 1 - Do Nothing – presents ongoing H&S risks associated with the non-compliance – Fire Safety legislation and H&S legislation breach* *Option 2 – Carry out works to improve compartmentation to meet the requirements of the external survey, In doing so making the Trust compliant with WHTM and H&S Legislation* *Preferred Option – This option provides a compliant solution reducing risk of fire to life, limb, and property. Underpinned by a full assessment of each element of work which will be logged on the electronic estates management system (Bolster) for record.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• Provides a fully auditable compliant solution to asset level including update of the Trust Fire Safety Management documentation, and Bolster system allowing ongoing management of each repair. • Removes all identified risk presented by insufficient compartmentation as detailed within the commissioned survey and provides a benchmark for future management.

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
• Non compliance with WHTM firecode • Non compliance with H&S Legislation • Non compliance with building documentation - The Fire Strategy for buildings	• Risks cannot be fully mitigated

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
Formal procurement exercise to be undertaken via issue through external consultant (Gleeds)
6.3 What is the approximate time line for procurement?
4 weeks (completed)

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:	25th April 2022

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)**	**Including VAT (£k)**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		

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

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
Compartmentation	£221,290				£221,290	£265,548
Overall Total	£221,290				£221,290	£265,548

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*This project will be managed against organisational SFI's and the estates project management process.*

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:	Jason Hoskins
Signature:	J.D.Hoskins
Service Area:	Estates, Environment and Capital
Date:	25/04/2022

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	15/03/2022
Divisional Senior Management Team	N/A
Executive Management Board	12/05/2022

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	LAUNDRY SERVICES DETERGENT TENDER REQUEST
DIVISION / HOST ORGANISATION	NWSSP
DATE PREPARED	29/04/2022
PREPARED BY	Oliver Rix – Business Manager Laundry Services
SCHEME SPONSOR	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 All-Wales Laundry Service was created on the 1st of April 2021 and launders 30 million pieces per annum to NHS Wales from the following five production units:

- Greenvale South - East Wales
- Glan Clwyd North Wales
- Llansamlet South - West Wales
- Glan Gwilli South - West Wales
- Church Village South - East Wales

The five Laundry Processing Units (LPUs) were previously operated by Local Health Boards and as such made their own provisions for products used within the laundry such as soap and detergent. The creation of the All-Wales service allowed synergy and standardisation in service provision and delivery in areas such as procurement of goods and services in the form of all Wales contacts

The service is currently under review and is developing a business case for the modernisation and rationalisation of the plant and equipment. This business case will see the decommissioning of Glan Clwyd, Llansamlet, Glan Gwilli and Church Village LPUs and their reprovision with two new units located in South-West and North Wales, together with the refurbishment of Greenvale. Table 1 below presents the draft time scales for this programme.

Table 1 Draft Indicative high level time frame

Unit	Unit	Action	Year					
			2023	2024	2025	2026	2027	2028
Southwest Hub	New Unit	Build / Commission						
Llansamlet LPU	Existing Site	Decommissioning						
Glangwili LPU	Existing Site	Decommissioning						
North Wales Hub	New Unit	Build / Commission						
North Wales LPU	Existing Site	Decommissioning						
Southeast Hub	Refurbishment	Refurbishment as per phasing plan	Group 1	Group 2	Group 3	Group 4	Group 5	
Church Village LPU	Existing Site	Decommissioning						

As part of the modernisation and rationalisation of the service there will be a reduction in LPUs from five to three resulting in the redistribution of current product on the following basis:

- Greenvale to increase capacity to include Church Village
- A new North Wales hub to replace Glan Clwyd
- A new Southwest hub to replace Llansamlet and Glan Gwilli LPU

The LPUs are currently utilising Christeyns for the provision of their laundry detergent have existing dosing equipment that varies in condition per site and have no management system in place. Initial pre-market engagement has identified a possible saving could be achieved by testing the market and driving competition and achieving economies of scale from an All-Wales Contract.

A supplier is required to supply all the laundry chemicals, detergents and related services including the supply, installation and maintenance of dispensing and monitoring/validation systems across all sites. With an All-Wales

Detergent Contract not being in place before, the option of this tender could provide further market competition that could lead to savings as a service.						
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	01/09/2022
Expected End Date of Contract	31/08/2027
Contract Extension Options **(E.g. maximum term in months)**	24 months (12+12)

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
Alternative option is to continue with the current arrangement where detergent and dosing equipment is ordered without a compliant contract in place. As the spend as a service across the five LPUs is currently in excess of £250,000 solely for detergent alone and not including dosing equipment or a management system this is not plausible, and a contract is required to rectify this. It should be noted that the dosing pumps are in various states of repair and currently no LPU has a management information system which provides a key element of the wash validation under BS14065

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The implementation of an All-Wales Laundry Detergent contract provides a compliant method in line with Standing Orders of continuous supply of detergent to the five LPUs. It also provides an opportunity for possible savings that would not have been achievable without having all LPUs under one contract due to economies of scale, as all five LPUs currently have individual non-compliant contracts which do not include dosing equipment and management software. New dosing equipment and detergent software can also lead to a reduction in usage which could lead to further savings. The Laundry Service is also going through a transformational project that will see the construction of two brand new laundries and redevelopment of one current site with four LPUs being decommissioned. The equipment for these new and redeveloped LPUs maybe provided by one supplier who will tailor the equipment design to whatever detergent and dosing equipment that the LPUs are signed up to.

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 non-compliant orders of detergent.	STA put in place to cover time period of tender currently as all LPUs are utilising the same supplier, this would need to be extended.
Failure of dosing equipment.	This would need to be replaced at a cost by the current detergent supplier as the dosing equipment is specifically designed for the product it produces.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☒	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☒	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			
The proposed agreement will be tendered under the open workflow procedure in Bravo for a single supplier to be awarded. As the value is above the threshold it will be advertised under Find A Tender Service (Via Sell2Wales). The decision to utilise the open procedure has been taken as suppliers are well established within a specialist category area. The length of the contract has been selected because of the need for the supplier to front load the contract with dosing equipment and MMI information systems. This will be awarded under the NHS Standard T&C's.			
6.3 What is the approximate timeline for procurement?			
The briefing paper was approved by the service on 7th April 2022, Director of Finance and Corporate Services on 8th April 2022 and by Director of Procurement and Health Courier Services on the 12th April 2022. Welsh Government have been advised of this tender due to its value and have confirmed that it has been noted. The Tender has been published the week commencing 2nd May 2022 with an anticipated contract start of 1st September 2022.			

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:	4th May 2022

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **2800**	**Including VAT (£k)** **3360**
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
Supply of detergent / dosing pumps / MIS system (Revenue)	400	400	400	1600	2800	3360
Overall Total	400	400	400	1600	2800	3360

8. PROJECT MANAGEMENT (if applicable)

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

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name:	Andy Butler
Signature:	
Service Area:	NWSSP Finance & Corporate Services
Date:	13 May 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	N/A
Divisional Senior Management Team	N/A
Executive Management Board	N/A

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	19 May 2022
HTW – Senior Management Team	N/A

TRUST BOARD

REMUNERATION COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	26 May 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Prof. Donna Mead OBE, Chair of Remuneration Committee
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Director of Organisational Development and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper had been prepared to provide the Trust Board with details of the key issues considered by the Remuneration Committee on 28 April 2022.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Trust Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing of note to report
ADVISE	**Authorisation of Redundancy Payment – Following Fixed Term Contract Completion** The Remuneration Committee approved a redundancy payment following completion of a fixed term contract.
ASSURE	Nothing of note to report.
INFORM	**Anonymous Communication** The Remuneration Committee noted the receipt of an anonymous letter which had been dealt with in accordance with the Trust Policy. A review of retention levels was being undertaken to understand any underlying reasons for the increase in staff turnover. The outcome of the review would be reported to the Quality, Safety and Performance Committee.
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TRANSFORMING CANCER SERVICES SCRUTINY SUB-COMMITTEE

DATE OF MEETING	26 May 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
OBC	Outline Business Case
FBC	Full Business Case
TCS	Transforming Cancer Services
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
IM	Independent Member
nVCC	New Velindre Cancer Centre
TCS	Transforming Cancer Services

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 4 May 2022.

1.2 This is not considered a full update on the Programme but a high-level record of the matters of business conducted by the TCS Programme Scrutiny Sub-Committee.

1.3 Key highlights from the meeting are reported in section 2.

1.4 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	**Finance Report** The TCS Finance Report was presented to the Sub-Committee, and it was noted that the year-end outturn was £37,909 underspend on Capital and £11,420 underspend on Revenue. A number of points of clarification were noted in relation to the following matters: • **Allocation from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management:** The Sub-Committee requested that the associated narrative be reviewed to reflect the correct position for this funding. • **Funding for site management, security, and legal matters:** The Sub-Committee requested that a brief addendum be provided for the next meeting to clarify how much funding the Trust had provided for the TCS Programme that was not specifically allocated and also the sources of the funding for the TCS Programme as a whole. The Sub-Committee **noted** the finance report and the requirement for a brief addendum to the finance report for the next meeting. **TCS Programme Risks and Issues Register** The Sub-Committee received and considered the TCS Programme Risks and Issues Register. Following discussion, the Sub-Committee

	highlighted that the latest risks and issues positions appeared to not be up to date, and that this matter had been raised at previous meetings. The Sub-Committee requested that all registers presented at each meeting needed to be accurate and reflect the most up to date position, even if there was no progress to report. More importantly, where a target date has passed, the update must provide an explanation for not meeting the target date and a revised date. The Sub-Committee **noted** the Risks and Issues Register.
ASSURE	**Projects 1 and 2: Internal Audit Reports** The Sub-Committee noted that the two reports had been presented to the Audit Committee and that several points had been raised that would be addressed by the Audit Committee. The reports were: - MIM Governance, which was classified as “green” - Substantial assurance level - Contract Management, which was classified as “yellow” – Reasonable assurance level The Sub-Committee requested, for future reporting, that any scrutiny and challenge made at the Audit Committee should be reflected in the Sub-Committee cover papers. The Sub-Committee **noted** the Internal Audit Reports and the actions being taken forward at the Audit Committee. **Communications & Engagement** The Sub-Committee received and **noted** the Communication and Engagement Update.
INFORM	There were no items identified to inform the Trust Board
APPENDICES	NOT APPLICABLE

TRUST BOARD

Communications and Engagement Update

DATE OF MEETING	26 May 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**
nVCC project board Enabling Works project board TCS Programme Board TCS Programme Scrutiny Sub-Committee	20 April 2022 21 April 2022 4 May 2022	Noted

ACRONYMS

nVCC	New Velindre Cancer Centre

1. SITUATION

2. BACKGROUND

This paper provides the Board(s) with an update on communications and engagement for the period for end of March to beginning of May.

3. ASSESSMENT

Over the reporting period we focused our efforts on:

- **Strategic counsel and preparing communications and engagement support ahead of phase three of site clearance works**
  - Producing communications action plan and drafting subsequent content for internal and external stakeholders
  - Coordinating briefing meetings with identified stakeholders; this included MS MP, ward Councillors, Hollybush Estate Residents Association and liaison with other key community groups.
  - Direct bilingual mail shots to local residents
  - Sharing content across Velindre Matters channels and monitoring social media, including responding to questions and messages
  - Liaison with Walters and Nexus, as well as ASDA to manage messaging.
  - Liaison with South Wales Police, Welsh Government and Cardiff Council communications to provide appropriate updates

- **Managing media enquiries and related social media commentary** as part of the site clearance works beginning. Media coverage outlined below:
  Since March, we are delivering daily reports summarisng social media output. The main commentary include:
  - Patient safety re: the lack of acute medical care provision on VCC site
  - Environmental destruction in the meadows
  - Response to the Aarhus Convention decision regarding of costs of legal challenge

- Air Quality monitoring
- Public Right of Way access

- **Responding to correspondence from a wide range of stakeholders.** There has been a considerable increase in correspondence sent to the Contact Velindre mailbox during the reporting period specifically relating to the clearance works. The key recurring themes are:
  - enabling works practical issues, contractors behavior
  - working to the required permissions
  - reporting of any activity outside licenses
  - traffic management
  - challenges in relation to the clinical model and patient safety
  - impact on trust in the Velindre brand and its wider reputation within the community
  - decision on the Hollybush emergency bridge and the potential alternative
  - noise pollution
  - air quality statistics and process
  - wildlife management
  - PROW – both in terms of access to existing Public Rights of Way and
  - Legal challenge and injunction process

36 individual pieces of correspondence have been received between 1 February and 14 April 2022. This does not include the correspondence received through the then elected Councillors and MS/MP but does include 19 queries received via the Handling Concerns mailbox.

The volume of comments/queries/complaints received by Cardiff Council prompted a discussion and agreement between our organisations on how to improve the process for processing correspondence in future. The process map for both a new internal process and joint process with Cardiff Council will be approved by the end of April 2022 and in advance of the commencement of the upcoming enabling works in early summer 2022.

- **Political stakeholder meetings** – in addition to the regular meetings with the local constituency MS and MP, we established open channels of communication with the elected Councillors for the ward, prior to the

commencement of pre-election guidance. During the pre-election period no meetings are taking place.

- **Petitions Committee** - during the reporting period, the Senedd Petitions Committee received further correspondence from both VUNHST and STNM. During its proceedings on 21 March, the Committee decided to close both Velindre petitions down which resulted in a limited number of social media posts by STNM supporters.

- **The development of the engagement hub space within VCC** – two hubs are now installed in the cancer centre to provide content and related surveys to gain further insight and engagement for the green ambitions and overall plans for the new Velindre Cancer Centre. The hubs include electronic surveys to allow us to map trends and questions on an ongoing basis. The surveys go live on 3 May subject to IPC approval.

- **Supporting the development of a wider value added programme including planning for a wider discussion with the local community.**

- **Supporting the distribution of any communications in support of legal action** (legal challenge and injunction process)

- **The recruitment of a new Senior Engagement Manager (starts on 3 May) and Senior Communications Manager (recruitment underway).**

For the next month, our priorities will be as follows:

- Plan for a comprehensive communication plan in support of the commencement of enabling works in early summer 2022.
- Plan for a comprehensive communication plan in support of the evaluation of the competitive dialogue process also in June 2022.
- Supporting the establishment of the Value Add programme in the community.
- Embedding the social media plan.
- Deliver communications in support of the injunction process.
- Continue to provide communications support to the Enabling Works team.
- Delivering a quarterly newsletter to the local community and digital updates.
- Launching the survey in the engagement hubs at VCC that allows us to track and score staff and patient sentiment, understanding and ideas.

- Continue to socialise the value add engagement programme to garner support and develop appropriate plans for each aspect of the programme to deliver in 2022.
- Introduction meetings with the newly elected Councillors
- Supporting the nVCC research and development working group, alongside its Trust counterpart.
- Supporting the patient engagement framework and related activities.

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

5.1 The Trust Board are recommended to **NOTE** the paper.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 10 MAY 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 10 May 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 15 March 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. Genomics Presentation

Members received an informative presentation on the All Wales Genomics Laboratory and how the Wales Infants and Children's Genome Service (WINGS) had pushed the boundaries of genomic testing in Wales to an unprecedented scale using whole genome sequencing which had the capacity to sequence the entire DNA structure of the human body in a matter of hours.

Members noted the Watson family's patient story (publically available on the BBC website) which shared their first hand experience of using the WINGS, when their baby suffered from breathing difficulties and complications to her nose and airways.

Members **noted** the presentation.

4. Chair's Report

Members received the Chair's Report and **noted**:

- An update on the proposal for an interim Chair of the Individual Patient Funding Request (IPFR) Panel,
- Attendance at the Integrated Governance Committee (IGC) meetings on the 30 March 2022 & 19 April 2022; and
- Attendance at key meetings.

Members **noted** the report.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- That WHSSC had been successful in publishing an article in the Applied Health Economics and Health Policy Journal on a "A Case Study on Reviewing Specialist Services Commissioning in Wales: TAVI for Severe Aortic Stenosis",
- The first two NRP (Normothermic Regional Perfusion) organ retrievals undertaken by the the Cardiff Transplant Retrieval Service,
- The stakeholder engagement being undertaken on the Genomics Delivery Plan for Wales,
- The positive feedback received following the Extension of the FastTrack Process for Military Personnel; and
- The findings of a review into Molecular Radiotherapy (MRT) to guide development of an all Wales MRT service.

Members **noted** the report.

6. Interim Appointment of Chair for the All Wales IPFR Panel

Members received a report proposing that an Interim Chair is appointed to the Individual Patient Funding Request Panel (IPFR) for a 3 month period to support business continuity and to allow sufficient time to prepare for, and undertake, a recruitment process to appoint a substantive Chair.

Members (1) **Noted** the report; and (2) **Approved** the proposal to appoint an interim Chair to the Individual Patient Funding Request Panel (IPFR) for a 3 month period to support business continuity and to allow sufficient time to recruit a substantive Chair.

7. Neonatal Transport Operational Delivery Network

Members received a report providing an update from the Neonatal Transport Delivery Assurance Group (DAG) established to provide commissioner assurance on the neonatal transport service.

Members (1) **Noted** the information presented within the report; and (2) **Received assurance** that there were robust processes in place to ensure delivery of the neonatal transport services.

8. Draft Mental Health Specialised Services Strategy for Wales 2022-2028

Members received a report presenting the draft Mental Health Specialised Services Strategy for Wales 2022-2028, and seeking endorsement for its circulation through key stakeholder groups for comment.

Members (1) **Noted** the draft Mental Health Specialised Services Strategy for Wales 2022-2028, and provided comments on the document,

(2) **Noted** that the draft Mental Health Specialised Services Strategy for Wales 2022- 2028 would be circulated through a comprehensive stakeholder list in a bilingual format for comment and that the suggested date of between 10 May and 6 June 2022, would be reviewed and extended; and (3) **Noted** that it was anticipated that the final strategy would be published during Winter 2022, and will be brought back to the Joint Committee for approval.

9. Preparedness for the COVID-19 Inquiry
Members received a report providing an update on WHSSC's preparedness for the COVID-19 Public Inquiry.

Members **noted** the report.

10. Disestablishment of the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group
Members received a report providing a brief overview of the work that had been undertaken by the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group and which was seeking support to disestablish the advisory group, as there was no longer a requirement for it to be established as a sub group of the Joint Committee.

Members (1) **Noted** the work undertaken by the Joint Committee's sub group the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group, (2) **Approved** the proposal to disestablish the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group; and (3) **Noted** that the work of the group had been incorporated into the Inclusion and Corporate Business Division within Social Services in Welsh Government (WG), and that further consideration was required on the system of oversight of health board commissioned LD placements.

11. Annual Governance Statement 2021-2022
Members received the Annual Governance Statement (AGS) 2021-22 for retrospective approval.

Members (1) **Noted** the report, (2) **Noted** that the Draft Annual Governance Statement (AGS) was endorsed at the Integrated Governance Committee (IGC) on 19 April 2022 and the draft was submitted to CTMUHB in readiness for the 29 April 2022 deadline set, (3) **Approved** the WHSSC Annual Governance Statement (AGS) 2021-2022, (4) **Noted** that the WHSSC Annual Governance Statement (AGS) 2021-2022 will be included in the CTMUHB Annual report being submitted to Welsh Government and Audit Wales by 15 June 2022, recognising that it had been reviewed and agreed by the relevant sub committees of the Joint Committee; and (5) **Noted** that the final WHSSC Annual Governance Statement (AGS) will be included in the Annual Report presented at the CTMUHB Annual General Meeting (AGM) on 28 July 2022.

12. Sub-Committee Annual Reports 2021-2022

Members received the Sub- Committee Annual Reports for the reporting period 1 April 2021 to 31 March 2022 which set out the activities of each sub-committee during the year and detailing the results of reviews into performance.

Members **noted** the Sub-Committee Annual Reports for 2021-2022.

13. Sub-Committee Terms of Reference

Members received the updated Terms of Reference (ToR) for the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC) and the Management Group (MG) for approval.

Members noted that ToR for the sub-committees of the Joint Committee were reviewed on an annual basis in line with Standing Orders and to ensure effective governance.

Members noted that ToR for the Welsh Renal Clinical Network (WRCN) were approved by the Joint Committee on 18 January 2022, and discussions were ongoing with Welsh Government concerning updating the ToR for the All Wales IPFR panel.

Members (1) **Noted** that the Terms of Reference were discussed and approved at sub-committee meetings on 30 March 2022 and 28 April 2022; and (2) **Approved** the revised Terms of Reference (ToR) for the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC) and the Management Group (MG).

14. COVID-19 Period Activity Report for Month 11 2021-2022

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 (1) **Noted** the report; and (2) **Agreed** to hold an extended session on activity reporting at the next meeting of the Joint Committee in July to scrutinise provider recovery reports.

15. Financial Performance Report – Month 12 2021-2022

Members received the financial performance report setting out the financial position for WHSSC for month 12 2021-2022. The financial position was reported against the 2021-2022 baselines following approval of the 2021-2022 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in January 2021.

The financial position reported at Month 12 for WHSSC was a year-end outturn under spend of £13,112k.

Members **noted** the report.

16. 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.

17. Other reports

Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Audit & Risk Committee (ARC)
- Management Group (MG),
- Quality & Patient Safety Committee (QPSC),
- Integrated Governance Committee (IGC),
- All Wales Individual Patient Funding Request (IPFR)Panel; and
- Welsh Renal Clinical Network (WRCN).

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	24 March 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Recruitment Modernisation Programme

The Director of People and Organisational Development and the Deputy Director of Employment Services gave a detailed presentation of the work being undertaken in Recruitment to support the significant increase in activity since the start of the pandemic. Looking back to when NWSSP was first established in 2011, significant progress has been made in streamlining the recruitment process, demonstrated by a reduction in the average time-to-hire from 132 to 71 days. New services have been taken on and the Welsh Language functionality has been enhanced. Last summer, further initiatives were progressed relating to the Workforce Directors' Responsiveness Programme including enhancements to TRAC, development of the applicant web page, and maintaining virtual pre-employment checks.

During late summer 2021, the service was faced with unprecedented and unplanned levels of recruitment across NHS Wales due to the Covid response, resulting in the usual high level of compliance with KPI targets not being sustained. This led to the need to review the way in which recruitment is undertaken in Wales and where applicable modernise the service further through changes to processes, technology, and education.

The Deputy Director provided details of specific initiatives under each of the headings of process, technology, and education. One key technological initiative is investment in pre-employment check software that enables identification documents to be held in ESR and viewed via the ESR app. This has been promoted by the Home Office, however the technology is not currently available, but it will be fundamental to virtual pre-employment checks continuing after the current proposed Home Office end-date of September 2022. Due to the short notice provided by the Home Office over this software, funding to purchase it still needs to be confirmed.

The Modernisation Action Plan is to be taken to the All-Wales Workforce and OD peer group meeting in early April, with a formal update to the May Committee.

The Committee **NOTED** the presentation.

Chair's Report

The Chair updated the Committee on the activities that she had been involved with since the January meeting. This included chairing her first Welsh Risk Pool Committee which had been very informative; attending the Hywel Dda Sustainability Committee; and also attending the NHS Wales Chairs' meeting which allowed her to keep updated on the latest developments and issues. Going forward there will be a number of attendances at board meetings, starting with Digital Health Care Wales and then Health Education and Improvement Wales. The Chair is keen that these are not used solely for NWSSP to update on performance, but to elicit a two-way exchange of ideas and information.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The IMTP has now been formally submitted to Welsh Government for their consideration;
- As part of a UK-wide response to the war in Ukraine, Welsh Government asked NWSSP to identify any surplus equipment and consumables that could be donated to Ukraine. Review of current stocks identified items to the value of £524k that could be donated as they are surplus to current requirements (PPE, ventilators, and medical consumables). Thus far, over £131k of surplus items has already been sent to Ukraine from NWSSP;
- The purchase of Matrix House in Swansea was completed by the end of March. The building is currently 75% occupied by NHS Wales, with Public Health Wales and the Welsh Ambulance Service NHS Trust as tenants in addition to NWSSP. Acquisition of this asset will lead to a reduction in future revenue costs to NHS Wales and the opportunity to create a wider public sector hub at some point; and
- The Minister for Health and Social Care visited our Imperial Park 5 Warehouse on 17th March, providing an opportunity to demonstrate to her the extensive range of services that now operate from this facility.

Items Requiring SSPC Approval/Endorsement

Lease Car Salary Sacrifice

In July 2021, the Committee agreed to reduce the CO2 emissions for Salary Sacrifice vehicles through the NHS Fleet scheme. Whilst the intentions of this decision were well founded, the implementation of the first phase from 120g/km to 100g/km has generated the following issues:

- Those staff who do not have driveways and therefore home charging facilities, are either unable to participate in the scheme or have a very limited choice of cars;
- Only certain EV and hybrid cars meet the lower CO2 limits – therefore a large number of small fuel-efficient cars e.g. 1 litre VW Polo, Ford Ka etc are no longer available to staff. This is particularly problematic to those staff who live in the more rural areas

In view of the above it is evident that some staff are opting not to apply for salary sacrifice cars but instead are continuing to use their private cars, commonly referred to as the 'grey fleet'. These cars are generally older and emit more pollution than the vehicles that were previously available on the lease car salary sacrifice scheme.

In view of this, it was proposed to reinstate the 120g/km cap for petrol and hybrid vehicles from 1st April 2022 but not to allow diesel vehicles to be ordered. The impact of this will be to increase the range of vehicles available, remove new diesel vehicles from the Scheme and provide greater access to those staff who do not possess home charging facilities.

It was also noted that NWSSP do not administer this Service to all Health Boards and Trusts, and it was agreed that the provision of the administration of service to an all-Wales service should be explored

The Committee **APPROVED** the proposed:

- Adjustment in the CO2 emissions;
- Removal of the ability to order new diesel cars on the scheme

Items For Noting

Energy Update

The Committee received a paper relating to the current situation with energy prices. Due to the nature of the markets and high expenditure, the Energy Price Risk Management Group (EPRMG) was formed in 2005 to manage exposure to risk across the NHS Wales energy contracts. The overarching aim of the group is to minimise the impact of energy price rises through proactive management and forward buying.

There have been very significant increases in gas and electricity prices during the year, particularly during recent weeks following the outbreak of the Ukraine war. The EPRMG strategy of purchasing ahead has meant that NHS Wales has benefitted substantially and avoided most of the price increases for gas and electric supply. Whilst this strategy has protected NHS Wales from the huge increase in market prices for 2021/22 it is likely that there will be very significant hikes in energy costs in 2022/23 because of the current contracts coming to an end.

The recent increase in energy costs is very unwelcome, but is unavoidable given the current war in Ukraine, the sanctions applied to Russia and the removal of Russian Gas and Oil from supplying the global market. However, the EPMRG will attempt to manage the energy costs for NHS Wales as best as we can over the year ahead.

The Committee **NOTED** the paper.

Finance, Performance, People, Programme and Governance Updates

Finance – The Director of Finance & Corporate Services reported that NWSSP was on track to meet each of its revenue financial targets for 2021/22 and the projected outturn on the Welsh Risk Pool was in line with the Integrated Medium-Term Plan. Additional capital funding had been received in quarters three and four, but plans were in place to ensure the funding was fully utilised by the end of the financial year.

Performance – Most KPIs are on track except for those relating to Recruitment Services which was the subject of the deep dive earlier in the agenda. The move towards qualitative output focused measures continues within NWSSP.

People & OD Update – Sickness absence rates remain at very low levels with an absence rate of 2.93% for the last quarter. Performance and Development Reviews and Statutory and Mandatory training results continue to improve although there is still room for further improvement. Headcount is increasing due mainly to the additional staff recruited as part of the Single Lead Employer Scheme. The ESR database has been modified such that most of the facilities it provides can be accessed and delivered in Welsh

Corporate Risk Register – there are two red risks. The first relates to the pressures currently being noted within the Employment Services Directorate, and particularly in Recruitment and Payroll Services, which was the subject of the earlier deep dive. The second refers to the energy price increases which again was the subject of an earlier agenda item.

Papers for Information

The following items were provided for information only:

- PMO Highlight Report
- Audit Committee Highlight Report
- Quality and Safety Assurance Report
- 2022/23 Forward Plan
- Finance Monitoring Returns (Months 10 and 11)

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 May 2022

TRUST BOARD

APPROVED POLICIES UPDATE

DATE OF MEETING	26/05/2022

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 & 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**
Infection Prevention and Control Divisional Group – Velindre Cancer Service	09/03/2022	ENDORSED FOR APPROVAL
Trust Infection Prevention and Control Management Group	23/03/2022	ENDORSED FOR APPROVAL
Executive Management Board	27/04/2022	ENDORSED FOR APPROVAL
Quality, Safety & Performance Committee	12/05/2022	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 the March 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 March 2022 Trust Board are outlined below:

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
IPC 07: Policy for the Prevention and Control of Methicillin Resistant Staphylococcus Aureus (MRSA)	Executive Director of Nursing, Allied Health Professionals and Health Science	Quality, Safety & Performance Committee	12/05/2022	**1**

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	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 policies that have been approved since the March 2022 Trust Board.

Ref: IPC 07

Policy for the Prevention and Control of Methicillin Resistant Staphylococcus Aureus (MRSA)

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Science
Document Author:	Infection Prevention & Control Team
Approved by:	Trust Quality, Safety & Performance Committee
Approval Date:	
Date of Equality Impact Assessment:	*January 2020*
Equality Impact Assessment Outcome:	*This policy has been screened for relevance to equality. No potential negative impact has been identified.*
Review Date:	Three years: May 2025
Version:	4

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

CONTENTS

ABBREVIATIONS

CANISC	Cancer Network Information System Cymru
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
CP's	Contact Precautions
CRA	Clinical Risk Assessment
HCW	Health Care Workers
HICK	Broviac Implants
ICNet	ICNet Clinical Surveillance Software
IPCT	Infection Prevention and Control Team
IV	Intravenous
MRSA	Methicillin Resistant *Staphylococcus Aureus*
MSSA	Methicillin Sensitive *Staphylococcus Aureus*
OCCH	Occupational Health
PICC	Peripherally inserted central catheter
PPE	Personal protective clothing
UHB	University Health Board
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust

1. POLICY STATEMENT

Staphylococcus aureus and Methicillin Resistant *Staphylococcus Aureus*

Approximately 30% of the population is colonised by *Staphylococcus aureus* (methicillin sensitive *Staphylococcus aureus*), which is usually present on the nose and/or skin. *S.aureus* infections acquired outside a healthcare setting typically involve the skin and soft tissue (e.g., impetigo, folliculitis, boils, and infected minor breaks of skin) and more rarely the bone and joints.

Healthcare associated *S.aureus* may infect the skin and soft tissue, usually as surgical wound infection, but also colonise the foreign bodies frequently used in patient care causing infections (e.g. intravascular line infection, prosthetic-related infections, urinary catheter-associated infections, ventilator-associated pneumonia). Infections can sometimes be severe and spread to the bloodstream.

Methicillin Resistant *Staphylococcus aureus* (MRSA) is resistant to antibiotics such as Flucloxacillin, an initial option for treating some infections. Some MRSA strains may also be resistant to a wider range of antibiotics leaving a limited choice of antibiotics to treat infections.

Methicillin Sensitive *Staphylococcus aureus* (MSSA) and MRSA are mainly transmitted by direct and indirect physical contact e.g. through the contaminated hands of health care workers (HCW) and / or re-useable equipment if not decontaminated correctly after use on another MSSA / MRSA colonised patient.

This policy sets out appropriate controls and clinical procedures in place to minimise the risk of transmission of MRSA between service users, patient's visitors and staff. The policy has been reviewed and updated.

2. SCOPE OF POLICY

The policy applies to all staff, in all locations of Velindre University NHS Trust ("the Trust") including those with honorary contracts and students placement.

3. AIMS AND OBJECTIVES

Provide the Trust with structured and appropriate guidance to staff for the prevention and management of MRSA colonisation/infection.

- Set out the requirements for all HCWs involved in the care and management of patients with MRSA.
- Ensure best practice and high quality of care.
- Provide staff with the screening process for admission to hospital.
- Ensure that patients with MRSA have effective and appropriate care wherever that care is delivered.

- Reduce the risk of transmission, acquisition, colonisation and infection with MRSA.

4. RESPONSIBILITIES

4.1 The Chief Executive

The Chief Executive has overall responsibility for implementation, monitoring and review of this policy.

4.2 Clinical and Operational Managers

Clinical and Operational Managers have responsibility to ensure that:

- Staff are informed of the policy.
- Practice complies with this policy.
- Equipment and training is available to facilitate compliance with policy.

4.3 Clinical staff working directly with patients and the public

Clinical staff working directly with patients and the public have responsibility to ensure that they:

- Familiarise themselves with the policy.
- When appropriate clinically risk assess patients for MRSA on every admission.
- Manage patients at risk of, or diagnosed with MRSA in a way that will reduce the risk of transmission from patient to patient or patient to staff.
- Report cases transferred in from other hospitals.

4.4 Infection Prevention & Control Team (IPCT)

The IPCT is responsible for:

- Providing advice on appropriate placement of patients with MRSA in hospital.
- Producing timely feedback on surveillance of MRSA acquisition for wards/units, departments and Trust.
- Ensuring that patients with first time isolates of MRSA have an Infection Prevention & Control alert placed currently on Cancer Network Information System Cymru (Canisc).
- Ensuring that clinical teams are informed about their patients following identification of MRSA either in pre-admission assessment clinics/outpatient department or when the patient has been an in-patient.
- Producing reports to relevant committees and groups and for the Trust Board on MRSA.
- Ensuring that all MRSA bacteraemias are reported to Public Health Wales via ICNet
- Supporting the investigation of and learning from any MRSA bacteraemia post infection reviews.
- Investigating suspected incidents of cross infection.

4.5 Domestic/Housekeeping Staff

Housekeeping **staff** are responsible for:

- Ensuring that they comply with the infection control management of MRSA patients as detailed and that they challenge or report any poor practice.
- Ensuring that enhanced cleaning is carried out for all MRSA patients in their area.
- Terminal cleans on discharge / negative results.

4.6. Distribution

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

5. DEFINITIONS

5.1 Staphylococcus Aureus

Is a Gram positive bacterium often found on the skin or in the nose of individuals. It colonises the skin or anterior nares (nose) of approximately 20 - 30% of healthy individuals but this percentage can rise in hospitalised patients. The organism can cause abscesses, wound infections and septicaemia. One strain of *S. aureus* known as MRSA is resistant to an antibiotic called methicillin and other antibiotics used to treat infection. This strain accounts for 2 – 3% of all *S.aureus* strains but is no more virulent or more readily spread than MSSA.

5.2 Methicillin Resistant *Staphylococcus Aureus* (MRSA)

Methicillin resistant *Staphylococcus aureus* is a significant cause of healthcare associated infection. It can result in blood stream infection (bacteraemia) that can be life threatening. MRSA can also cause skin and wound infections, urinary tract infections and pneumonia. These infections require treatment with antibiotics**.**

It can be easily transmitted by direct skin contact or by indirect contact via equipment and fomites. It has the capacity to survive in the environment for prolonged periods and is resistant to a wide range of antibiotics.

5.3 Carriage

A person who harbours MRSA with no overt signs or symptoms of clinical disease, but who is a potential source of infection. Recognised carrier sites for MRSA include the nose and throat and certain skin sites, such as perineum, groin, axilla and buttock. The carriage of MRSA can be transient, intermittent or of long duration (chronic).

Transient carriage

Occurs when MRSA is present on the hands, arms, face or inside the nose for a short period of time, i.e. a few hours. Staff often become transient carriers when caring for patients with MRSA**.**

5.4 Colonisation

Colonisation by MRSA is harmless and asymptomatic to the patient but in a small number of cases it can cause infection ranging from minor skin infections to BSI's. MRSA colonisation can only be identified by taking swabs from the following sites: nose, groin, wounds, sputum (if the patient has a productive cough) and urine sample (if the patient has a catheter in situ).

Patients colonised with MRSA can be a significant issue in healthcare settings because:

- Patients colonised with MRSA who undergo invasive procedures are at risk of developing an MRSA infection.

- The presence of patients colonised with MRSA in hospitals is a potential source of infection for other patients.
- Should MRSA infections develop they are harder to treat as the antibiotics they are susceptible to are more limited.

5.5 Infection

With MRSA occurs when the presence of MRSA causes clinical consequences, e.g. inflammation, swelling and pus formation. MRSA infection can occur in the skin and soft tissues, lungs, bones and joints or in the blood stream i.e. MRSA bacteraemia.

5.6 Panton Valentine Leukocidin

Panton Valentine Leukocidin (PVL) is a toxic substance produced by some strains of *S.aureus*, which is associated with an increased ability to cause disease. The incidence is low at present.

PVL can be produced by both methicillin sensitive and methicillin resistant strains of *S. aureus.* At present in the UK the majority of isolates are methicillin sensitive.

The infection control measures used to prevent the spread of PVL-positive MRSA are the same as for any type of MRSA infection; this includes screening and the decolonisation regime.

PVL MRSA affects healthy children and young adults and is usually community acquired. Staff should wear face masks during intubation and chest physiotherapy. Closed suction should be used.

Patients identified on screening as having a PVL producing strain of MRSA may need specific screening and treatment. In this instance advice should be sought from the IPCT as family members may require screening.

6. IMPLEMENTATION/POLICY COMPLIANCE

6.1 Background

Patients may be carriers of MRSA or contract it through transmission from another affected person. MRSA can cause wound, respiratory, urinary or blood stream infections. The Clinical Risk Assessment (CRA), (Appendix 7) in this policy ensures staff screen patients that are at a higher risk of infection from MRSA (for example, previous MRSA history or admission).

The ‘Implementation of modified admission MRSA screening guidance for NHS’ from the Department of Health in 2014 required MRSA screens for acute and elective admissions in England to be streamlined to the following:

- All patients admitted to high risk units.
- All patients previously identified as colonised with or infected by MRSA.

Routine MRSA screening has been shown to detect MRSA colonisation early and provides the opportunity to eradicate carriage to prevent transmission and/or infection. Following an evaluation of the Health Protection Scotland’s Pathfinder Programme, the Chief Medical Officer (CMO)/Chief Nursing Officer (CNO) Wales implemented targeted MRSA screening across Wales. CMO/CNO letter stipulates the introduction of routine MRSA screening for all patients in the following patient groups, as a minimum and includes:

A requirement to use CRA to assess each admission as to whether the patient:

- Has a past history of colonisation/infection with MRSA at any time
- Is resident in a care home, other institutional setting or is a transfer from another hospital
- Has a wound or in-dwelling device (e.g. gastrostomy, urinary catheter, long term intravascular device) present on admission

A requirement to swab screen any patient who answers yes to any of the above questions using a minimum of 2 swab sites (nasal/perineum or nasal/throat if perineum/ groin is deemed difficult or unacceptable).

- A record of the assessment and results of the swab.
- Prioritisation (within existing schemes of prioritisation) for pre-emptive isolation/cohorting pending swab results.

6.2 Risk Factors for MRSA carriage

Patients who are risk from colonisation or infection from MRSA are those who;

- Are known to be carrying MRSA, or to have done so previously.
- Are admitted from care homes.
- Have been in hospital within the past 12 months.
- Are transferred from other hospitals or from abroad.
- Have received repeated course of antibiotics.
- Have renal disease or diabetes.
- Have skin breaks for example for pressure sores, leg ulcers, central/peripheral venous catheter, percutaneous endoscopic gastrostomy tubes and any other indwelling devices.
- Have certain active dermatological conditions, for example psoriasis or eczema.
- Oncology patients with head and neck cancer (based on local data).

6.3 Diagnosis of Infection

Any patient found to be a carrier of MRSA should be assessed for evidence of infection, for example sepsis syndrome, skin and soft tissue infection, pneumonia, bone/joint infection, device related infection, endocarditis. The need for in dwelling catheters and intravascular devices should be reviewed and they should be removed when possible to minimise risk of subsequent infection.

MRSA isolated from sputum or from urine, usually represents colonisation but patients should be carefully assessed for active infection.

Eradication of MRSA from catheterised patients usually requires catheter removal or at least change, with or without systemic antibiotic therapy. Advice should be sought from the microbiologist.

MRSA isolated from non-inflamed skin or ulcers, or from other sites where there are no overt signs of infection implies colonisation rather than infection and should be managed as such without oral or parenteral antibiotics. MRSA isolated from a clinically infected wound, or inflamed ulcer, should be interpreted according to the clinical picture.

6.4 Screening

Screening should be carried out according to the guidance below or as directed by the IPCT. A patient screen should only include:

- Nasal swab.

- Perineal swab (or groin if perineum not accessible).
- Swabs of any breaks in skin, including wounds, vascular access devices and drain exit sites (see appendix 1).

*Charcoal (black) swabs should be moistened with sterile saline or sterile water prior to use.

The MRSA screen is requested via the Welsh Clinical Portal. Give additional information if submitting additional swabs of any indwelling devices/ and or wounds and provide the relevant clinical information.

6.5 Who should be screened?

All patients who will have planned admissions for long courses of daily radiotherapy or inpatient chemotherapy should be screened for MRSA on their first appointment with the Oncologist, or at the time the treatment plan is devised. This will ensure that screen results are returned before admission and that no patient colonised or infected with MRSA is placed on an open ward.

6.5.1 Patients requiring peripherally inserted central catheters (PICC) and Broviac Implants (Hickman Line)

All patients scheduled to receive a PICC or a Hickman line must be screened where possible, two weeks before insertion of the device. This will allow time for turnaround of results and decolonisation if necessary. If the PICC or Hickman line is an emergency, a screen for MRSA should be taken as soon as possible. (See appendix 3).
The same principles apply to patients for whom a Hickman line is planned.

6.5.2 Patients undergoing radiotherapy as inpatients

All planned admissions to the inpatient wards, for example those undergoing prolonged courses of radiotherapy, should be screened no later than one week prior to admission or at their first appointment at VCC.

6.5.3 Patients undergoing chemotherapy as an inpatient

All planned admission to the inpatient chemotherapy ward should be screened for MRSA no later than one week prior to admission or at the first outpatient appointment in VCC.

6.5.4 Patients with head and neck cancers.

Patients with a head and neck cancer should be screened for MRSA at least one week prior to admission or at their first appointment in VCC.

Historical data shows that some patients with head or neck cancers are positive for MRSA in the throat and on that basis, throat screens may in special circumstances be requested by the IPCT but should not be included as part of a routine screen.

6.5.5 Outreach patients.

A number of patients do not attend VCC, instead they attend “Outreach” clinics hosted by surrounding Health Boards. These patients are attended by Velindre oncologists and Velindre specialist nurses. For those patients for whom an admission to VCC is planned, the specialist nurse or oncologist must screen or arrange for the patient to be screened for MRSA. Staff who place the PICC, or admit the patient must then access the results of the MRSA screen from the relevant UHB microbiology department. Please seek help from the IPCT if difficulties are experienced.

6.5.6 GP screening

It may on occasion be more convenient for patients to be screened for MRSA by their own GP. If this is the case the fact should be documented and the responsible clinician

should obtain the results of the screen from the patients GP. A written record from the GP handed to the patient is acceptable.

6.5.7 Unplanned emergency admissions

In the case of unplanned or emergency admissions patients should be screened for MRSA within 48 hours/ 2 days of admission. Use CRA when deciding which patients to isolate. For example where possible isolate patients with head and neck cancers who have not been screened. Contact the IPCT for advice.

6.5.8 Patients known or suspected to be MRSA positive

Any patient known to be or suspected to be MRSA positive should be isolated and screened with contact precautions (CP's) continuing until the MRSA screen results are returned.

6.5.9 Isolation of patient with MRSA

Separation of patients with MRSA (in an individual room) from others in order to prevent or limit the direct or indirect transmission of MRSA to other people who are susceptible.

6.5.10 Cohort nursing of patients with MRSA

A group of patients with MRSA who are separated from patients who do not harbour MRSA in a geographically distinct area or with physical separation in the same room. Isolation in separate rooms is preferable to cohort nursing. Ideally, the same nursing staff should provide daily care for the same cohort for the duration of the isolation.

6.5.11 Previously decolonised patients

Patients for whom there is documented evidence of a successful decolonisation programme can be nursed on the main ward but should be screened on each further inpatient admission.

6.5.12 Patients who have been hospitalised elsewhere since screening

Patients who have previously screened negative for MRSA should be rescreened if they have been admitted to another hospital, hospice or care home since their last admission to VCC e.g. patients who are admitted on a 3 weekly cycle of chemotherapy.

7. DECOLONISATION

Decolonisation should be prescribed to treat a patient who has tested positive for MRSA. An assessment of previous history must be taken prior to starting treatment to identify previous colonisation/ or any decolonisation treatment already received.

The IPCT will direct decolonisation and rescreening, maintain records, and enter Information into the patient electronic record and alert system. The prescription chart for MRSA Decolonisation should be completed by doctors or nurse prescribers.

7.1.1 Treatment

Mupirocin nasal ointment and Octenisan body wash are the agents used for decolonisation. A prescription chart for MRSA only Mupirocin nasal ointment 2% should be applied to the inner surface of each nostril, (anterior nares) three times daily for 5 days. The patient should be able to taste the Mupirocin at the back of the throat after application (See appendix 2).

7.1.2 Using Octenisan wash lotion

Octenisan is a mild and gentle antimicrobial wash lotion for whole body cleansing including the hair. It is suitable for all skin types with a skin-neutral pH value and is free of artificial colours and perfumes. Daily showers or baths should be taken using Octenisan wash lotion for five days. The skin should be moistened and the Octenisan applied thoroughly (without dilution) to all areas before rinsing in the bath or shower. Special attention should be paid to known carriage sites such as the axilla, groin and perineal area. The Octenisan should also be used for all other washing procedures and for bed bathing (See appendix 2).

The hair should be washed with Octenisan twice in the five days then washed with normal shampoo. Clean clothing, bedding and towels should be provided after each application of Octenisan.

7.1.3 Failure to decolonise

Patients should normally receive only two attempts at decolonisation as more are thought likely to promote resistance to the products used. Patients who still test positive for MRSA after two attempts are regarded as chronically colonised and should be managed with contact precautions (CP's) thereafter. Further courses of decolonisation treatment may be recommended if the patient is to have surgery or other invasive procedure. If a third attempt is required Neomycin nasal ointment may replace Mupirocin nasal ointment on advice from the IPCT or microbiologist only.

7.1.4 Throat colonisation

In cases where throat colonisation is proved the IPCT may advise that patients gargle with 0.2% chlorhexidine gluconate mouthwash (e.g. Corsodyl®) mouthwash twice a day. If the patient has dentures or other dental prostheses, these should be soaked daily in 0.2% chlorhexidine gluconate mouthwash.

7.2 Rescreening

Three negative screens are required to prove decolonisation has been effective. The first screen should be collected at least 48 hours after the completion of decolonisation and parenteral antibiotics. Rescreens two and three must only be collected after the results from the previous test have been received.

7.2.1 Staff screening and management

Do not routinely screen staff for MRSA unless there is a clear epidemiological reason for doing so.

If staff are identified as MRSA positive, consider excluding staff from work, reducing their Interaction with patients, and offering decolonisation therapy as deemed appropriate.

8 CLINICAL MANAGEMENT & INFECTION CONTROL PROCEDURES / CONTROL MEASURES

Control measures include:

- Hand hygiene.
- Appropriate use of protective equipment.
- Maintenance of appropriate cleaning procedures (and correct use of appropriate cleaning products).

- Rational use of antibiotics.
- Appropriate disposal of waste.
- If a patient is colonised with MRSA, a single room is preferred. Decisions on individual cases should be risk assessed by clinicians/patient access with the support of IPCT.

8.1.2 Standard Infection Control Precautions

Standard infection control precautions include the use of gloves and aprons (personal protective clothing – PPE) when handling body fluids, decontaminating the clinical environment and medical equipment, and the disposal of sharps, linen and waste**.** Hand hygiene is the foundation of standard precautions and the prevention of infection.

8.1.3 Isolation of the patient

Please see appendix 5 & 6 for additional information on precautions & decontamination.

Patients known to be MRSA positive must be isolated ideally in an ensuite room. A Contact Precaution (CP's) Isolation sign (see appendix 4) must be fixed to the cubicle door. If ensuite is not available a commode must be placed in the isolation cubicle. Where possible the cubicle door must remain closed. Monitoring equipment, for example blood pressure cuffs and stethoscope must be dedicated to the isolated patient.

Staff who will have direct contact with the isolated patient or the patients' environment must don personal protective equipment (PPE) before entering an isolation cubicle. Gloves and aprons must be changed between care procedures and hand hygiene must be performed after glove removal. The PPE must be removed before leaving the cubicle and disposed of into the infectious waste stream (orange) located inside the cubicle. Hands must be washed after removal of gloves and before leaving the isolation cubicle. Once outside the cubicle staff must apply alcohol hand rub to the hands. All staff must employ CP's if they are to have direct contact with the patient, or the patients' environment.

Prior to transferring the patient to a single room, the implications of MRSA colonisation, infection and treatment should be clearly explained to the patient or relative. Leaflets which provide information on MRSA should be available on all wards.

- Isolate patients for as short a time as possible to minimise feelings of stigma, loneliness, and low mood.
- Provide clear information to patients about the need for the use of protective equipment to reduce feelings of stigma.
- Be consistent in the use of protective equipment to ensure that patients have confidence in the decision to place them in isolation.

8.1.4 Rehabilitation

For rehabilitation purposes, for example mobilising and practising the stairs patients can leave the cubicle. Therapy staff must use CP's and decontaminate any equipment before use on the next patient. Patients must decontaminate their hands before leaving the cubicle.

8.1.5 Patients who wish to leave their room

Patients who wish to see visitors in the hospital gardens or merely wish to sit in the garden can do so provided they:

- Decontaminate their hands before leaving the cubicle **and**

- Do not have direct contact with other patients **and**
- Do not go into the bed areas of other patients.

8.1.6 Transfer of patients who are colonised or infected with MRSA between wards/ other care settings.

- Do not transfer patients between wards, units, hospitals, or other clinical settings unless it is clinically necessary.
- Inform the receiving ward/unit and the ambulance/transport service that the patient is colonised/ infected with MRSA.

8.1.7 Visitors and relatives

Visitors and members of staff from other departments must report to the nurse-in-charge before entering the room.

There is no restriction on the number or type of visitors to the patient. Visitors do not need to wear gloves and aprons unless giving direct care to the patient. Relatives must decontaminate their hands with soap and water before entering and leaving the cubicle or apply alcohol foam/gel to the hands. Visitors should not visit other patients after visiting a patient with MRSA.

8.1.8 After death

Use standard infection control measures. Lesions and puncture sites should be covered. In VCC a body bag is used for all diseased patients. Relatives, friends and carers may view the body without restriction.

8.1.9 Using the public washrooms and toilets

Whenever possible patients with MRSA should be last to use the showers or bath which should be decontaminated using detergent and disinfectant after that use. If for any reason a patient needs to use the shower ahead of the other patients the shower/bath should be decontaminated immediately after use.

8.1.10 Outbreaks

In the case of outbreaks the Infection Prevention & Control Team will investigate the source of the outbreak and manage accordingly. Where there are not enough cubicles the affected patients will be cohorted, (nursed together in the same bay with access to restricted bathroom and toilet facilities). Only rarely has carriage by healthcare workers (HCW's) been implicated in an outbreak, however, carriage of MRSA by HCW's must be considered in when there has been failure to control outbreaks.

8.2 Communication

Clinical Staff must

- Check the patients' Cancer Network Information System Cymru (CANISC) record and front sheet/page for "alerts" which will indicate that patient has MRSA.
- Inform portering staff of the patient's status and the infection control precautions required when requesting movement of the patient.
- Inform the receiving ward / department that the patient is MRSA positive.
- Inform the receiving healthcare establishment of the patient's status.
- Inform ambulance control when requesting transport.

Where possible confirmed MRSA cases should attend at the end of the treatment list to reduce contact time with fellow patients.

Patient information which advises on MRSA is available from the IPCT on request.

8.3 Healthcare Personnel

- Routine screening of staff is not recommended but may be considered in an outbreak situation or if transmission continues on a unit despite active control measures.
- It must be emphasised that MRSA colonisation poses a little to no risk to healthy individuals. If a staff member does become colonised and shares accommodation with other healthcare workers or other vulnerable individuals (e.g. immunocompromised), they should contact the IPCT for further advice.
- Decolonisation of known MRSA positive staff members is attempted to prevent transmission of MRSA to vulnerable patients.
- All decolonisation and follow-up screening is undertaken by the Occupational Health Department (OCCH) and not done at ward level. OCCH should be informed immediately when a staff member is known to be MRSA positive.

8.3.1 Nasal Carriage

Nasal carriers should be given 2% Mupirocin which is part of the decolonisation pack obtainable via OCCH on prescription. If the staff member works in a non-high risk area they can continue to work once treatment has started. If they work in a high-risk area the IPCT, in conjunction with OCCH will review their work status on an individual basis.

8.4 Decontamination of the patient environment and medical equipment

Please refer to Appendix 6 for further detail.

9 REFERENCES / BIBLIOGRAPHY

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Guidelines for the control and prevention of meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities by the Joint BSAC/HIS/ICNA Working Party on MRSA. Journal of Hospital Infection 2006; 63S: S1 – S44 https://pubmed.ncbi.nlm.nih.gov/16581155/

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DoH England, MRSA Screening Guidance (2014) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/345144/Implementation_of_modified_admission_MRSA_screening_guidance_for_NHS.pdf

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10 GETTING HELP

10.1 Further information and support:

Velindre IPCT: 02920196129, internal extension 6129.

11 RELATED POLICIES

This policy should be read in conjunction with:

- IPC 04 Decontamination Policy
- IPC05 National Infection Prevention and Control Manual
- IPC 10 Hand Hygiene
- IPC 15 Control & Management of Multi Drug Resistant Bacteria
- IPC 21 Management of Respiratory Infections
- Cleaning Standards Manual 2015 https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-health-and-social-care/addendum-key-standards-for-environmental-cleanliness/

12 INFORMATION, INSTRUCTION AND TRAINING

12.1 Training

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

12.2 Key guidance

- National Infection Control Policies for Wales
- NHS Wales. Healthcare Associated Infection Wales. Commitment to Purpose; Elimination preventable healthcare associated infections (HCAIs) 2011
- Healthcare Associated Infection (HCAI): Guidance Set. Healthcare Associated Infection and Antimicrobial Resistance and Prescribing Programme (HARP) 2019.
- Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) guidelines for the prevention and control of Methicillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities. September 2021
- National Infection Prevention & Control Manual (NIPCM)

13 MAIN RELEVANT LEGISLATION

- Health and safety act at Work Act 1974
- The Control of Substances Hazardous to Health Regulations (COSHH) 2002
- Personal Protective Equipment at Work Regulation (2002)

Appendix 1 – Screening for MRSA

All inpatients should be screened prior to admission. For unplanned admission screening for MRSA must be carried out within the first 48 hours of admission. Please inform IPCT when a patient known to be MRSA positive is admitted. Ext. 6129.

Use standard wound swabs in charcoal medium.

Swabs Should Include
Nose (anterior nares)
Perineum (or groin if perineum inaccessible)
Any wounds
Any invasive device

If possible soak the swab in normal saline (it improves pick up)

- Swab left and right anterior nostril with five strokes, using the same swab.
- Swab the perineum/groin with five strokes, one swab.
- All swabs should be identified, labelled and put into **one** microbiology clini-pac.
- The nature of the specimen should read “nose and perineum swabs”.
- The investigation requested should read “MRSA screen”.

Wound screening.

Any wounds the patient may have at the time of screening should also be swabbed.

Each wound swab should be identified, labelled and have a separate form requesting for Culture & Sensitivity (not MRSA screen). Wounds swabs and screens should not be taken until at least forty eight hours after the course of decolonisation is completed.

Three negative screens are required before contact precautions can be discontinued.

Appendix 2 – Guidelines for Administration of MRSA Decolonisation Therapy

Infection Control Precautions

The aim of decolonisation is to eradicate the carriage of MRSA and/or treat localised infection. Staff must adhere to standard precautions for infection control and isolation when caring for MRSA positive patients. Hand decontamination and the use of protective clothing (gloves and apron) are essential in prevention of cross infection of other patients.

1. **Mupirocin (Bactroban) Nasal Ointment 2% - Administer three times daily**
   Instruct the patient to wash his/her hands and then apply the preparation with a fingertip to inner surface of each nostril covering the posterior and anterior nares then wash hands afterwards. If the patient is unable to do this then the nurse is to apply the preparation to a cotton bud/swab and gently apply to inside of each nostril. **Duration of treatment – 5 days.**

2. **Octenisan – Daily Wash**
   If there is a pre-existing skin condition a dermatological opinion should be sought. If skin irritation occurs discontinue treatment and seek advice from the infection control nurse.
   Use a washing agent instead of soap. Preferably the patient should bath or shower. If a blanket bath is performed apply solution to a wet disposable flannel or sponge and wash all parts of the body, thoroughly, making lather. Rinse off with clean warm water. Shampoo hair with Octenisan twice during the course of the treatment (suggest day 2 and 5). Apply to wet hair, lather and rinse off with warm water. Can use shampoo or shower gel after rinsing off Octenisan. **Duration of treatment – 5 days.**

Patient Screening

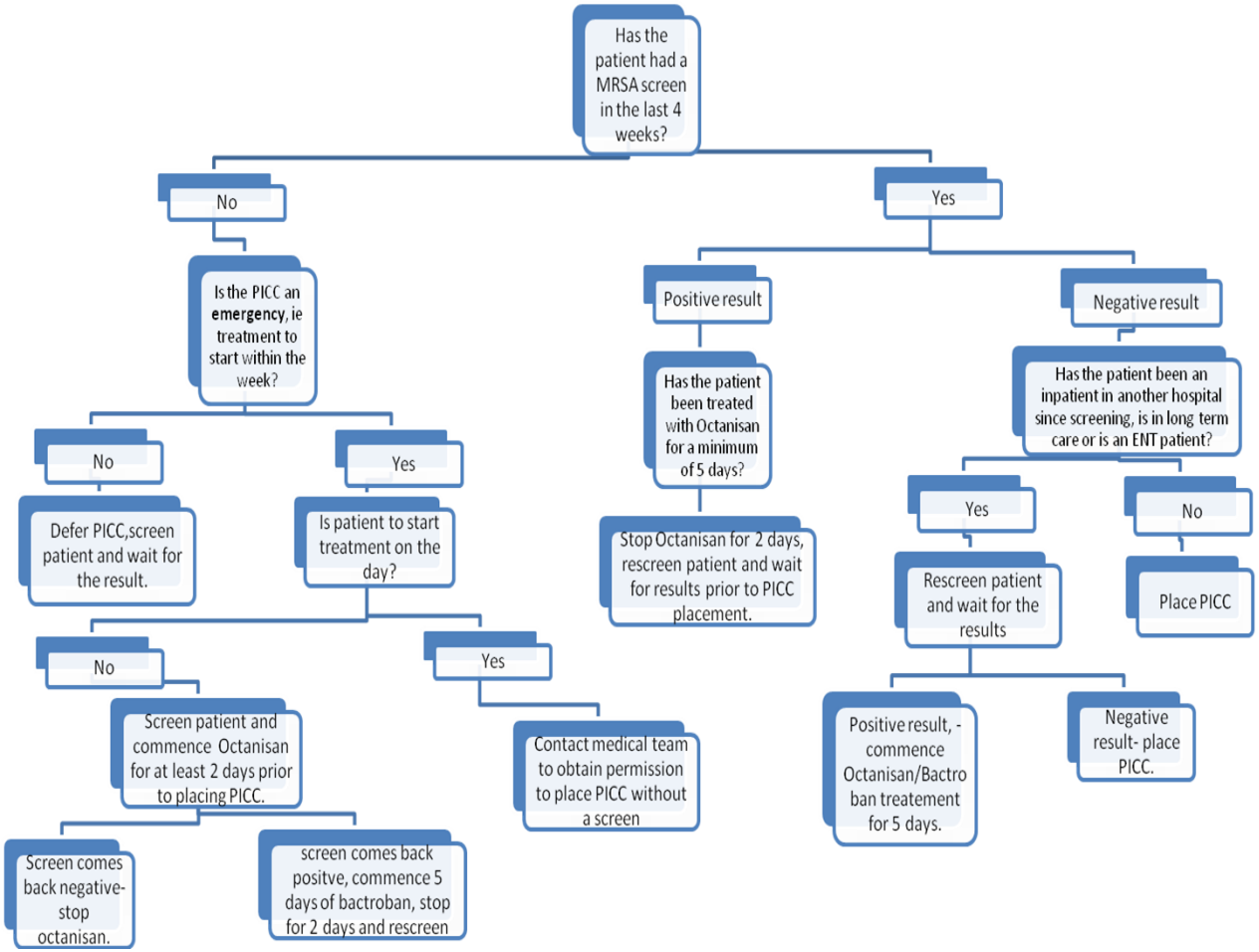
After 5 days decolonisation wait 48 hours before screening patient. Screening sites:

- Nose
- Perineum or Groin
- Any wounds, cuts, broken skin
- IV sites

Send for C&S rather than part of the MRSA screen

Await result, if positive recommence decolonisation for a further 5 days, if negative rescreen and await result. Continue until 3 negative screens obtained. Seek advice from the IPCT if eradication has not been achieved after two treatments.

Appendix 3 – Screening for MRSA pre-implantation of a PICC



Appendix 4 – Isolation nursing door sign.

Canolfan Ganser Felindre
Velindre Cancer Centre

GIG CYMRU NHS WALES

Contact Precautions

STOP

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

Staff members:

Hands

Decontaminate hands before entering this room.

Personal Protective Equipment

Wear disposable apron and gloves before entering this room.

Door
Keep door closed

Risk assessed ☐
Door required to remain open.
Initials: ☐ Date: ☐

Before leaving

Decontaminate equipment prior to removal from room.
Discard gloves and apron in healthcare waste bin.
Decontaminate hands.

Developed by the infection control team 2018

Appendix 5 – Contact Precautions:

Personal Protective Equipment (PPE)

- Gloves should be worn if there is any risk of contact with blood and body fluids. If gloves have been worn they should be removed and hands decontaminated before leaving the room/area.
- Plastic aprons must be worn when direct contact with the patient or the patient's equipment is anticipated.
- Face protection e.g. masks, visors/goggles must be worn if there is a risk of aerosol production or splashing from blood or body fluids and secretions. Face protection e.g. masks, visors/goggles must be worn if there is a risk of aerosol production or splashing from blood or body fluids and secretions.
- All PPE should be disposed of before leaving the room and hand decontamination performed.

Disposal of Waste

- All infected waste should be disposed of into the appropriate clinical waste bag (HTM 07-01 Safe Management of Healthcare Waste 2006).

Linen

- All linen should be placed in the appropriate bag for infected linen and returned to the laundry.
- Curtains, including window curtains, adjacent to MRSA positive patients should be changed when a patient has been transferred/discharged or when visibly soiled.

Instruments or Equipment

Whenever possible instruments and equipment such as writing materials, sphygmomanometers and stethoscopes should be designated for MRSA positive patients.

If this is not possible, such items should be cleaned and disinfected before use on another patient. For more information, see IPC 04 Decontamination Policy.

Cleaning

Daily Cleaning

If the patient is in a single room, the nurse-in-charge must ensure that the appropriate cleaning is carried out by liaising with Operational Services teams.

If the patient is not in a cubicle, the bed space where the patient is present should be cleaned twice a day with a hyper chloride releasing disinfectant, (e.g. Oxivir).

Cleaning On Discharge

The patient's room must be cleaned thoroughly with hyper chloride releasing disinfectant. Curtains will also need to be changed.

All hospital furniture (e.g. bed frame, tables) and any dust collecting ledges should also be wiped with hyper chloride releasing disinfectant.

The mattress should be decontaminated with hyper chloride releasing disinfectant and the mattress checked for strike through damages.

Ultraviolet light clean should then be carried out in accordance to instructions.

Management of spillages of blood and body fluids

Body fluids should be mopped up using a mop with an absorbent washable mop heads or wiped up with an absorbent disposable material and the surface then cleaned and disinfected using hyper chloride releasing disinfectant.

- Protective clothing (gloves, aprons and goggles) should be worn.
- The spillage must be covered with absorbent disposable pad to remove excess fluid.
- Absorbent granules can be applied to larger spillages.
- Hyper chloride releasing disinfectant should be applied to the spillage.
- Disposable cloths/mops should be used to remove spillage.
- Finally wash affected area with detergent and water.

Disposal of sharps waste

No special precautions required dispose of as per normal routine.

Collection and transportation of biological specimens.

No special precautions or labelling required. Other Clinical Specimens for histology or cytology investigations do not require special precautions

Appendix 6 – Decontamination of the patient environment and medical equipment

Decontamination of the patient environment and medical equipment

Domestic staff. Cubicles should be cleaned and disinfected daily using yellow coded cleaning materials. The isolation cubicle should be cleaned last to avoid cross contamination during the cleaning process. All waste clinical and domestic should be disposed of into the infectious waste stream.

Nursing staff. All medical equipment should be cleaned and disinfected following discharge of the patient. Patients should be encouraged to keep possessions to a minimum to aid cleaning**.** Medical/surgical supplies not used by the patient should be disposed of into the infectious clinical waste stream (orange bag) and not returned to stock. In order to minimise waste and facilitate cleaning supplies of medical/surgical stock kept in the patients' room must be kept to a minimum.

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Long stay patients (over one week). Domestic staff must clean and disinfect isolation cubicles daily. Nursing staff must clean and disinfect all medical equipment including the bed and wall mounted equipment once weekly.

Portering staff. Gloves and aprons should be donned before entering the cubicle. After assisting the patient into the wheelchair or onto the trolley porters should dispose of gloves and aprons into the orange infectious waste stream before leaving the cubicle. Hands should be decontaminated outside the cubicle using alcohol foam before touching the wheelchair or trolley. On reaching the receiving department the porter should don gloves and aprons before assisting with the patient. The areas of the wheelchair or trolley which have come into direct contact with the patient should be decontaminated using disposable wipes, gloves and aprons should then be disposed of on the spot and hands decontaminated.

Radiotherapy staff. Gloves and aprons should be worn by staff attending the patient. Following treatment the areas with which the patient has had direct contact for example treatment couches should be cleaned and disinfected with Chlorclean after use by the patient (NB: This will change to hyper chloride releasing disinfectant in the future).

Radiology staff. Gloves and aprons should be worn by staff attending the patient. Treatment chairs, beds, couches and wheelchairs with which the patient has had direct contact should be cleaned and disinfected using hyper chloride releasing disinfectant after use by the patient

Outpatient staff (including phlebotomy and chemotherapy). Gloves and aprons should be worn by staff attending the patient. Treatment chairs, beds, couches and wheelchairs with which the patient has had direct contact should be cleaned and disinfected using hyper chloride releasing disinfectant after use by the patient.

Appendix 7 – IPC Clinical Risk Assessment. Adapted with permission from Cardiff & Vale University Health Boards' MDRO procedure (Updated November 2017)

Infection Prevention and Control (IP&C) Admission Risk Assessment	**NO**	**YES**	If '**YES**' to any question action the following immediately	Initial
Carbapenemase Producing Organism (CPO)				
In the last 12 months has the patient had any healthcare contact outside of the U.K.? Healthcare abroad includes the whole range of in-patient care, also dental care, cosmetic surgery, elective surgery (including day surgery) and fertility treatments			Isolate (High priority) and contact precautions Seek advice from IP&C / Microbiology out of hours. Screen for CRO & MRSA	
In the last 12 months has the patient been an in-patient or transferred from a hospital /healthcare setting in the UK in known high prevalence areas?			Screen for CRO & MRSA Discuss with IP&C	
Does the patient have any IP&C flags (on CANISC/ ICNet) for any multi-drug resistant organisms?				
Does the patient have a history of MDRO infection/colonisation (Inc. *Candida auris*)?			Discuss with IP&C	
MRSA				
Is patient screened for MRSA routinely on admission?			Screen for MRSA: Nose Groin Invasive device site(s) Wound(s) ...../...../..... (Screen sent date / time / initial) Refer to local MRSA Procedure / Clinical Risk Assessment	
Does the patient have a previous history of MRSA?				
On admission does the patient have a wound or invasive device?				
Has the patient been transferred from a hospital outside of the Health Board/Trust?				
Has the patient been admitted from a Nursing Home or Long-term care facility?				
Diarrhoea and Vomiting				
Does the patient have a history of diarrhoea / vomiting within the last 48 hours that may be infectious?			Isolate / cohort (High priority) Contact Precautions Send two separate diarrhoea samples for Microbiology and Virology Refer to local Viral Gastroenteritis Procedure	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

CHAIR'S REPORT

Date of meeting	26/05/2022

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.

Matters addressed in this report cover the following:

This Chair's report gives an update on the following matters:

- Board Development and Board Briefing Sessions
- Extraordinary Private Board Meetings
- Independent Members Group
- International Nurses Day 12th May 2022
- Football Association Wales Special recognition Award for the Welsh Blood Service
- The Trust Wellbeing Centre
- The National Service of Thanksgiving to Celebrate Her Majesty's Platinum
- Her Majesty's Lord-Lieutenant of Mid Glamorgan's Awards Ceremony
- Arts in Health visit to Y Bwythyn

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 / Board Briefing Sessions

The Board met as part of its programme of Board Development and Briefing sessions on 26 April 2022. The following topics were discussed:

- **Equality, Diversity and Inclusion Programme**

  The first session of the Board Equality, Diversity and Inclusion (ED&I) Development Programme was delivered to the Board. The Head of the Equality and Human Rights Commission Ruth Coomb was invited to speak. Ruth discussed the report 'Is Wales Fairer' the state of Human Rights in Wales 2018 and the findings of this report. She discussed the impact of COVID-19 and also the decline of household incomes and the increase of the use of food banks since 2020. She also talked about the Public Sector Equality Duties, and the Trust's Social Economic Duty, finishing with the Commissions Strategic Priorities for the period 2022-2025. The Board was asked to complete an ED&I Baseline Assessment Tool in preparation for the next session.

- **Annual Self-Assessment of Board Effectiveness** – The Board is required to undertake a self-assessment of its effectiveness for the period April 2021 to March 2022. Both internal and external sources of assurance in support of the assessment process formed part of the discussions. Internal sources of assurance discussed include assessment against the Code of Good practice, Committee delegation, accountability and partnerships. The Audit Wales structured assessment and Shared Services Partnership Audit and Assurance formed part of the external sources of assurance that were discussed. The Trust Board welcomed the input to the session from our Internal Audit partners.

- **Health and Social Care** – The Health and Social Care Act for Wales 2020 for the improved quality for health services was shared with the Board. Information on Duty of Candour in terms of its purpose and procedure was discussed. There was clarification provided on the Trust's responsibility to establish high level planning and preparation to ensure the effective implementation for duty of quality and candour.

- **Radiation Services** – Under this item on the agenda, it was an opportunity for the Trust Board to virtually meet a number of the Radiation service senior team. The Head of Radiation Services led a discussion which included an overview of the methodology for

the delivery of Radiotherapy which provided an understanding of evolving technological advancements and the contributions of Radiotherapy to cure cancer either alone or in combination with Surgery or Chemotherapy. The staff mix required for Radiotherapy and staff challenges were discussed. The presentation concluded with an overview of the Transforming Cancer Services Change Programme and the Proposed Clinical Service Model.

Patient Engagement Strategy Update – The Assistant Director of Communications and Engagement presented the process for developing the new cancer Patient Engagement Strategy for the Trust. This forms part of the Health and Social Care Act which emphasises inclusion of patient voice. It was an opportunity for the Trust Board to discuss the approach at today's meeting prior to the Strategy being presented for approval

2.2. Extraordinary Private Board Meetings

The Chair would like to note the following Extraordinary Board Meetings took place during this period:

- On **20th April**, an Extraordinary Board meeting was held to agree on matters relating to the Enabling Works Injunction Process. This meeting was held in private given the confidential nature of this matter being in live ligation.

- On **26th April**, an Extraordinary Board meeting was held to agree on matters relating to the Enabling Works Injunction Process. This meeting was held in private given the confidential nature of this matter being in live ligation.

- On **5th May**, the Board met to approve a matter relating to the competitive dialogue process for the new Velindre Cancer Centre. This meeting was held in private given the commercially sensitive nature of the matters being discussed.

2.3. Independent Members Group

An Independent Members Group meeting took place on 28th April. A summary is provided below of the matters discussed:

- Discussion of Escalation Letter, as referred to in the Chief Executive Officer's report
- Discussion of Board Development schedule
- Noting the work and progress of the NHS Wales Public Appointees Task and Finish Group on the Independent Members on role profile (attached)
- Confirmation on Independent Member progress for Mandatory Training
- Confirmation of approach and form for year end PADR exercise between the Chair and Independent Members
- Update on Board paper writing training for Trust staff

2.4. International Nurses Day 12th May 2022

The Trust took the opportunity to celebrate International Nurses Day on 12th May at both the Velindre Cancer Centre and the Welsh Blood Service. The Chair and the Chief Executive, along with the Executive Director of Nursing, AHPs and Health Science took the opportunity to celebrate the achievement of staff. The Chair and Chief Executive were able to pass their congratulations onto staff in person and appreciate their efforts and hard work.

The celebrations actually started on the 11th when we had two of our nurses, Helen Way and Ceri Stubbs, representing the Trust at the Florence Nightingale Service in Westminster Abbey. The service is held annually to celebrate nursing and midwifery and all staff and the importance of supporting one another through challenging times. The service also included a COVID-19 Pandemic Roll of Honour, carried by the UK's Chief Nursing Officers, to remember the nurses, midwives, nursing associates and health care support workers who lost their lives during the pandemic.

The Chair would also like to particularly congratulate Rachel James who was awarded one of three national; “Excellence Awards” to celebrate International Nurses Day. We were delighted to host a visit from the Chief Nursing Officer, Sue Tranka, to present the award.

2.5. Football Association Wales Special recognition Award for the Welsh Blood Service

The Football Association Wales have decided to give the Welsh Blood Service a special recognition award in celebration of our Blood Sweat and Cheers community partnership we have been developing with them over the past 18 months. This is a fantastic honour and we are thrilled to be receiving it and delighted to hear the Football Association Wales hold our special relationship in such high regard, as do we of them. The partnership has grown from strength to strength thanks to the hard work and dedication of our donor engagement/communications team and Community Partnership Officer and we look forward to bigger and greater things as we develop the relationship further during the 2022/23 season.

2.6. Trust Wellbeing Centre

The Chair and Chief Executive Officer visited the Wellbeing Centre on 18th May. It offers a space to step away from the hospital environment, for a chance to relax and recharge. The

Centre demonstrates the Trust's commitment to ensuring the wellbeing of its staff, and will no doubt contribute to improving the emotional wellbeing of staff. An opening ceremony for the Centre is scheduled to take place from the 23rd to the 27th May where various activities are planned to promote wellbeing.

2.7. The National Service of Thanksgiving to Celebrate Her Majesty's Platinum

Dr Seema Arif, a Consultant Clinical Oncologist who was awarded a Members of the Order of the British Empire (MBE) in the New Year's Honours List, has been invited to attend the National Service Thanksgiving to celebrate Her Majesty's Platinum Jubilee, taking place on 3rd June. We are proud to have representation from the Trust at this prestigious event.

2.8. Her Majesty's Lord-Lieutenant of Mid Glamorgan's Awards Ceremony

The Chair was invited to attend the Awards Ceremony which took place on 7th April. Approximately 100 people attended the event on April 7, to mark the new appointments and celebrate high achievers from the reserve and cadet communities.

2.9. Arts in Health visit to Y Bwythyn

On 23rd May, the Chair and other members of the Arts MDT visited the Y Bwthyn, the specialist Palliative Care Unit at the Royal Glamorgan Hospital. The team had been kindly invited to look at the ways in which staff prepared and implemented their Arts in Health for their new building. The excellent learning and ideas that the team picked up from the visit will feed into the development of the Arts in Health strategy which is due to be presented to the Trust Board at the July meeting.

3.0 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.

4.0 RECOMMENDATION

The Board is asked to **NOTE** the content of this update report from the Trust Chair.

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

DATE OF MEETING	26.05.2022

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	Steve Ham, Chief Executive
EXECUTIVE SPONSOR APPROVED	Steve Ham, Chief Executive

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
N/A		Choose an item.

ACRONYMS	

1. SITUATION/BACKGROUND

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

Matters addressed in this report cover the following:

- International Nurses Day - 12th May
- Blood Health National Oversight Group (BHNOG) Annual Conference – 27th April
- Milestones for a number of Transforming Cancer Services Projects
- Joint Escalation and Intervention Arrangements Update
- Order for a Final Injunction Granted by High Court
- Update on Setting Up an NHS Executive for Wales
- Appointment of Alan Prosser as Director of the Welsh Blood Service
- Welcome to Chris Moreton, Deputy Director Finance

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 International Nurses Day - 12th May

Along with the Chair, the Chief Executive would like to also thank all our nurses for the truly amazing difference they make to our patients, donors and recipients of blood and transplantation products every day. The theme of the day was leadership and, along with many of the executive team, the Chief Executive had the pleasure of being able to join a celebration event to hear about the leadership stories of three of our outstanding nurses. During this session we heard a very powerful message to our patients written by one of our Nurses Rachel Gibbons:

''Dear patients, you are not simply another name or diagnosis. We do not forget you when we walk away to return home. Each joy you feel and each tear you cry marks us: we are here for you.

Dear relatives, we cannot carry your pain but we feel it. As we pass our strength to you through the holding of your hand, we are weakened in the shadow of your distress, but we are here for you.

Dear family and friends, we are drained, we are tired, we are quiet. Some days we have little left to give. Our hearts are exposed. Bear with us. This is the path we chose.''

The Chief Executive, with the Chair and other executive colleagues had the pleasure of visiting many front line teams during the day to be able to celebrate together:

2.2 Blood Health National Oversight Group (BHNOG) Annual Conference - 27th April

The Chief Executive would like to note the key role of the Welsh Blood Service in the leadership and facilitation of the 2022 Blood Health National Oversight Group Conference which was held on 27 April at Llanerch Vineyard, Pontyclun and was attended by over 70 delegates and guest speakers from across NHS Wales and the UK.

The conference focus was placing the patient's wellbeing at the heart of transfusion practice and featured 17 speakers with expertise in blood health, service improvement, clinical services, serious hazards of transfusion (SHOT), laboratory services and donor engagement.

2.3 Milestones for a number of Transforming Cancer Services Projects

The Chief Executive would like to recognise a number of significant milestones which form part of the Trust Board agenda today: the full business cases for the Radiotherapy

Satellite Centre; the Integrated Radiotherapy Solution; and significant progress on the competitive dialogue process for the new Velindre Cancer Centre. Given the commercial and confidential nature of the stage of the competitive dialogue process, this paper forms part of the private agenda. Work on developing a business case for a new Velindre Cancer Centre began in 2009 and then in 2013, in response to growing challenges, a programme of work was established which became Transforming Cancer Services in south east Wales. The Chief Executive would like to thank all the staff, patients and wider stakeholders who have contributed and shaped the process over these years to enable the Trust to reach the milestones of being able to present these matters to the Board for consideration today. The Chief Executive would also like to thank in particular the Project teams across all these important projects for the patients, families and carers and staff of south east Wales.

2.4 Joint Escalation and Intervention Arrangements

The Chief Executive would like to note that the Trust has been informed that Welsh Government officials will be recommending to the Minister that the escalation status of Velindre NHS Trust remains unchanged at 'routine arrangements'. This recommendation is formed on the on the basis of a tripartite group discussion between Welsh Government officials, Audit Wales and Healthcare Inspectorate Wales. There were a couple of matters noted, which the Chief Executive has responded to the Director General on.

2.5 Order for a Final Injunction Granted by High Court

The Chief Executive would like to note that on the 26th April the High Court granted Velindre University NHS Trust an Order for a final injunction. The injunction prohibits the Defendants named or identified in the order, which includes "persons unknown" from undertaking direct action within the Land specified in the Order. The Final Injunction Order will remain in place until 1 July 2025. The communications around this matter aimed to reassure the local community that it will not impact their day to day lives in the area at all, including being able to peacefully protest. It only covers those undertaking unlawful direct action.

2.6 Update on Setting up an NHS Executive for Wales

Following the Ministerial Statement issued on 18th May, the Director General wrote to NHS Wales Chief Executives to provide a formal update on formal update on plans to establish an NHS Executive for Wales, including the start of a formal programme to take this work forward. The letter is attached to this report – Appendix 1.

2.7 Welcome to Chris Moreton, Deputy Director Finance

The Chief Executive is delighted to welcome Chris Moreton to the Trust as Deputy Director Finance. Chris is a CIMA qualified finance leader with over 16 years experience spanning several sectors including financial services, technology, public sector and NHS. He brings prior NHS Wales experience through his financial commissioning role with the Emergency Ambulance Service and the national Mental Health and Learning Disabilities Framework for independent sector providers.

Chris has a keen interest in exploring the intersection between finance and sustainable development and actively promotes the role that finance professionals can play in enabling sustainable organisations. He is Chair of the Foundational Economy All Wales Group as part of the NHS Wales Finance Academy programme and also a Trustee at Cynnal Cymru – Sustain Wales.

2.8 Appointment of Alan Prosser as Director of the Welsh Blood Service

The Chief Executive is pleased to announce Alan Prosser has been appointed Director of the Welsh Blood Service. Since 2019, Alan has fulfilled the role of Interim Director at WBS, successfully leading the Service through the challenging times of the pandemic. Alan's permanent appointment comes at a time of great opportunity for the WBS as we finalise the service strategy for the next five years and as we continue to

explore how we work together between the two divisions and across the Trust as we serve the people of 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.
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.

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

All Chief Executives
NHS Wales Health Collaborative
Delivery Unit
Finance Delivery Unit
Improvement Cymru
cc: NHS Confederation

Ein cyf/Our ref:

18 May 2022

Dear Colleague

UPDATE ON SETTING UP AN NHS EXECUTIVE FOR WALES

Following the Ministerial statement today, I am writing to provide you with a formal update on plans to establish an NHS Executive for Wales, including the start of a formal programme to take this work forward. You may wish to share this letter more widely within your organisations.

Setting up an NHS Executive is an essential part of making our health system fit for the future – it will drive improvements in the quality and safety of care, as well as ensuring consistency and equity with the implementation of clinical standards across the NHS.

As you know, the decision to establish an executive function was announced in *A Healthier Wales* in 2018 and reconfirmed in the Programme for Government. This decision was based on the findings and recommendations of both the Organisation for Economic Co-operation and Delivery (OECD) Quality Review and the Parliamentary Review of the long-term future of Health and Social Care, published in 2018. Both of these reviews called for a stronger centre, additional transformation capacity and streamlining of current structures.

Work on establishing the NHS Executive was paused in early 2020 to focus efforts on the Covid-19 response. However, this has allowed further work to be undertaken to ensure that learning from the pandemic is built in to proposals. Building on this, the decision has now been taken by Ministers to establish the NHS Executive in a hybrid model, rather than a standalone body at this time. It will comprise a small strengthened senior team within Welsh Government, bolstered and complemented by the bringing together of existing

expertise and capacity from national bodies within the NHS, which will operate under a direct mandate Welsh Government.

Role and purpose

The NHS Executive's key purpose will be to drive improvements in the quality and safety of care - resulting in better and more equitable outcomes, access and patient experience, reduced variation, and improvements in population health.

Working on behalf of Welsh Government, the NHS Executive will provide strong leadership and strategic direction – enabling, supporting and directing the NHS in Wales to transform clinical services in line with national priorities and standards by:

- Strengthening national leadership and support for quality improvement;
- Providing more central direction to ensure a consistent and equitable approach to national and regional planning based on outcomes;
- Enabling stronger performance management arrangements, including capacity to challenge and support organisations that are not operating as expected.

Functions

The high level functions proposed for the NHS Executive are:

Reinforcing and refocusing national leadership for quality improvement and transformation including:

- Developing quality indicators and outcomes;
- Driving the implementation of the National Clinical Framework and other national programmes of work;
- Developing bespoke mechanisms for the system to learn from transformational success and share best practice – with a greater expectation of compliance across the system.

Planning

- National and regional planning capability and support for national decision making alongside regional and local delivery.
- Development of the NHS Wales Planning Framework
- Supporting and challenging local IMTP development
- NHS emergency planning arrangements
- Design and delivery of the NHS Wales Planning Programme for Learning to enhance planning capacity and capability across Wales

Enable stronger performance management and quality improvement support arrangements

- Building highly skilled additional capability and capacity to support organisations at risk of, or in escalation, that can be deployed flexibly across Wales.
- Organising and leading performance management and delivery conversations with all NHS bodies
- Leading escalation arrangements and support

Building the NHS Executive

The NHS Executive will bring together and repurpose - where necessary - existing national capacity into a single delivery and accountability structure, operating against a mandate agreed by the Health and Social Services Group in Welsh Government. However, bringing

this existing system capacity together will now be done in a virtual way and with as little disruption to staff as possible. The logistics of this will be looked at as part of the implementation programme that will now be taken forward and with the engagement of staff.

In the first instance, the national bodies that will come together virtually under the banner of the NHS Executive will include:

- Finance Delivery Unit;
- Performance Delivery Unit;
- Improvement Cymru; and
- NHS Collaborative, including key national programme directors, clinical networks and national implementation programmes.

As well as:

- Additional capacity to evaluate and support efficient and effective deployment of workforce resources;
- Increased capacity and expertise to enable accelerated support for organisations in escalation;
- Central planning and transformation capacity and expertise;
- Building capacity to support the Chief Digital Officer for Health and Care

Under these new arrangements statutory accountability mechanisms will not change. All NHS organisations are already directly accountable to Ministers, and the Welsh Government, and will continue to be. Ministers will also continue to set priorities, targets and outcome measures for the NHS, which will feed into the mandate for the NHS Executive and wider NHS. However, the NHS Executive will provide additional capacity at a national level to oversee and support delivery of these priorities.

Implementation programme and transition

Within Welsh Government we are now taking steps to set up a formal implementation programme, which I will chair. This will oversee the establishment of the NHS Executive and the detailed work that will now begin. Our aim is to have made substantial progress on how the NHS Executive will operate in practice by the end of this year.

The views of staff within Welsh Government and the national NHS bodies that will form part of the NHS Executive, as well as wider stakeholders are going to be particularly important to the successful delivery of this work. The implementation programme will include engagement with NHS Chairs and Chief Executives, the leads of national NHS bodies, Welsh Government and NHS staff and wider stakeholders to help shape what the NHS Executive will do and how it will operate. More will be shared on this in due course.

I appreciate your continued support and engagement on the development of the NHS Executive and look forward to discussing this further with you.

Yours sincerely

Judith Paget CBE

TRUST BOARD

Developing our Future Strategic Direction 2022 – 2032: enabling strategies (sustainability, people, digital and estates)

DATE OF MEETING	26/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carl James, Director of Strategic Transformation, Planning and Digital
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB Shape Strategic Development Committee	09/05/2022 16/05/2022	Endorsed Endorsed

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Velindre University NHS Trust has been working to refresh its strategic plans with the aim of setting up a clear strategic direction of travel for the 2022 - 2032 period. This includes a Trust purpose and vision; a set of strategic goals; and a coherent set of strategies to support their delivery by 2032.

1.2 The process commenced with a number of Board sessions regarding the purpose and vision for the Trust. This was followed by a series of conversations with the wider organization on the purpose and vision, a set of strategic goals for 2032; together with discussions regarding the ambitions for the organisation.

1.3 A series of engagement activities occurred from December 2019 to April 2022. A wide range of staff and wider stakeholders were engaged with (patients, donors, Community Health Councils etc) using a variety of approaches (face-to-face workshops, Teams events and surveys on the various public websites and platforms e.g. Facebook and Twitter.

1.4 The development process has been significantly elongated by the Covid-19 pandemic which commenced in March 2020.

1.5 Notwithstanding this, the Trust Board approved 'Destination 2032'; the Trust 10-year strategy on 27th January 2022. In support of its delivery, the Cancer Service five year strategy (2022 -2028) is in place and the Blood and Transplant Service five year strategy is currently being finalised.

1.6 In support of these key organisational/service strategies, a suite of enabling strategies have been developed to facilitate their delivery. The development of these strategies has been based on engagement over a period of time with staff, patients, donors and wider partners, with much of the information being collected via 'business as usual' processes.

1.6 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The development of the enabling strategies has been disrupted significantly by the Covid pandemic. Notwithstanding this, continuous progress has been made with the timetable for completion set out in Table 1.

Table 1

Strategy	Current position	Expected Board approval date
Velindre University NHS Trust 2022 – 2032	Approved	27th January 2022
Velindre Cancer Centre 2016 - 2026	Existing	Complete
Welsh Blood Service	Final draft being developed with sign off by WBS Senior Leadership Team expected by end of May 2022	July 2022
Enablers		
People	Final draft	26th May 2022
Digital	Final draft	26th May 2022
Sustainability	Final draft	26th May 2022
Estates	Final draft	26th May 2022

2.2 Given the ongoing challenges presented by the pandemic, a pragmatic approach has been adopted using existing information/evidence bases.

2.3 A number workshops where held to achieve alignment and integration between the strategic goals for 2032, the known priorities/service models of blood and cancer services (i.e. service delivery/targets via a hub and spoke) and a number of key policy/strategic requirements (e.g. carbon reduction; increasing use of technology; staff well-being (agile working). Further public engagement was undertaken using a public survey on internet/social platforms with the analysis set out in Fig. 1 – 4.

2.4 This resulted in final amendments being made to the enabling strategies which are attached for consideration as follows:-

Annex 1 Sustainability strategy

Annex 2 People strategy

Annex 3 Digital strategy

Annex 4 Estates strategy

2.6 It is important to note that the strategies are intended to set out a clear vision and direction of travel to enable the tactical implementation of them through the Integrated Medium Term Plan. Therefore, each of the strategies have not been definitively costed at this stage. Similarly, a number of the Measures of Success in each of the strategies may be amended as the Trust progresses through the development / implementation work.

2.9 The development of an overall prioritized blueprint for the Trust will be undertaken in June to September 2022 as part of the development of the Executive Management Boards Transformation / Ways of Working Programme.

Discussion at the Strategic Development Committee on 16th May 2022

2.10 The Strategic Development Committee received the draft strategies on 16th May and Independent Members of the Committee raised a number of points. These are set out below together with the action taken.

Sustainability Strategy

i. Could you develop a small number of case studies that define 'current' and 'future' state? Yes and this will be taken forward and feature in the final published versions.

ii. Requirement to achieve Carbon 'Net Zero'; was this NHS Wales wide or a requirement for each statutory organisation? This is confirmed as an NHS Wales requirement by 2030 and not specific to individual organisations'. A change has been made to the strategy to reflect this i.e. The Trust will support NHS Wales in achieving Net Zero by 2030 and will work to achieving 'Net Zero' as an organisation at the earliest opportunity.

People Strategy

iii. Could you develop a small number of case studies that define 'current' and 'future' state? Yes and this will be taken forward and feature in the final published versions.

iv. How does the strategy deal with the immediate 'in-year' workforce recruitment challenges? It provides a range of actions that are currently being taken forward. The Committee was also informed that a recruitment

taskforce is being established to focus on high risk/hard to recruit staff cohorts in 2022/2023.

Digital Strategy

v. How realistic and achievable is the strategy in the context of global recruitment challenges and available budgets? This was acknowledged as a real challenge for all NHS organisations. Notwithstanding this, the ambitions and deliverables set out in the strategy are considered to be realistic and in alignment with the Welsh Government Digital Strategy/NHS Wales, and address the areas that donors, patients and staff have identified as important to them. A tactical implementation plan is being developed together with a five year funding strategy for the digital service which will assist in determining when each element of the strategy can be delivered.

Estates Strategy

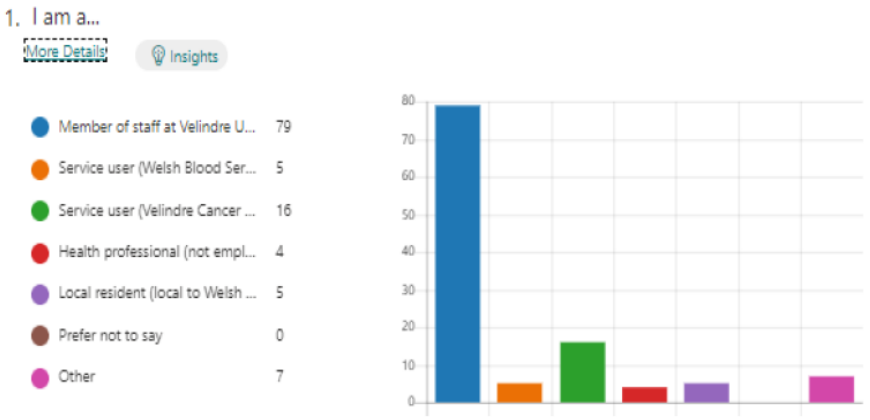
vi. Could you develop a small number of case studies that define 'current' and 'future' state? Yes and this will be taken forward and feature in the final published versions.

vii. How achievable are the range of targets set out within the strategy? The targets have been reviewed and are consistent with the national targets and policy requirements. Notwithstanding this, the Trust will work with all NHS organisations and the Welsh Government to continuously review the targets to ensure they remain realistic and achievable. The target relating to carbon Net Zero has been changed in respect of the information set out in 2.10 (ii).

Fig.1 Overall Feedback

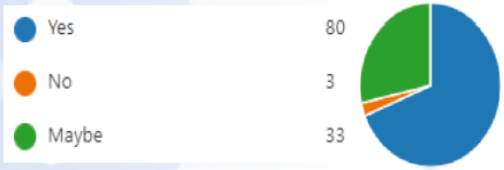
Headline Figures

- In total, the engagement survey received 116 responses. 68% of responses came from Velindre employees.
- The survey was shared extensively across internal comms and on each of the Trust and divisional social media channels



- Asked if each strategy (Digital, Sustainability and Estates) had prioritised the right areas, respondents told us:

Digital



Sustainability

Estates

Fig.2 Feedback on digital strategy

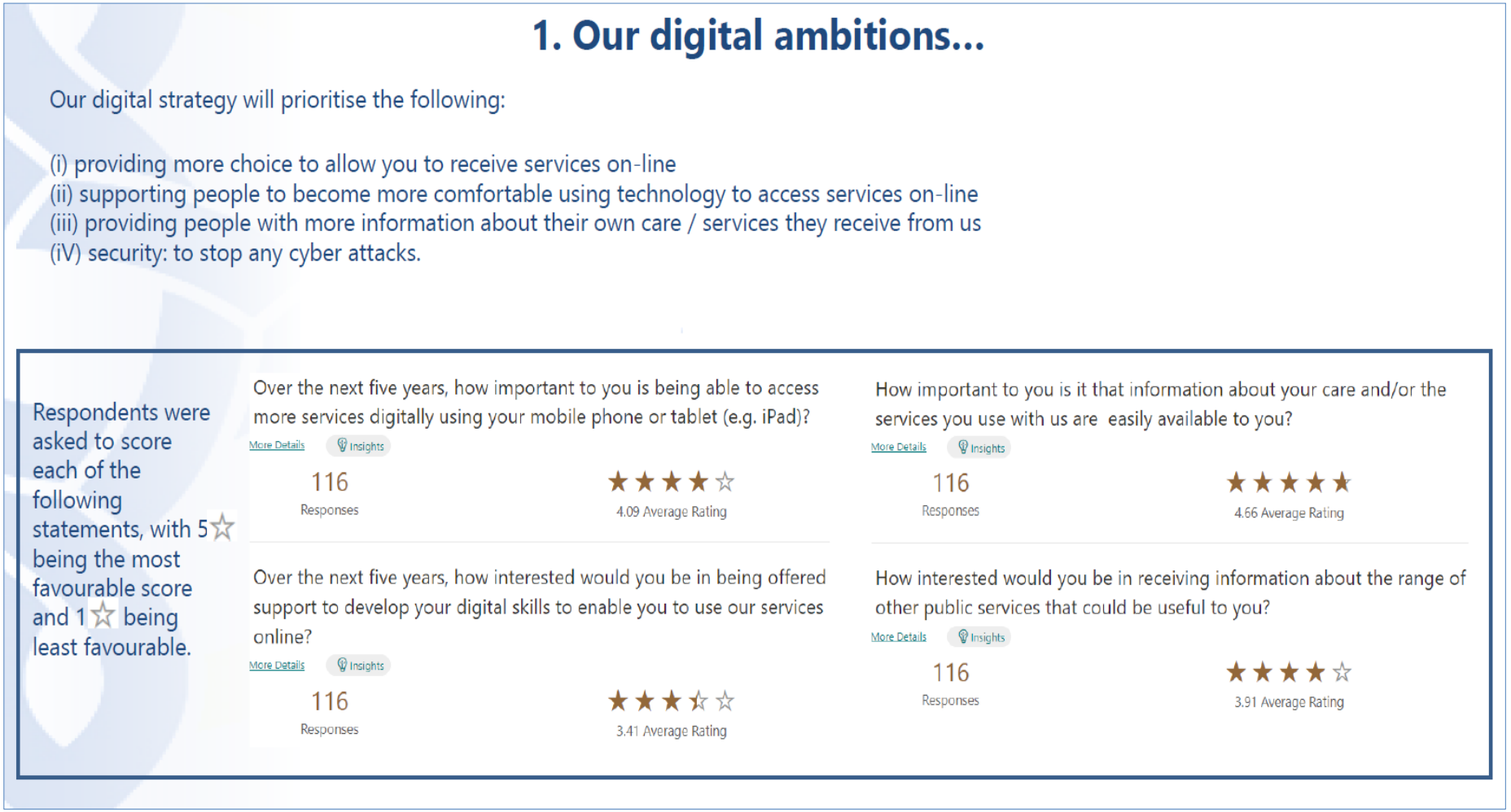
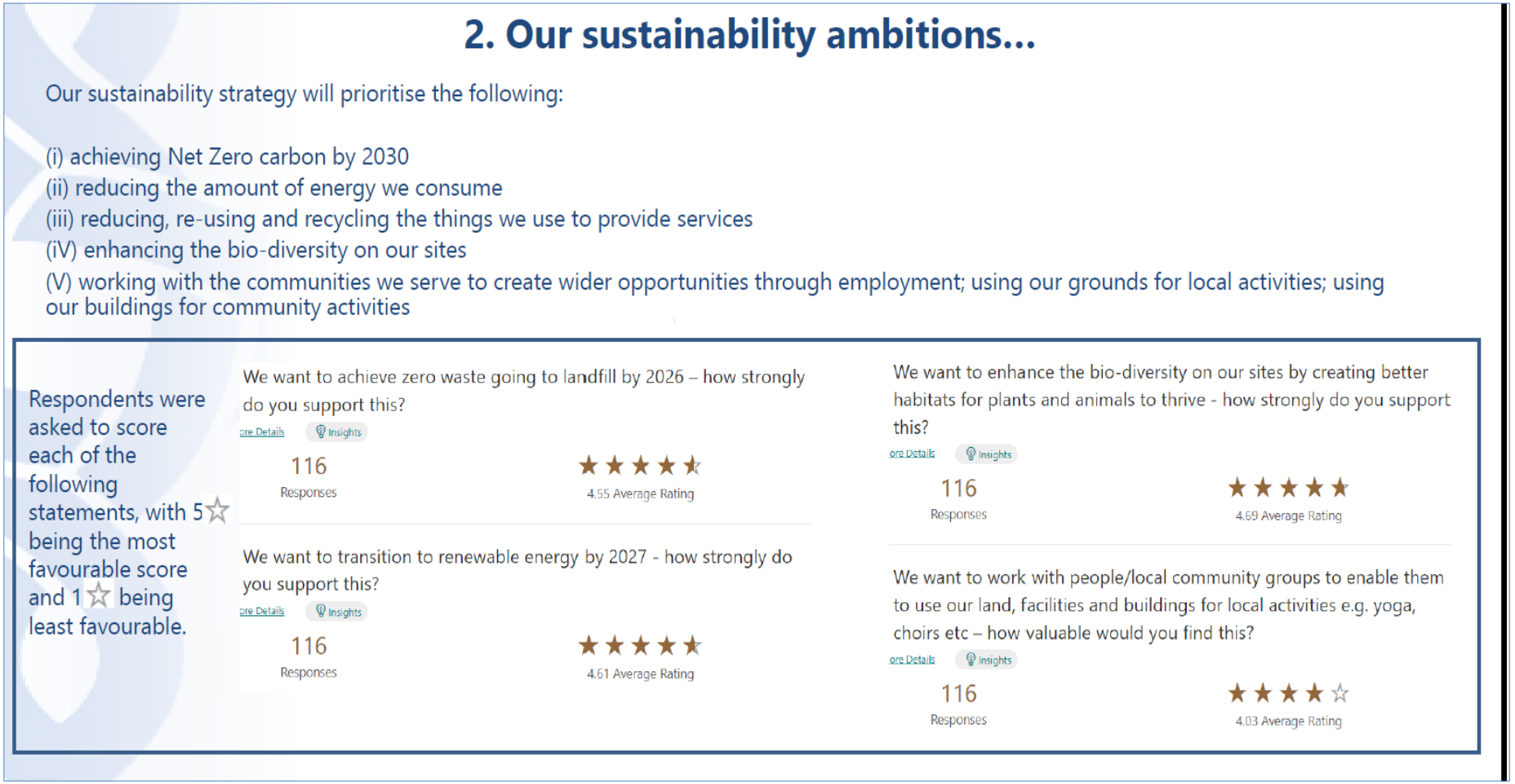
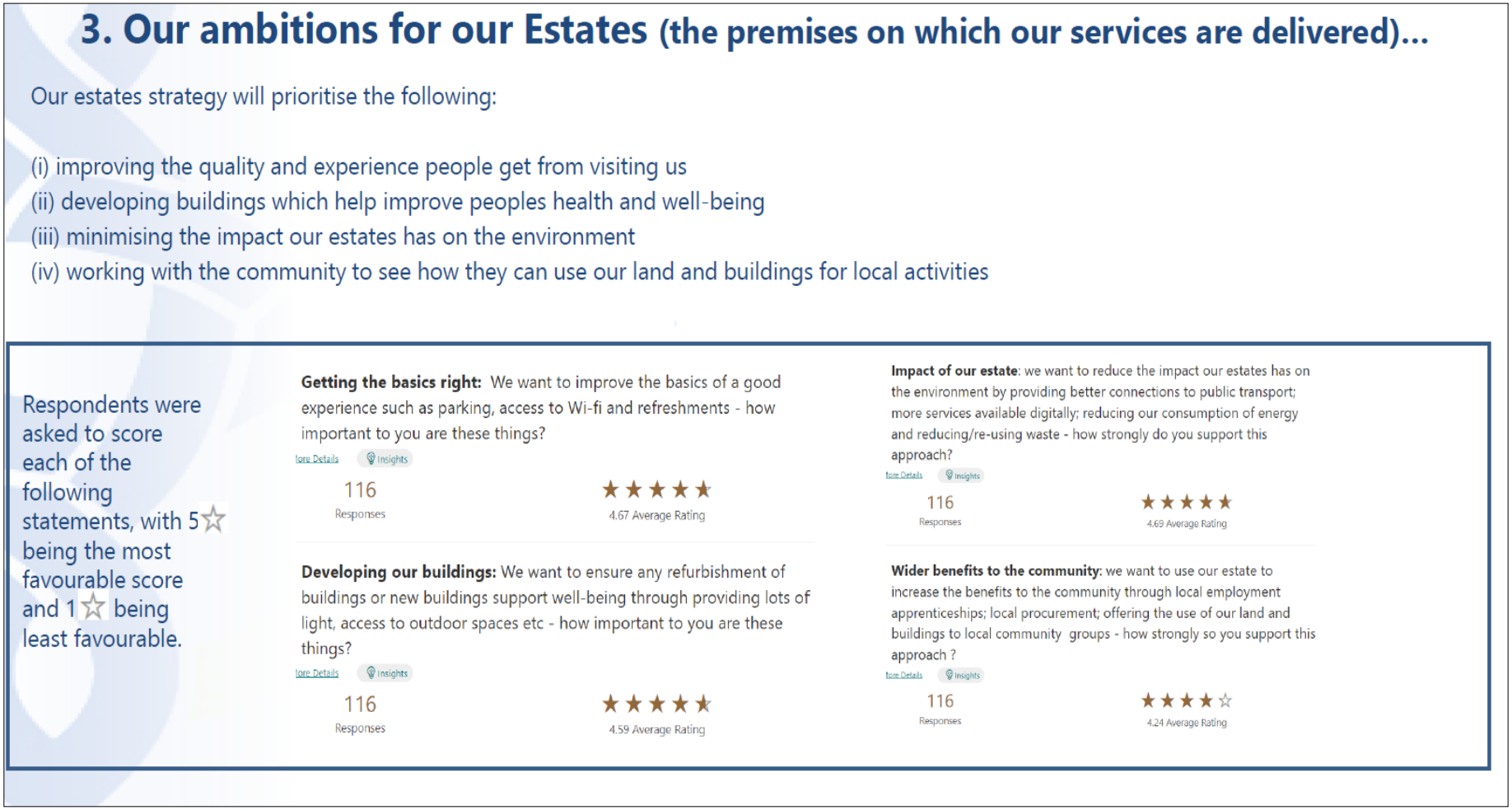


Fig. 3 Feedback on sustainability strategy



Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Fig. 4 **Feedback on estates strategy**



2.11 A communications and engagement plan is being developed to support the launch of the Trust strategy and supporting plans.

2. 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	Yes
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.

3. RECOMMENDATION

4.1 The Trust Board is asked to:

(i). approve the:
- Sustainability Strategy 2022 – 2032
- People Strategy 2022 – 2032
- Digital Strategy 2022 – 2032
- Estates Strategy 2022 – 2032

(ii). note that 'current/future' case studies will be included in the final versions.

Annexes

Annex 1 Sustainability Strategy

See attached

Annex 2 People Strategy

See attached

Annex 3 Digital Strategy

See attached

Annex 4 Estates Strategy

See attached

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Sustainability Excellence: our strategy 2022 -2032

Ensuring we contribute to a better world for future generations in our community and across the globe…

…acting today, for a more sustainable tomorrow

Foreword

Introduction

Why do we need a Sustainability Strategy?

Where are we now?

Moving Forward, Moving Faster…

What we want to achieve

Sustainability Excellence - Our themes

- Theme 1 - Creating Wider Value: our organisational approach
- Theme 2 - Sustainable Care Models
- Theme 3 - Eliminating Carbon
- Theme 4 - Sustainable Infrastructure
- Theme 5 - Transition to a Renewable Future
- Theme 6 - Sustainable Use of Resources
- Theme 7 - Connecting with Nature
- Theme 8 - Greening our Travel and Transport
- Theme 9 - Adapting to Climate Change
- Theme 10 - Our People as Agents for Change

Measuring our Success

Foreword

A very warm welcome to 'Sustainability Excellence', the sustainability vision and strategy for Velindre University NHS Trust. We are very proud of the excellent care and services we provide to patients, donors, wide range of partners and our track record of success. We care deeply about the communities we serve and see clearly the difference that a sustainable approach across the organisation will make in supporting us to continually improve the quality, safety, experience and outcomes of the services we provide.

We are keen to build upon our past as we look to the future and our Trust strategy 'Destination 2032' strategy sets out a clear direction for the organisation over the coming years as we seek to achieve our purpose and vision.

Our purpose: To improve lives

Our vision: Excellent care, Inspirational Learning, Healthier People

We have identified five strategic goals which we will focus on delivering over the coming years. We believe that the delivery of these goals will see the Trust provide services to patients, donors and our partners that are comparable with best in the UK and Europe.

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority

Strategic Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all

Strategic Goal 5: A sustainable organisation that plays it part in creating a better future for people across the globe

These are exciting times for the Trust and with a wide range of opportunities ahead of us. The importance of environmental interventions, sustainable solutions and working with our communities to deliver safe, high quality services and our long-term goals cannot be overstated.

"Sustainability Excellence' sets out our sustainability vision and strategy for the next ten years and will help us to transform health services and health across Wales..

Introduction

As a public service organisation in Wales we recognise the responsibility vested in us by the people we serve to make the country a better place to live, work and enjoy. We fully recognise the impact we have on the environment, the communities we operate in, the people we provide services for and the staff who work for us.

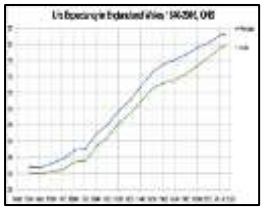
Our Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. The delivery of the strategy provides us with an exciting challenge which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity across Wales.

We are really excited to be able to set out our journey to sustainability in the Sustainability Strategy and the benefits it will realise over the coming years. As an anchor organisation we are committed to embedding sustainability within our own organisation and becoming an exemplar in Wales. This Sustainability Strategy provides a roadmap to achieving a sustainable future which will enable us delivering high-quality clinical services whilst reducing our impact on the planet and providing a wider range of benefits for the communities we work and live in.

Why do we need a Sustainability Strategy?

We serve a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities, requiring us to better coordinate and join up care.

We serve a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities, requiring us to better coordinate and join up care.



We serve a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities. This requires us to make a broader contribution to the communities we serve to improve their health, wealth and prosperity

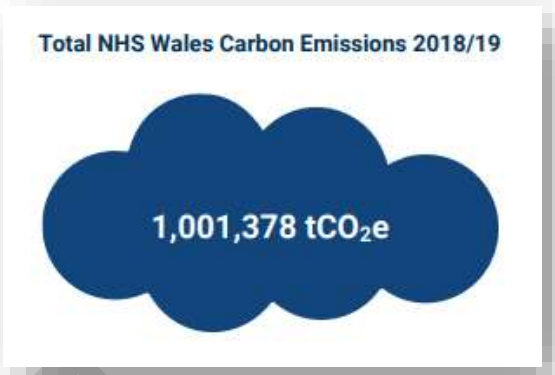
A Healthier Wales sets out a clear path to move from ill-health to well-being.

The climate emergency and need to develop a sustainable approach to living on the planet; a global challenge we need to respond to

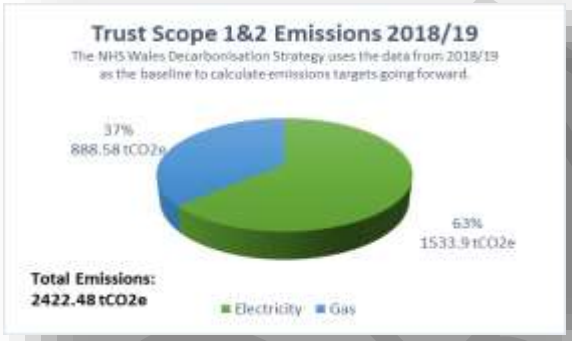
We need to reduce carbon emissions, drive energy efficiency, reduce plastics and waste, improve air quality and use resources more efficiently to move from ill-health to well-being

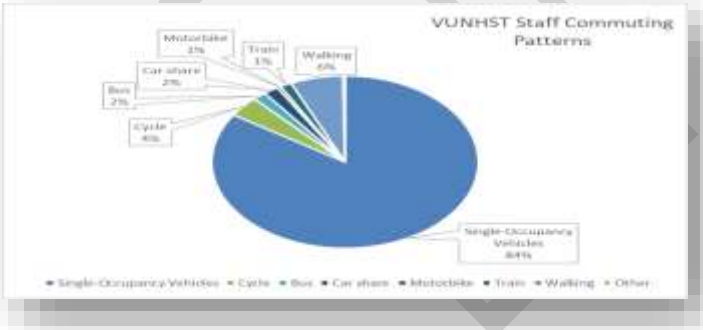
Technology, the 4th Industrial revolution, provides healthcare with the opportunity to transform the way we deliver services, increasing the value for patients, donors and our partners in a more sustainable way.

Where are we now?



We recognise that, inevitably, our day-to-day operations have an impact on the environment. The NHS is responsible for 2.6% of the total carbon footprint in Wales.. The consumption of resources is necessary for the provision of healthcare services and to provide a comfortable environment for patients, donors, staff and visitors. We also have a responsibility to be transition to a new, sustainable world which minimises the use of resources and creates wider value.





Moving forward, moving faster….

We are passionate about sustainability and we know the communities we serve and our workforce are too. We have an uncomplicated goal; to become a sustainable organisation that plays a part in creating a better future for people across the globe.

World Bank predicts by 2050, there will be 143 million climate refugees *– Environmental migrants are people who are forced to leave their home region due to sudden or long-term changes to their local environment.*

The pioneering 2015 Well-being of Future Generations Act (the "Act") and the 2016 Environment (Wales) Act 2016 provides Wales with an exciting opportunity to lead the way internationally and this strategy outlines our sustainability aims and enables real action to create positive and significant change.

This strategy is the start of a new phase of close engagement and collaborative working with others to share our resources and to work together do more with what we collectively have. Delivering our ambitions will require a collective effort from us all.

The Earth is on course to lose up to one in six of all its species, if carbon emissions continue as they currently are.

To achieve this vision, we set out what we want to achieve together with ten themes which we will focus on to deliver our ambitions. These are driven by the United Nations Sustainable Development Goals and the Well-Being of Future Generations Act, which together ensure we achieve the Trust Well-being Objectives.

The Intergovernmental Panel on Climate Changes 6th Assessment Report states the evidence is clear: the **time for action is now.** The world needs to halve emissions by 2030 and the **next few years are critical.**

What we want to achieve…

Our vision: a sustainable organisation which contributes to a better world for future generations locally and across the globe

Deliver sustainable services which add wider social value for the communities we serve

Be recognised as an exemplar organisation of delivering the Well-Being of Future Generations Act

A biodiversity net gain and enjoyment of our green spaces to improve health and well-being

Be carbon 'Net Zero'

Use minimum resources efficiently: zero waste to landfill by 2025 and reduced consumption of energy and water

Our Key Themes

We have identified a number of key themes which we will focus on to deliver our ambitions to become sustainable organisation. In each theme we set out what we want to achieve, our objectives and the actions we will take.

Theme 1: Creating Wider Value: our organisational approach

Theme 2: Sustainable Care Models

Theme 3: Eliminating Carbon

Theme 4: Sustainable Infrastructure

Theme 5: Transition to a future of renewables

Theme 6: Sustainable Use of Resources

Theme 7: Connecting with Nature

Theme 8: Greening our travel and transport

Theme 9: Adapting to Climate Change

Theme 10: Our people as agents of change

Theme 1: Creating Wider Value: our organisational approach

What do we want to achieve?

Embed sustainability within our organisation and create more value for the people we work for and the communities we work within

Our objectives are to:

- Ensure sustainability is embedded into our organisational conscience and decision-making
- Improve life for people who live in the communities we serve

We will:

- Maintain an ambitious and current sustainability strategy
- Routinely report performance against our sustainability goals to senior management, the Board, public and wider stakeholders
- Collaborate with regional health boards and local artists to create an arts programme, to improve wellbeing of patients, donors, staff and visitors. Evidence-based research has shown similar programmes improve the treatment experience, while supporting the local economy, culture, and community integration
- Work with NHS Wales Shared Services Partnership (NWSSP) to drive the greatest benefits from our procurement activities whilst driving down emissions
- Work with the Future Generations Commissioners Office to embed the Well-Being of Future Generations Act and to share our knowledge and learning widely with others
- Adopt the principles within the Place Making Charter and work with our local communities and partners to maximise the benefits of our resources to drive prosperity, health and wealth
- Play an active role as an Anchor Institution, creating broader social value for local communities through employment opportunities, contributing to economic and social prosperity of the local community
- Support our Local Health Boards, Local Authorities and other partners to improve population health and well-being
- Work with stakeholders to identify how people can use our buildings as a community asset

Theme 2: Sustainable Care Models

What do we want to achieve?

We want to deliver the highest quality of care which minimises our impact and supports our journey to a sustainable planet.

Our objectives are to:

- Improve the environmental sustainability of our care pathways
- Maximise the use of technology and digital services to reduce the environmental impact of care
- Collaborate with patients, donors and our partners to deliver models of care that reduce the number of visits to our sites through the provision of care at home or closer to home

We will achieve this by:

- Identifying carbon hotspots in our clinical services and pharmaceuticals and put in place actions plans to mitigate impacts and source alternatives

- Educating staff about high carbon impact services, equipment and pharmaceuticals and encouraging and supporting them in exploring alternatives

- Further evolve our clinical service models which are based on a 'hub and spoke' model; seeking to deliver more services at home and locally where appropriate

- Delivering our digital strategy which will Increase access to services, information and care for people through mobile devices and wearables

Theme 3: Eliminating Carbon

What do we want to achieve?

We want to be a carbon Net Zero organisation.

Our objectives are to:

- Contribute to NHS Wales achieving carbon Net Zero by 2030
- Become a Net Zero carbon organisation at the earliest possible time

We will achieve this by:

- Implementing our carbon reduction plan which includes actions to:
  - reduce the emissions from our estate and facilities
  - reduce our consumption of energy
  - retrofit our existing buildings to improve efficient use of energy
  - reduce the waste we produce
  - green our procurement activities and decarbonising our supply chain

- Reducing unnecessary travel related to our services
- Reducing the footprint of the estate to optimal size that meets operational requirements
- Hardwiring carbon reduction and sustainability requirements into our core business processes and decision-making e.g. business cases; procurement; infrastructure developments
- Accelerating our approach to agile working, enabling a minimum of 30% of our staff to work remotely

Theme 4: Sustainable Infrastructure

What do we want to achieve?

Provide buildings which improve the well-being of our patients, donors and staff to reduce our environmental impact

Our objectives are to:

- Reduce the environmental impact of building works during design, refurbishment, construction, operation and decommissioning stages

We will achieve this by:

- Developing sustainability guidelines for all capital projects including major refurbishments, driving resource efficiency through the implementation of our Estates strategy
- Designing to BREEAM excellent as a minimum standard in all of our new buildings in the major capital programme, together with the requirement for them to be developed using the circular economy principles
- Prioritising access to nature, natural light, ventilation, green space and easily accessible and active travel infrastructure in the development and refurbishment of the Trust estate
- Investing in a range of new building and facilities which includes:
  - major refurbishment and infrastructure upgrade at Welsh Blood Service (Llantrisant) by 2022/2024
  - construction of a Radiotherapy Satellite Centre at Nevill Hall by 2024
  - construction of a new Velindre Cancer Centre by 2025
- Work with contractors to take a whiole life cycle costing approach to all major capital projects, building refurbishments and new buildings
- Develop the ability to weight and use social value outcomes within our descision-making when procuring new services in the design and building of a new space e.g. the use of a local supply chain and SME's



Theme 5: Transiton to a Renewable Future

What do we want to achieve?

We want to reduce our overall energy requirements and transition to renewable sources.

Our objectives:

- Reduce our consumption of energy by 70% and improve water efficiency year-on-year
- Purchase 100% of our energy from renewable sources by 2027

We will achieve this by:

- Improve our metering and monitoring of energy across our estate
- Delivering a programme of targeted energy and water efficiency schemes to drive down use.
- Embedding more efficient practices, new technologies and improve staff awareness to improve utility efficiency in our everyday lives
- Respond quickly to any preventable energy inefficiency such as overheating or leaks through effective monitoring and leak detection systems
- Understanding the whole value chain effects of the products we utilise and the sustainability implications of our models of care and service. This will also require a focus on supporting sustainable local supply of appropriate services and products.
- Introduction of new technologies to support the management and control of resource

Theme 6: Sustainable Use of Resources

What do we want to achieve?

We want reduce, re-use and recycle resources annually and adopt a circular economy approach as the 'way we do things around here'.

Our objectives are to:

- Reduce our waste by 33% 2030 in accordance with the Welsh Governments 'Beyond Recycling' targets
- Achieve 'zero waste to landfill' by 2025
- Have 70% of our waste recycled by 2025

We will achieve this by:

- Focus our action on plastic by:
    - Apply the waste hierarchy, rethinking traditional waste models and working closely with our staff and supply chain, moving towards a circular economy
    - Deliver initiatives to reduce waste including:
        - Food: through reduction, re-use and sustainable treatment
        - Plastic: by targeting the 15 plastic product groups the vast majority of waste; replacing single use products and plastic with reusable alternatives where there is a viable and lower carbon option
        - Promoting a culture of re-use, re-purpose, refurbish and pass-it-on for items where this is possible e.g. furniture and equipment
- Developing a plan which sets out or transition to renewables which includes:
    - specifying renewable energy when we enter into new energy purchaisng arrangments
    - determing the viable potential of renewable eneregy in our buildings (on-site or sourced)
- Work with NHS Wales Shared Partnership Procurement and other partners to procure goods and services with the highest standards of producer responsibility that minimise packiging and offer alternative solutions to waste reduction and take back options

Theme 7: Connecting with Nature

What do we want to achieve?

We want maximise the quality and benefits of our green space, buildings, facilities and resources to enhance nature, biodiversity and well-being.

Our objectives are to:

- Improve the well-being of our patients, donors and staff through their connection with the natural environment
- Increase biodiversity by protecting and enhancing natural assets
- Maximise the quality and benefits from our green spaces

We will achieve this by:

- Raising awareness of the benefits of nature for physical and mental well being
- Working with local communities, the voluntary sector and business to identify how we can make our land, buildings and facilities available to the public to wider social activities which support health and well-being
- Developing a Biodiversity Enhancement Plan (BEP) which sets out how we will deliver a biodiversity net gain e.g. through reduction of mowing, sowing wildflowers and removing invasive species on all sites; and site refurbishments and new building developments
- Designing services, buildings and facilities which provide people with the opportunity to connect with green spaces and nature at our locations
- Create a wide range of activities and cultural programmes which enhances the place we live, work and play. This will include arts programmes, allotments, nature trails on our estate, community benefits and accessible activities
- Providing patients, donors and staff with opportunities to participate in well-being initiatives on our sites which add wider social value such as art exhibitions walking, yoga, beekeeping, gardening schemes, singing etc.
- Developing our approach to providing locally produced food to reduce the environmental impact and develop local resilience e.g. local food growing schemes and incorporation of products into Trust catering services
- Maximising the use of our green space to help mitigate the effects of climate change e.g. planting of additional trees and carbon sequestration
- Employing green social prescribing as a holistic method of treatment, to enhance patient experience by connecting them with the surrounding natural environments.

Theme 8: Greening our Travel and Transport

What do we want to achieve?

We want to reduce the health impacts associated with our business and support a transformation in the way we travel

Our objectives are to:

- Decarbonise our transport and travel operations
- Encourage sustainable and active travel wherever possible seeking to reduce business mileage by 70%
- Provide more care and services at home or closer to home

We will achieve this by:

- Strengthening our Green Transport Plan to increase the use of sustainable and active travel
- Work with our strategic partners to better connect our estate to local integrated transport to reduce traffic impacts and increase the use alternative methods (e.g. walking, cycling, bus/metro)
- Improving green travel and access options to our services, buildings and facilities for patients, donors and staff
- electrification of our fleet and use of other modes for operational purposes
- Improving our facilities for staff actively travelling to work e.g. shower and changing facilities
- Actively marketing the Trusts cycle to work scheme, car sharing and use of the bus/metro at discounted prices for public service employees

Theme 9: Adapting to Climate Change

What do we want to achieve?

We want to ensure our organisation is well prepared to manage the impacts of climate change

Our objectives are to:

- Assess and understand the impacts of climate change on our services and communities
- Ensure our infrastructure, services, procurement activities and local communities are well prepared to mitigate and manage them

We will achieve this by:

- Working with Public Health Wales, the Welsh Government and partners to analyse the available data, understand risks and impact and develop solutions
- Invest in mitigation and adoption technologies to build resilience in our services
- Constantly review and adapt our business continuity and resilience plans to reduce the risk of service disruption and the impact on our patients, donors and communities
- Design-in climate change adaption measures into all future building refurbishment and new buildings

Theme 10: Our people as Agents for Change

What do we want to achieve?

We want to develop a workforce which place sustainability at the heart of everything we do.

Our objectives are to:

- Support staff to develop the knowledge and skills to improve sustainability at work and home.
- Empower staff to make sustainable choices in the services we provide which improve their well-being

We will achieve this by:

- Delivering education and awareness programmes to raise sustainability and provide staff with opportunities to participate and make a difference
- Provide a knowledge hub of resources for every member of our workforce to access to enable them to deliver sustainable practice
- Include sustainability in all job descriptions and performance reviews
- Develop communities of practice and a range of 'Sustainability Heroes' who can provide leadership, enthusiasm and fun to encourage participation
- Encourage staff to take up opportunities to formal education and training programmes to increase our expertise e.g. degree and MSc
- Strengthen our succession planning by increasing apprenticeship opportunities support and work placements with local universities and NHS Wales Shared Services Partnership
- Integrating sustainability into our research, development and innovation portfolio to develop a compelling evidence base showing the benefits
- Supporting research examining issues relating to sustainable healthcare and environmental issues

Measuring Our Success

The Trust is committed to demonstrating leadership in sustainability and this comprehensive plan represents a route map for it to deliver significant improvements, with the help of its staff, key partners and other stakeholders.

Creating Value with our Communities: our approach	• Social value calculator/assessment tool • % apprenticeships/student places offer to local communities • % of building assets available for use by local community stakeholders (i) % availability to local community utilised • Social value: community benefits audits • % of goods and services procured locally
Sustainable Models of Care	• % patients/donors rating care as excellent • % patients / donors rating the environment as excellent • % of patients receiving care at home or in local community • % of consultations carried out digitally
Eliminating Carbon	• % CO2 emissions • % of carbon footprint from procurement activities
Capital Projects and Infrastructure	• % of new buildings and refurbishments achieving BREEAM excellent • Life cycle costs (sustainability) of major refurbishments and new builds • % of our fleet hybrid or electric

Sustainable Use of Resources	• Annual Net Zero Reporting to Welsh Government to
	• Water consumption
	• Energy consumption
	• Gas consumption
	• Annual EFPMS return
	• % of energy from renewable sources
	• % of waste reduction overall
	  - % of waste to landfill
	  - % recycled

Connecting with Nature	• Value of natural capital • Net biodiversity gain from the baseline audit in 2019 • % of trees new trees planted (of overall estate)
Travel and Logistics	• % staff walking to work • % staff cycling to work • % staff using public transport to travel to work • % staff car sharing • % single occupancy car travel to work • % of staff working from home • Business mileage per annum
Adapting to Climate Change	• BREEAM excellent buildings • Air quality on Trust sites • Risk rating in Trust Assurance Framework
Our people as agents for change	• % of staff receiving sustainability induction • Social value calculator/assessment tool • Staff awareness of sustainability (annual staff survey) • % sickness absence • % staff recommending us as an employer

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

People Strategy

Being an Employer of Choice

DRAFT

Published: TBC

Contents

Foreword

A very warm welcome to the People strategy, the People vision and strategy for Velindre University NHS Trust. We are very proud of the excellent care and services we provide to patients, donors and wide range of partners and our track record of success. We care deeply about the communities we serve and see clearly the difference that a talented, motivated and valued workforce makes to the quality, safety, experience and outcomes of the care and services that we provide.

We are keen to build upon our past as we look to the future and our Trust strategy 'Destination 2032' strategy sets out a clear direction for the organisation over the coming years as we seek to achieve our purpose and vision.

Our purpose: To improve lives

Our vision: Excellent care, Inspirational Learning, Healthier People

We have identified five strategic goals, which we will focus on delivering over the coming years. We believe that the delivery of these goals will see the Trust provide services to patients, donors and our partners that are comparable with best in the UK and Europe.

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority

Strategic Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all

Strategic Goal 5: A sustainable organisation that plays it part in creating a better future for people across the globe

These are exciting times for the Trust and with a wide range of opportunities ahead of us. The importance of the talented staff in delivering safe, high quality services and our long-term goals cannot be overstated. This is set within the context of a workforce shortage in the NHS across the UK and global competition for talent.

This strategy sets out the workforce we require now, and in the future, and how we will work with our staff and partners to attract, retain, value and reward people for what they do in work.

Our People Strategy: Becoming an Employer of Choice

These are exciting times for Velindre University NHS Trust when we consider the opportunities ahead for Blood and Cancer Services in Wales.

Our People Strategy describes how we will create the workforce we need to deliver our vision 'Healthy People, Great Care, Inspirational Learning'.

It sets out our strategic priorities and the approach we will take to deliver them. The strategy builds on our successes and is supported by feedback from staff surveys – it will be grounded in our values, to Be Accountable, Be Bold, Be Caring, Be Dynamic. We will ensure we are always aligned to our values.

Our People and the needs of our patients and donors are changing and so is the way we deliver care. Shortages of clinical staff nationally, an older workforce and population and changes to education pathways means our people profile is evolving.

As a Trust we value our staff and recognise they are all core to the success of our organisation. Our overall aim is to develop our staff, support career pathways, develop leadership, skills and the knowledge they need to deliver the care our patients and donors need now and in the future to support their wellbeing and to recognise and value their diversity as part of a bi-lingual culture.

The Strategy will build on a strong foundation as a good employer and is key to delivery of our service and clinical plans.

Our vision is to have a:

Skilled and Developed People: an employer of choice for staff already employed by us, starting their career in the NHS or looking for a role that will fulfil their professional ambitions and meet their personal aspirations.

Planned and Sustained People: having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing.

Healthy and Engaged People: within a culture of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and cultural identity

This People Strategy will ensure that our Trust is best placed to continue to deliver world class services for our donors, patients and carers. This will only be possible if we have the right workforce in the right place with the right sills at the right time.

This People Strategy is the response to the Trust-wide strategy that has redefined our ambition for excellence by building on our strategic strengths and addressing our challenges. It is part of this Trust's ambition to be outstanding for donors, patients and carers, forward thinking for staff and a partner in delivering healthcare across the region. Ensuring that our staff are looked after and developed will be core pillars of success for this strategy.

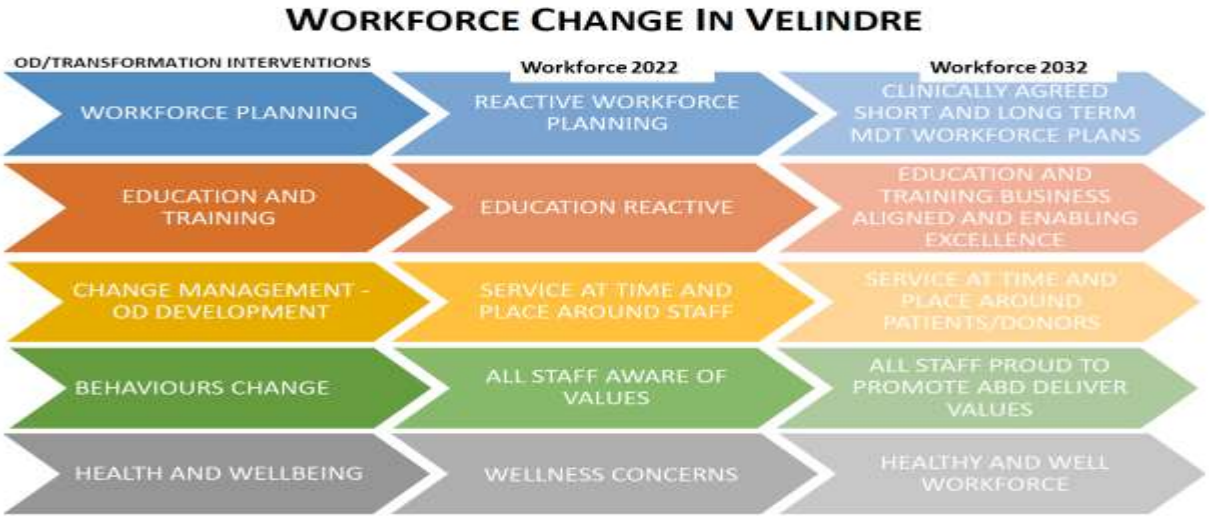
Our journey so far

Velindre is committed to being an employer of choice, offering an excellent working and development environment, with staff dedicated to providing outstanding care every time for our patient and donors and recognising that the key quality and strategic objectives can only be achieved through a combination of a well led, engaged and efficient people. We strive to behave in line with our values which we are always continuing to review.

The Trust is dedicated to providing opportunities for staff to engage and develop. It strives to provide opportunities for staff to learn and has strong relationships with academia through the Trust Academic Board. There is a range of health and wellbeing initiatives that are being made available to staff across our sites and on-line health and wellbeing resources that can be accessed at any time.

Models of care and service delivery need however to be constantly replaced and updated to support a changing NHS landscape and to meet the requirements of NHS Wales's service delivery strategy. Velindre University's NHS Trust is modernising in response to new healthcare options, the national Workforce Strategy, changing social expectation and expectations of patients and donors, rapid advances in technology and economic pressures. Additionally, the expectation that people have of their working lives and career pathways are evolving. The development of our people is key to transformation.

The graphic below summarises some of the key elements of our workforce change over time. A Healthy, Skilled and Planned workforce are integral parts of the transformation.



Our Workforce Response

We have developed a number of themes which will support us in attracting, developing and retaining a workforce fit-for-now and fit-for-the future.

Theme 1: Our People Wellbeing and Engagement

We will ensure our staff feel valued and supported.

Our objectives are to …

- Develop a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement
- Provide an Engagement Strategy to ensure staff are informed, involved, issues are raised and resolved, staff are rewarded and engagement can be measured
- Deliver an Equality, Diversity and Inclusion plans and Welsh Language Plan promoting a culture of true inclusivity, fairness and equity across the workforce. Our people are reflective of the Welsh population's diversity, Welsh language and cultural identity

We will …

- Demonstrate exemplar employment practices with a clear focus on equality, diversity and inclusion
- Support managers and staff to hold wellbeing and attendance conversations
- Provide effective work/life balance offers as we develop our agile and hybrid working arrangements
- Offer flexible career opportunities to meet changing needs
- Ensure our staff have access to appropriate support for mental and physical health concerns
- Deliver fair rewards and recognition, including addressing pay gaps across protected characteristics
- Continuously listening to staff and fostering a culture of care, compassion and inclusivity in line with our values

Theme 2: Our People Supply and Shape

We will have the right people with the right skills in the right place at the right time

Our objective is to …

- Develop effective people plans having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing

We will …

- Aligning to our Education Strategy, develop a Talent Management process that supports career pathways so staff have opportunities to grow professionally and internal and external pathways are visible to current and new staff

- Review our people plans to have the right skill mix of staff, maximising opportunities for new roles. This will include the implementation of delegation frameworks to support the development of Health Care Support Workers and further introduction of Advanced Practice and Physician Associate roles

- Maximise opportunities for all entry pathways including Apprenticeship, Graduate entry as well as Supported Recruitment to ensure an inclusivity in our supply routes
- Further embed our workforce planning process and develop our workforce information to maximise the opportunities for new ways of working

Theme 3: Skilled and Developed People

We will continually develop our staff to support them to achieve excellence in everything they do.

Our objectives are to…

- Develop a competent, capable and caring workforce
- Undertake a leading role with academic and national partners
- Provide high quality, technology enabled learning environments
- Develop new training pathways

We will …

- Develop a capable workforce including:
    - Meaningful Performance and Development Reviews that support, motivate and develop our staff
    - Assurance of safety through 85% compliance on Statutory and Mandatory Training
    - A Management and Leadership development offer that is flexible and supports 'just for me, just in time' development
- Working with our service improvement and research colleagues we will develop training and development pathways that respond to changing models of service delivery, delivering quality care
- Working with academic and service leaders in innovation technology we will development excellent learning environments for our staff building on the work already stared with virtual learning environments
- Through our Academic Board the Trust we will work with partners to achieve an academic profile showcasing its work on innovation and research

Theme 4: Leadership and Succession Planning

We will develop Compassionate Leaders and Managers which sustain our future requirements

Our objectives are to..

- Provide effective leadership development
- Promote a coaching culture at all levels to encourage compassionate leadership behaviour
- Establish a Talent Management process to spot and manage talent at all levels
- Embed team based working delivering high quality outcomes

We will …

- Enhance the Trust Inspire Leadership and Management Programme to continue its development of foundation and intermediate development programmes for leaders and managers supporting individuals through a bespoke offer of learning to deliver quality services
- Develop the talent management process ensuring it is systematic, equitable and inclusive across the Trust.
- Work with senior leaders in creating compassionate conditions in which all employees can thrive and work at their best.
- 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

Theme 5: Digital Ready People

We will create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology

Our objectives are to.. …

- Create new Digital Leadership at all levels of the organisation
- Provide education to support a culture where utilising digital tools becomes second nature
- Work with partners in Academia to promote the digital vision of the Trust and attract talent

We will …

- Ensure our staff have the skills required to access to high quality information, to deliver high quality, safe services
- Support service transformation by including attracting and deploying digital talent within the transformation teams.
- Utilise the digital platforms to provide access to wellbeing resources for staff
- Encourage self-directed learning for all by developing digital literacy and utilising publicly available resources

Theme 6: Attracting and retaining the best talent

We will seek to identify the best talent locally and across the globe to work in our organisation.

Our objectives are to…

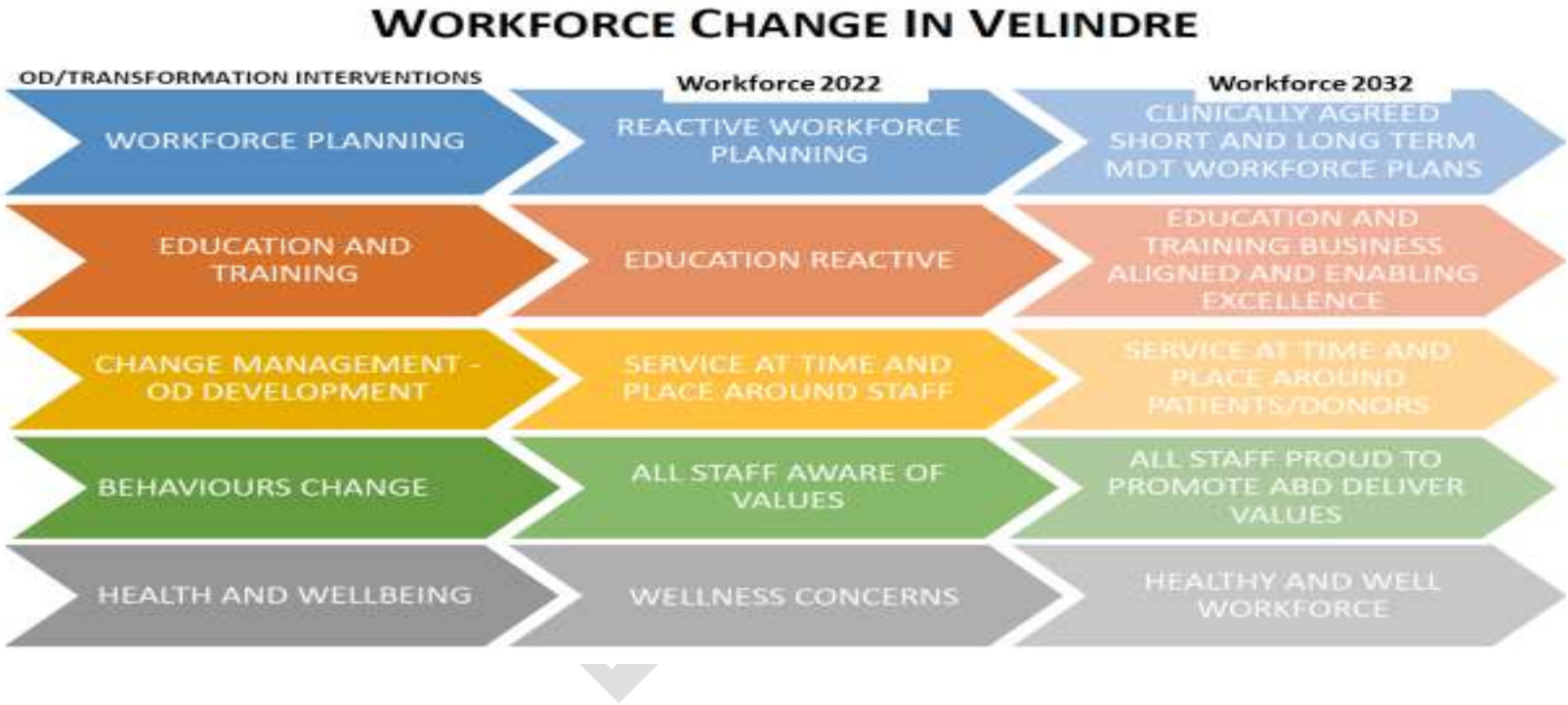
- Supply and retain appropriate trained and skilled staff
- Development of realistic and sustainable workforce plans
- Be a workplace that staff would proudly recommend to their friends, family and colleagues as a great place to work

We will …

- Create new approaches to recruitment marketing, targeting specific areas of shortage and using a range of communication channels to engage prospective staff
- Grow our Welsh speaking workforce by focussing on bi-lingual recruitment and developing language skills of staff
- Promote the Trust as a local employer of choice, working with our Academic colleagues to provide pathways into employment at all levels, ensuring inclusivity at all levels
- Ensure our recruitment processes are agile, assessing our time to hire regularly
- Develop wellbeing and engagement of all staff through listening, dialogue and involvement
- Recognise our staff for their achievements

Our Future People - Workforce 2032

With the successful implementation of the above themes the Trust will enable the transition of its people across all its key deliverable areas to create a Health and Engaged, Skilled and Developed and a Planned and Sustained Workforce



Measures for Success

People Wellbeing and Engagement

- Positive feedback from staff regarding wellbeing support
- % of staff recommending the organisation as a good employer in staff survey
- % sickness absence
- % of formal staff grievance cases

People Supply and Shape

- Number of Apprenticeships and Graduate Programmes offered/filled
- HCSW Delegation Framework in place
- Diversity of the workforce
    - Ethnicity
    - Gender
- % Welsh Language learners
- % Welsh Language speakers

Leadership and Succession Planning

- % of managers completing the Inspire Programme

Skilled and Developed People

- % Personal Development Reviews completed
- % Statutory and Mandatory training completed
- New Training pathways in place

A Digital Ready People

- Number of Digital Apprenticeships and Graduate trainees offered/filled

Employer of Choice – Attraction and Retention

- % Turnover rate
- % staff recommending the organisation as an Employer of Choice to family and friends

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

Digital Excellence: Our Strategy 2022 - 2032

… Enabling Services of Tomorrow … Today

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Foreword

A very warm welcome to 'Digital Excellence', the digital vision and strategy for Velindre University NHS Trust. We are very proud of the excellent care and services we provide to patients, donors, wide range of partners and our track record of success. We care deeply about the communities we serve and see clearly the difference that digital technology and insight can make in supporting us to continually improve the quality, safety, experience and outcomes of the services we provide.

We are keen to build upon our past as we look to the future and our Trust strategy 'Destination 2032' sets out a clear direction for the organisation over the coming years as we seek to achieve our purpose and vision.

Our purpose: To improve lives

Our vision: Excellent care, Inspirational Learning, Healthier People

We have identified five strategic goals which we will focus on delivering over the coming years. We believe that the delivery of these goals will see the Trust provide services to patients, donors and our partners that are comparable with best in the UK and Europe.

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority

Strategic Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all

Strategic Goal 5: A sustainable organisation that plays it part in creating a better future for people across the globe

These are exciting times for the Trust and with a wide range of opportunities ahead of us. The importance of digital technology, digital services and good information and insight in delivering safe, high quality services and our long-term goals cannot be overstated.

One of the most important components of our future success will be how well we embrace the opportunities that digital services offer. "Digital Excellence' sets out our strategy for the next ten years and will help us use technology and insight to support our vision of excellence.

Digital Excellence: what does digital mean for you?

Digital can mean a variety of different things to a variety of different people. What does it mean for our donors, patients, carers and staff?

Digital technology and services provide the opportunity to make a real shift in the relationship between health and care professionals, the people they serve, and the healthcare services we provide. Designing services in partnership with patients and donors will allow us to re-imagine services and provide a more personal experience; enabled by digital technology.

It is important we understand what it means for each group. What does digital mean for a ……..

Blood donor……..

- I can manage my donation appointments on the move
- I can view my donation history and understand where my donation has gone
- It allows me to keep my details up to date
- It helps me identify donation sessions close to my current location
- It signposts me to other services I may find useful
- It lets me see what difference my donation is making

Patient

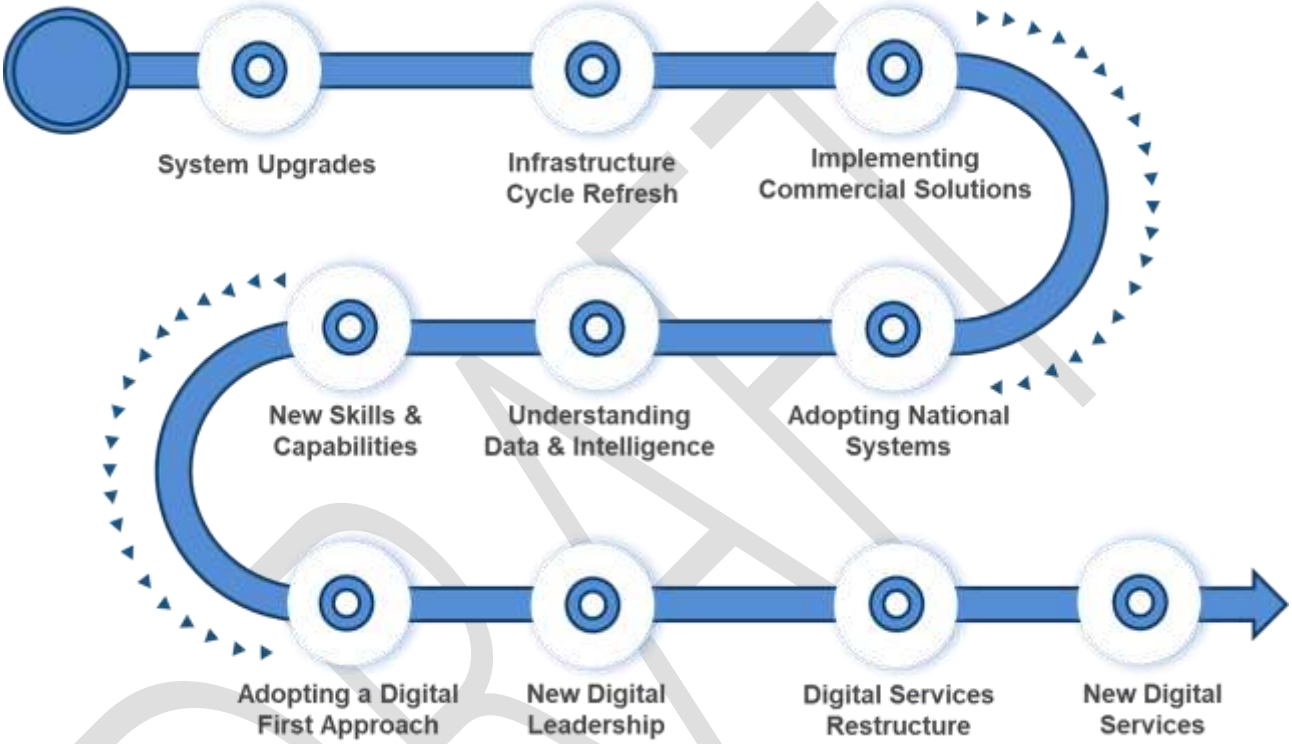
- It gives me information about my health and care and supports me to make more informed decisions over what I need from the services you provide
- It gives me more choice about where/how I access the services I need
- It signposts me to other services I may find useful
- It provides information for families/carers who support patients receiving care

Member of staff and other healthcare partners…..

- It makes my role easier and more efficient
- It connects me to my team and my organisation
- It gives me flexibility in how and where I work
- It allows me to innovate and explore better ways of doing my job. It gives me the right information at the right time
- It allows me to share information across organisations to improve care

Our journey so far

Velindre University NHS Trust has built a proud history of significant developments in digital services which have made a difference to the quality, safety and experience of the services we provide …



These achievements over the last 5 years have put strong foundations, skills and capabilities in place to support the next stage of digital transformation.

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Looking to 2028: our digital transformation

Our vision: to ensure patient, donor and staff experience of digital services is the same as our care…… outstanding

To deliver our vision, we have set out a number of themes which will support us in delivering a connected, people focused, personalised and sustainable future.

Theme 1: Ensuring our Foundations

We will empower our staff to have access to high quality information, equipment and technology they require 24 hours a day 7 days a week to deliver high quality and safe services.

Our objectives are to …

- Maintain resilient hardware and software across the organisation
- Develop and implement a suite of application services which maximise the benefits of an integrated all-Wales systems approach
- Deliver digital systems and services which are designed with interoperability and integration as a core requirement

We will …

- Develop a 'fit-for-the future' infrastructure that is resilient with hybrid of cloud and data centre / on premise deployment
- Design all systems around the national principles (e.g. open; inter-operable;) to support integration across organisations
- Implement a range of national systems including Welsh Clinical Portal, Welsh Patient Administration System, WLIMs, ePrescribing
- Continually develop and maximise the benefits of our existing business systems including the Blood Establishment Computer System (eProgesa) and Digital Health Care Record
- Implement local solutions relevant and appropriate to the needs of the population we serve
- Strengthen our prioritisation and governance arrangements to maximise the benefits of any investment in digital services and technology
- Design and implement a new strategy for the telephony services used across the Trust to include the adoption of new digital telephony services, such as those available via Microsoft Teams

Theme 2: Connected and Inclusive Services

We will support people to become more digitally confident, included and connected.

Our objectives are to …

- Digitally connect our donors, patients and carers and staff to our services 24/7
- Place information which is uncomplicated and accessible into the hands of patients and donors to enable them to make better decisions about the services and support they require
- Deliver the technology which supports the provision of more services at home and locally as possible
- Provide our staff with the technology to work from a wide range of locations across Wales
- Reduce digital exclusion of people across Wales

We will …

- Create a new Integrated Platform for our digital patient and donor services, to include the delivery of a suite of mobile 'applications' for clinical and non-clinical services
- Work with patients/donors and third parties to explore opportunities to develop a suite of 'apps' that that can be plugged in or out easily which provide new forms of value
- Work with the local/national programmes to ensure staff have devices to use anytime/anywhere and access to mobile working e.g. .Gov.roam etc.
- Fully implement Office 365 and realise the benefits of connected working
- Implement the digital requirements of the Transforming Cancer Services/Velindre Futures and Blood and Transplant Futures transformation programmes
- Hardwire the digital inclusion principles into our day-to-day activities and decision-making by :
    - developing a digital inclusion programme to support patients, donors, volunteers and the public in accessing our services (including training; provision of tablets/devices etc.)
    - delivering our programme of work in the Digital Communities Initiative
    - sharing and learning from best practice with *Digital Communities Wales* to co-ordinate our approach for maximum impact
- Build local and national partnerships to share ideas and co-ordinate activities with others in their area

Theme 3: Insight Driven

We will optimise the use of data and knowledge to help us make informed and insight driven decisions within the organisation and in collaboration with partners across organisational boundaries.

Our objectives are to …

- Develop a data-driven, insight led culture and evidenced-based decision making within the organisation at all levels

We will …

- Improve the quality of our data by driving data standards; identifying data champions; and improving data sharing protocols
- Work with the Digital Health and Care Wales (DHCW) to maximise the benefits of the National Data Resource (NDR) and integrate it with our data lake
- Develop the business intelligence service to :
    - democratize data, supporting frontline staff to own and analyse it
    - provide a range of standard reports using PowerBI and other tools
    - provide expertise to undertake bespoke analysis

- Establish a programme of work which will seek to identify further opportunities in the following areas:
    - operational and clinical intelligence
    - tools and business insight
    - robotic Processing Automation
    - artificial intelligence
    - knowledge and skills sharing and learning

- Facilitate an open culture that encourages colleagues to challenge and question the ways of doing things by using data to drive service improvements and measure outcomes
- Provide staff with training and support in a range of areas data standards; data analysis; and the use of analytical tools and techniques
- Build partnerships with academia to develop new methods of training and education in data science at all levels of the organisation
- Provide opportunities for research studies with local universities, offering MSc and PhD students the opportunity to use our data to provide us with insights and develop impactful research
- Implement linked outcome reporting such as Patient Reported Outcomes Measures (PROMS) and Patient Reported Experience Measures (PREMS)

4: Safe and Secure Systems

We will secure our data and information through an effective approach to cyber security, working in collaboration with the Cyber Resilience Unit and the National Cyber Security Centre.

Our objectives are to…

- Maintain compliance with national policies and the Network and Information Systems (NIS) Regulations
- Increase awareness and training of cyber security principles
- Reduce the risk of a cyber-security breaches

We will …

- Implement our strategic delivery plan for cyber security
- Develop and test cyber security business continuity and disaster recovery plans
- Conduct periodic exercises simulated on cyber attacks
- Ensure the Trust is fully compliant with the Network and Information Systems (NIS) regulations
- Implement the national Vulnerability Management Solution (VMS)
- Ensure all devices across the Trust utilise automated patch management
- Develop new policies and procedures to support our security delivery plan
- Implement new controls for third party removable media scanning
- Enable further system protections and disable legacy communication protocols
- Develop and implement Microsoft InTune for enhanced Mobile Device Management (MDM)

Theme 5: A Digital Organisation

We will work with patients, donors, staff and partners to create a service culture that embraces the use of digital technology to get the best quality services from it.

Our objectives are to…

- Create strong digital leadership at all levels of the organisation
- Build a highly skilled digital team that has the capacity and capability to deliver the our digital ambitions
- Create a digitally literate workforce which embraces the use of technology to improve the services we provide
- Become a paperless organisation

We will …

- Strengthen our digital education and training programme from 'ward/lab to board' to improve knowledge and understanding
- Work with the Intensive Learning Academy and other partners to develop the core digital competence of the workforce aligned to their role
- Identify a range of digital leaders and support them in attaining digital/transformation qualifications e.g. degrees, MSc
- Build the capacity and capability of the Digital Directorate to support the delivery the digital transformation roadmap
- Create uncomplicated ways to share learning and knowledge through communities of practice; 'lunch and learns'; sandpit environments; and online resources that staff can use to acquire skills and knowledge
- Actively promote digital as a profession within other clinical and non-clinical professions
- Operationalise the principle of 'Bring Your Own Device' to allow staff to access Trust digital services using the mobile technology of their choice
- Develop a plan to transition to a paperless organisation

Theme 6: Working in Partnership

We will work with partners to make Wales the area that innovators want to come to learn about digital excellence.

Our objectives are to…

- To build a network of partners and capabilities which enable us to maximise the benefits from research, development and innovation
- To become an exemplar within NHS Wales for digital innovation

We will …

- Develop a suite of technology partners to support all aspects of our digital transformation blueprint
- Develop an agreed work programme(s) with local universities in stated areas of shared interest to drive the use and evaluation of digital technology in healthcare
- Recruit students and academic personnel to drive forward our research, development and innovation plans for digital technology
- Develop a Collaborative Centre for Learning, Technology & Innovation to be a physical and virtual point of contact for all partners and stakeholders to collaborate and innovate
- Establish partnerships which enable us to implement the concepts of SMART technology in our new infrastructure including the Welsh Blood Service (Llantrisant), the Radiotherapy Satellite Centre and the new Velindre Cancer Centre. This will allow us to share the knowledge, innovation and learning across Wales

How will digital technology make a difference for our patients and donors?

Rachel's Story: a cancer patient

Rachel is referred to us by her Local Health Board after surgery for breast cancer. Rachel books her first appointment to see a consultant on-line using an app. She books her car parking on-line and emails her consultant on our platform with the questions she has in advance of her first appointment. She is able to access her medical records and information and uses our app to tell us how she is feeling in advance of her first outpatient appointment. This allows us to support her as she is feeling anxious and provide her with useful information and access to other services which can assist e.g. therapies; financial information etc.

Rachel arrives for her first consultant appointment and parks in her allocated space and checks in using the digital check-in desk. This immediately alerts us that she has arrived and helps us ensure that she is seen on-time. Rachel uses the Velindre app on her wearable device to access the wayfinding function which helps her easily find the cafeteria and outpatients department. Rachel's clinical information and the data she shared with us whilst waiting to see the consultant is all available to Dr Davies when she sits down with her for the consultation.

Rachel and Dr Davies agree a treatment plan which includes radiotherapy, systematic anti-cancer therapy together with mindfulness and support from the Maggie's. Rachel downloads our app onto her wearable watch device and IPad and this allows her to monitor her health and share her data with us on a number of vital signs (bloods, temperature, heart rate) and her diet and sleep patterns. Our artificial intelligence systems monitor Rachel's health remotely 24/7 to ensure there are no concerns whilst she is waiting to start here treatment. If anything is of concern, the remote monitoring triggers an automatic email to Dr Davies and the clinical team who review her situation and provide her with clinical guidance. Rachel also has video calling access to our teams to address any questions she has or any concerns she has during her time with us. She also has access via our platforms to our Support Community which consists current and previous patients/families who provide support for each other through shared experiences.

Following her first appointment and treatment Rachel goes home and we keep in touch via the app. Rachel continues to monitor her vital signs and health information on the app and share her data with us for us to monitor. Unfortunately, Rachel begins to feel unwell at 3am and calls our 24/7 intelligent assistant for information which provides her with information and re-assures her that. It also books a virtual call with her Cancer Nurse Specialist the following day. Rachel discusses her concerns with our Cancer Nurse Specialist the next day and they agree that she needs to speak to an oncologist locally at the V@UHW facility for further examination. They book the appointment on-line and Rachel speaks to Dr Davies in the afternoon who prescribes some anti-biotic. Rachel continues to feel unwell and Dr Davies decides to admit Rachel to the Cancer Centre for further review. Rachel has her own room and uses the IPad or change the lighting and temperature in her room, order food and keep in touch with family and friends. She is still sharing her data with us (blood pressure, sleeping hours) and Dr Davies visits her with all her information available immediately on Dr Davies IPad in real time. This allows the cause of the problem to be quickly diagnosed with no unnecessary delays and the infection to be treated quickly. Rachel returns home and continues to monitor her health on her wearable/IPad device which we monitor remotely. Rachel continued to talk to the clinical team and ask any questions she has whilst receiving her treatment.

Her treatment was successful and she continues to monitor her vital signs using our app and share her data with us whilst she continues her recovery. Our clinical team will continue to monitor Rachel's recovery using the data she provides via her wearable device and IPad using our artificial intelligence systems. This will alert us immediately to any concerns. She is also a regular contributor to the Support Community accesses a range of other local services through the signposting on our platform such as the local gym, choir and walking routes.

Malik's Story: a blood donor

Malik lives in West Wales and is in his first year of University. He has never donated blood but a friend mentioned it to him whilst talking over lunch. Malik searched for blood donation on his phone and clicked on the Blood and Transplant Services link. Malik was taken to our platform which provided him with a wide range of information and videos about why he should consider donating, the blood journey and the way in which it changes people's lives. Malik wanted further information so clicked on the 'send me more info' button and received an automatically generated email and offer to speak with an intelligent assistant 24/7 or have a virtual chat with one of our recruitment team. Malik goes onto our platform and selects a time/date which suits him to speak to our recruitment team to discuss the opportunity further.

Malik calls Tracey, in our recruitment team via FaceTime, and they discuss a range of issues which Malik had identified in an email he had sent Tracey in advance. Malik decides he wants to become a blood donor but donating needs to work around his busy life. He sets up his user-ID online and logs into the donation app and completes the donor application form on-line in 5 minutes sends it off. We undertake all the necessary checks to ensure it is safe for Malik to be a donor and email Malik back. Tracey follows-up with a FaceTime call to thank Malik for becoming a donor. Tracey also mentions that our platform offers a wider range of information and signposts to a range of other local services that Malik may find of use such as information of health living, local clubs and amenities such as gyms, libraries, local transport etc.

Malik books his blood donation appointment on-line using his watch. He books his appointment at a location which suits him in 2 weeks' time after using our platform to access the local bus times to ensure he can attend the donation clinic easily. Malik receives information about his appointment and a few days before receives an email asking for some information to allow us to undertake the donor screening process in advance of him arriving for his appointment.
On the day of his first donation, Malik gets an automated reminder text message to his watch with a personal thank you message from one of the people who has received blood – this reminds Malik of why he is donating.

Malik arrives at the donation venue and checks in digitally and waits for his appointment. The donation is a local sports club and he is able to use the free public Wi-Fi that we have worked in partnership with the local community to provide. The Wi-Fi has enabled the sports club to allow local children to use it as a community facility in normal hours and transformed the opportunities for some of the local children who didn't have Wi-Fi access at home.

Malik donates his first pint of blood and is thanked by our staff and returns home. Malik receives an email from us which offers him the opportunity to 'follow his bloods' journey – showing him how it's processed and where it's going to. In two months, Malik receives his automated reminder that he is now able to book his next appointment. When he arrives he tells our staff that he's been using our platform to access information about healthier lifestyles and has joined the local yoga class and volunteers with a local charity in his spare time; all as a result of the signposting available on our platform.

Measuring Our Success

Ensuring our Foundations
• % User Satisfaction with Digital Service Desk
• % of critical IT system service availability / uptime against agreed targets
• % of Incidents responded to within agreed targets
• % of Service Requests completed within agreed targets
• % of critical IT systems that support single sign-on (SSO)

Connected & Inclusive Services
• % of patients/donors who believe health and well-being improved due to online services
• % of patients/donors seeking health/service information on-line
• % of patients using applications to monitoring their health digitally
• % of consultations performed virtually
• % donors booking on-line
• % of patients / donors notified with via their communication preference of choice (SMS, email, other approved comms channels etc.)
• Mobile 'app' usage / interactions
• % buildings with free public wi-fi

Insight Driven
• % data quality (accuracy and timeliness)
• % of staff using local business analysis tools and standard reports
• % of data validation / corrections performed

Safe & Secure Services
• % compliance against NCSC '10 Steps to Cyber Security' standards
• Number of incidents reportable under NIS Directive
• Number of IT Business Continuity Incidents
• % compliance with cyber security statutory and mandatory training

• % staff clicking on phishing campaigns/awareness

A Digital Organisation
• % of Trust expenditure (revenue & capital) invested in digital
• hours / £££s saved through digitisation / automation of paper-based manual processes
• Number of 'Digital Champions' within the Trust
• % of staff achieving required digital skills/capability required of their job competencies
• % of clinical/nursing/clinical sessions identified for digital leadership/development
• % of staff with formal digital qualification e.g. BCS; degree; MSc
• % of staff with a mobile device
• Number of Digital Apprenticeships

Working in Partnership
• Participation in national / regional groups – e.g. AOS
• No. of academic establishments with whom we actively collaborate (e.g. PhD students, university placements)

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Estates Excellence: Our strategy 2022-2032

Supporting wellbeing through creation of a high quality, flexible, safe estate for today, and for future generations

Contents

Foreword

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These are exciting times for the Trust and with a wide range of opportunities ahead of us. The importance of the estate in delivering safe, high quality services and our long-term goals cannot be overstated.

The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in. The estate is an important component of our future success and it is vital that we embrace the opportunities that the estate, sustainability and wider opportunities offer to create social value in the communities we serve.

"Estates Excellence' sets out our strategy for the next five years and will help us maximise the opportunities. It sets out what estate we require now, and in the future, and how we will work with our patients, donors, staff and communities to ensure they have a safe and enjoyable experience which helps to improve their overall health and well-being. It also sets out how we can use our estate and facilities to make a wider contribution to communities and society.

Why do we need a new strategy?

We serve a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities, requiring us to better coordinate and join up care.

People's expectations are changing with the reasonable expectation that our services will be personalised to their needs. Our buildings, facilities and green spaces are a vital part of patient, donor and staff experience, are pivotal in improving mental health and well-being and will play an important role in developing thriving and resilient communities.

A Healthier Wales sets out a clear path to move from ill-health to well-being. Reducing the environmental and health impact of our estate is a priority for NHS Wales.

The climate emergency and need to develop a sustainable approach to living on the planet; a global challenge we need to respond to

We need to reduce carbon emissions, drive energy efficiency, reduce plastics and waste, improve air quality and use resources more efficiently to move from ill-health to well-being

Technology, the 4th Industrial revolution, provides healthcare with the opportunity to transform the way we deliver services, increasing the value for patients, donors and our partners in a more sustainable way.

Where Are We Now?

Our Estate

Our blood and transplant service covers the whole of Wales and our cancer services covers South East Wales. Both are delivered through a 'hub and spoke' model with services being delivered within the home, locally with communities, and at a number of fixed locations we own, lease or share with our partners:-

Headquarters (HQ)

The headquarters building located in Nantgarw houses the executive and corporate functions.

Cancer Services

We deliver these services from a number of locations:-

Velindre Cancer Centre

Velindre Cancer Centre is based at Velindre Hospital in Cardiff and provides specialist non-surgical cancer services to approximately 1.5 million people living in South East Wales. The Centre was constructed in 1966 and has been subject to various extensions through each decade since opening, the last major construction being in the 2000's. The hospital occupies a footprint of 14,718m2, with 70% of buildings being 40 years of age.

Velindre@ facilities

We provide services across South East Wales from buildings and facilities across our partner Health Board sites.

Blood and Transplant Services

We have a number of locations including:-

Talbot Green, Llantrisant: constructed in 2003/4 and was extended in 2017-2019 to provide a Clinical Services and Hospital Lab Area. The building occupies a footprint of 6,981m2 with 80% of the site being 18 years of age.

Dafen: situated in Llanelli and is the primary base for the collection teams in West Wales. The building occupies a footprint of 356m2, and houses all consumables required to support collections. This building is leased until 2025.

Bangor

This is the primary base for the collection teams in North Wales. The building occupies a footprint of 520m2, and houses all consumables required to support collections. This building is leased until 2024.

Wrexham (Pembroke House)

Pembroke House occupies a floor area of 465m2 in size is leased until 2025. The main purpose of this building is to act as a stock holding unit providing north wales hospitals with blood products together with the main base of operations for the collections team in the north east region of Wales.

We will also provide services from various buildings across Wales which are owned by a range of partners to support our 'hub and spoke' model of service delivery. These include buildings within local communities and at local hospital sites.

Condition of our Estate

The condition of the estate is managed through the strategic investment and operational maintenance plans to maintain high quality buildings and facilities for patients, donors and staff.

The Condition of our Estate

Velindre Cancer Centre				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
63	70% >40 years	64	100	80
Welsh Blood service HQ				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
8595	18 years	100	95	95
Dafen				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
95	15 years	100	100	95
Pembroke House				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
100	25	99	100	99
Bangor				
Physical Condition B %	Building Age	Functionality Above code F %	Space Utilisation F or Above %	Fire Safety Condition B %
90	20	100	100	99

Estates Excellence: transforming our Estate

Our vision:

A sustainable estate which provides a great experience for all

Delivering the transformation we have developed four themes

Theme 1: A safe and high quality estate which provides a great experience

Theme 2: Healthy buildings and healthier people

Theme 3: Minimising our impact

Theme 4: Using our estate to deliver the maximum benefit and social value to the community

Theme 1: A safe and high quality estate which provides a great experience

Our Objectives are to:

- Develop an estate which supports delivery of excellent frontline services
- Provide a first class experience for patients, donors and staff when using our buildings and facilities
- Achieve all statutory obligations regarding the estate and buildings while reducing operating costs
- Design in excellence by adopting a sustainability first approach to all new buildings

We will achieve this by:

- Designing the estate around the hub and spoke clinical models used by the blood and transplant and cancer services
- Continuously engaging with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs
- Investing our resources wisely to ensure we comply with all statutory legislation and infection prevention control requirements
- Getting the basics in place with all buildings having comfortable surroundings, sufficient and accessible car parking, Wi-FI and easy access to and from via public transport
- Investing in our estate through the capital programme to ensure all of our facilities always achieve a minimum of Category B standard
- Improving the information we have on the performance of the estate to enable an effective risk-based approach to its management and prioritisation of resources
- Designing to BREEAM excellent as a minimum standard in all of our new buildings in the major capital programme, together with the requirement for them to be developed using circular economy principles
- Investing in a range of building and facilities which are designed with sustainability at their heart to achieve BREEAM Excellent. These include:
    - major refurbishment and infrastructure upgrade at Welsh Blood Service Head Quarters in 2022/2024
    - construction of a Radiotherapy Satellite Centre at Neville Hall by 2024
    - construction of a new Velindre Cancer Centre by 2025

- Working with contractors to take a whole life cycle costing approach to all major capital projects, building refurbishments and new buildings

Theme 2: Healthy buildings and healthier people

Our Objectives are to:

- Provide buildings and places that help improve the health and well-being of patients, donors and staff
- Use our buildings as a resource to support improved health and well-being within the local communities we serve
- Raise awareness and promote the benefits of natural capital for physical and mental health and well-being amongst our patients, donors, staff and wider communities

We will achieve this by:

- Integrating formal carbon reduction and sustainability requirements into project briefs, tender documents and contracts to ensure that our current and future estate is refurbished, designed and constructed to have a low carbon impact
- Designing our buildings to promote sustainable behaviours and to be adaptable and resilient against climate change, supporting our journey towards low carbon patient and donor pathways. This will include:
    - providing patients, donors and staff with better access to amenities, with all having access to rest areas, food and beverages and outdoor spaces of curiosity and enjoyment
    - creating flexible working spaces that allow individual control of lighting and environmental conditions to promote multi-functionional use of space that may be tailored to meet individual requirements
    - prioritising access to natural light, ventilation, green space and active travel infrastructure in the refurbishment and development of the Trust estate
    - focussing on interior and exterior design to include selection of materials that soften the internal space and make the setting pleasant to work in
    - maximising the opportunity to redesign our buildings and workspaces to offer more flexible working through the use of digital technology

- Working with our staff, local communities, the voluntary sector and business to identify how we can make our land, buildings and facilities work better for people to support health and well-being. This will include:
    - plans which creates green spaces that people can use to find calm in their busy day such as repurposing unused areas of roof space and walls and increasing bio-diversity
    - use of our estate daily for activities which create joy such as walking, gardening schemes, bee-keeping, local food growing
    - creating space to provide the potential for food growing schemes

Theme 3: Minimising our impact

Our objectives are to:

- Reduce our use of energy to run the estate Reduce our operational carbon emissions by 100%
- Develop a multi-skilled and knowledgeable workforce to support the transformation of our estate

We will achieve this by:

- Improving our monitoring and management of energy used to run the estate through the introduction of SMART technology and the Internet of Things
- Implementing our decarbonisation plan to reduce and eradicate carbon from the estate
- Establishing an ambitious programme of carbon, energy and finite resource reduction projects to drive down use of energy and transition to 100% renewables including:
    - improving our metering and monitoring of energy across our estate
    - responding quickly to any preventable energy inefficiency such as overheating or leaks through effective monitoring and leak detection systems
    - retrofitting our existing buildings to improve efficient use of energy
    - improving the utilisation of clinical space to improve efficiency and maximise the use of our assets for excellent clinical care, experience and outcomes
    - improving the efficiency and productivity of our long-term assets through disposal and rationalisation in accordance with the hub and clinical models of the blood and transplant and cancer services
    - reviewing the potential for reducing the need for the current Headquarters building in the future
    - upgrading our existing buildings, plant and equipment to reduce consumption and use energy more efficiently
    - greening our estates procurement activities and decarbonising our supply chain
    - specifying renewable energy when we enter into new purchasing arrangements for electricity reduction and lifecycle costing
- Seeking ways to improve the air quality at our sites
- Developing an education and action programme to promote sustainable behaviours amongst our staff and people who use our buildings
- Developing useful information for our staff, patients, donors and partners which can support behaviour changes that reduce our energy consumption
- Working with staff to implement our agile working policy to reduce the need for staff travel and use of buildings
- Identifying opportunities for sharing facilities with partner organisations to reduce our collective estates footprint
- Develop a workforce which has the skills and competence to support a green and sustainable estate.

Theme 4: Using our estate to deliver the maximum benefit and social value to the community

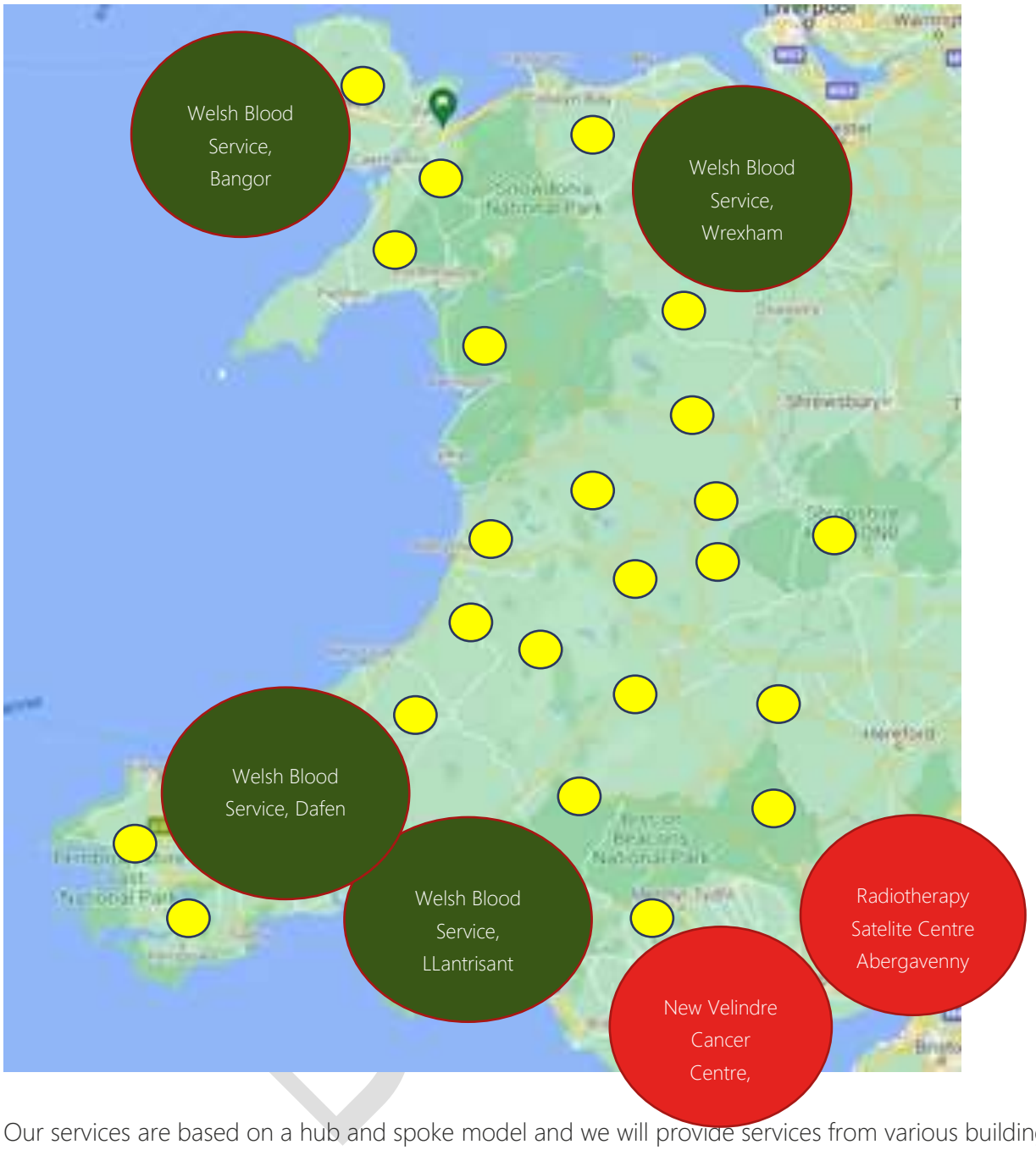
Our objectives are to:

- Use our buildings and facilities as community assets to increase the value our local communities can generate from our services
- Use our estate to help reduce inequalities in Wales and maximise the benefit to people, local communities and Wales

We will achieve this by:

- Working collaboratively with community partners to maximise the use of our buildings and grounds for the people we serve. We will:
    - engage with stakeholders to plan and deliver buildings and facilities across Wales which are strategically connected to our partners plans to improve access to services
    - identify opportunities to share buildings and assets with partners to make it easier for people to meet their needs in 'one stop'
- Developing training, work placements, apprenticeships and employment opportunities for local people, learners and students.
- Seeking to re-use, re-purpose and bring back to life buildings in local communities which support community resilience
- Working with partners and the local community to identify ways in which local groups can use our buildings and estate as a community resource to generate health, wealth, prosperity and joy locally. For example, use of our estate by local schools, charity group meetings, film screenings or arts programmes
- Identifying a range of offers we could make across our estate which makes a difference locally such as the provision of broadband Wi-Fi in the local buildings we use which can be routinely used by the community
- Sourcing and procuring goods and services to run the estate locally where possible to increase wealth and prosperity

What will our estate look like in 2032?



Our services are based on a hub and spoke model and we will provide services from various buildings across Wales some which we own/lease and some provided by our partners. Key

- Blood and Transplant Service buildings owned by the Trust
- Cancer Service buildings owned by the Trust
- Illustration of the multiple venues across Wales we will collect blood and blood products from

Measuring Our Success

A safe high quality estate which provides a great environment for visitors and staff	• Annual backlog maintenance • % Planned preventative maintenance undertaken on time • % of estate Cat B standard • BREEAM excellent buildings • Compliance with statutory requirements • Security incidents • Accidents/incidents/near misses
Health Buildings, Healthy People	• % patients and donors rating the environment as excellent • % of staff rating their working environment as excellent • Compliance with equality, diversity and disability legislation
An efficient estate which minimises the Trusts energy use and carbon footprint	• Annual EFPMS return • % utilisation of the estate • CO2 emissions • Overall carbon footprint of the estate • Water consumption • Energy consumption • Gas consumption • % of energy from renewable sources • % of waste reduction overall • % of waste to landfill • Overall waste created (i). % recycled (ii). % landfilled • Operating costs as % of budget • % staff awareness of sustainability activities across the Trust

Using our estate to deliver the maximum benefit and social value to the community	• % of building assets available for use by local community stakeholders (i) % availability to local community utilised • % biodiversity net gain on estate • % staff travelling to work by (i). Walking (ii) bike (iii). Public transport (iv) car (v). single occupancy car journeys

TRUST BOARD COMMITTEE

PATIENT ENGAGEMENT STRATEGY

DATE OF MEETING	26.5.22

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Anna-Marie Jones, Business Support Manager Non Gwilym, Assistant Director of Communications Cath O'Brien, Chief Operating Officer
PRESENTED BY	Non Gwilym, Assistant Director of Communications
EXECUTIVE SPONSOR APPROVED	CATH O'BRIEN, CHIEF OPERATING OFFICER

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
STRATEGIC COMMITTEE	16.5.22	ENDORSE FOR BOARD APPROVAL
EMB SHAPE	21.3.22	IN SUPPORT

ACRONYMS	
VCC	Velindre Cancer Centre

SLT	Senior Leadership Team
PEG	Patient Engagement Group

1. SITUATION/BACKGROUND

Velindre University NHS Trust has identified a need for a new patient engagement strategy and in February 2021, agreed that the first phase of the strategy's development should focus on patient engagement relating to the delivery of its cancer services.

Over the past 12 months, and with the support of CWMPAS (formerly known as the Wales Cooperative Centre), a core group of staff and patient representatives have shaped the development of a new strategy learning from organisations in Wales and further afield.

A Patient Engagement Steering Group was established to shaped the goals and 'what good looks like' which included representatives from organisations such as Community Health Councils, health boards and the third sector.

The two phases of work focused on a review of the current patient engagement approach and practice at Velindre and learning from others with direct experience of both delivering and receiving patient engagement. This work has resulted in the production of a Patient Engagement Strategy which is available to you as Appendix 1. The document sets out an ambition for what we want to deliver in terms of patient engagement with seven specific goals in support.

Initial feedback and emerging themes were shared with the Velindre Cancer Centre (VCC) Senior Leadership Team, Patient and Carer Liaison Group for feedback in autumn 2021. A draft strategy was shared for comment with Executive Management Board in December 2021 and a draft strategy agreed in March 2022. The draft strategy was then considered at the Strategic Committee in May 2022 where the following feedback and changes were requested by the Independent Members of the Committee:-

Strategy document

1. Alter detail on strategy document on Goal 6 to ensure that it's not an expectation that everyone is eligible to take part in research
2. Goal 5 add how you will support patients

Cover Paper

1. Separate strategic and operational
2. Refer to how we will help patients who feel like 'they have fallen off a cliff'
3. Ensure we spell out on how we will dovetail our patient engagement strategy with that of the health boards

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Strategic

The strategy sets out a new ambition for Velindre Cancer Services through a series of goals that focus on patient engagement in a number of key areas:

Individual treatment and care
Service delivery, performance, quality and assurance
Service design, improvement, transformation and innovation
Research
Strategy and Future Planning
Statutory obligations of patient experience, citizen engagement, equality and Welsh Language

Our ambition is to deliver patient engagement or Velindre Cancer Services that puts patient's experience, needs and ideas at the heart of how we plan and deliver our services now and for the future.

The seven Patient Engagement Goals were co-produced with patients, staff and a wide range of other stakeholders including community heath councils, cancer charities and Health Boards.

The regional and national nature of our cancer services necessitate effective collaboration and partnership in everything we do. Our strategy has been benchmarked and informed by other engagement strategies from Health Boards, Trusts and beyond to ensure that our work was informed by best in class from elsewhere. Establishing a baseline has enabled us to strengthen relationships with health board Engagement leads and Community Health Council leads in advance of the establishment of the new Citizen Voice Body due to replace the Community Health Councils in April 2023.

Our aim is to ensure the best experience for patients, from the start of their journey with us at Velindre Cancer Centre to the end. We are currently establishing new processes to capture and implement improvements based on patient feedback and to enshrine equality of access and care for all.

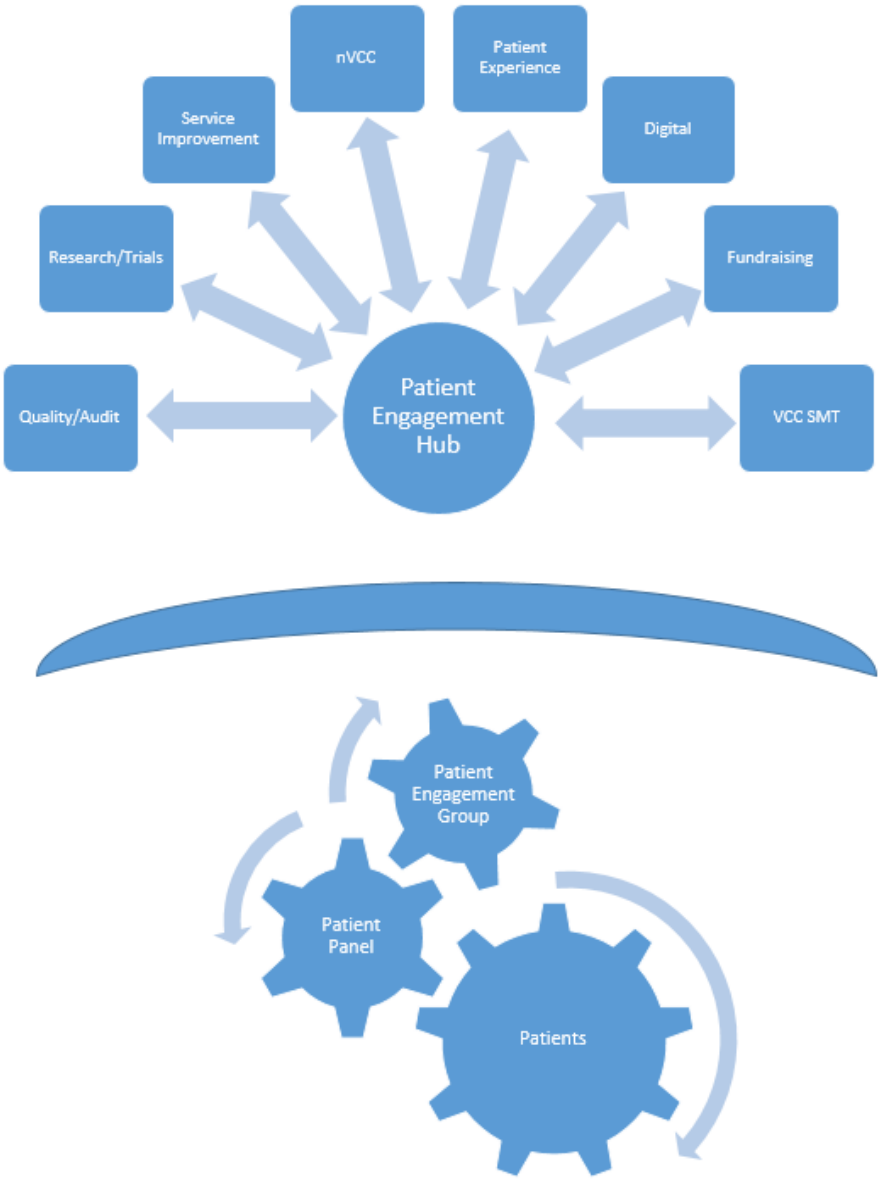
Our new Patient Engagement Strategy goals will lead to the development of action plans that will demonstrate how we will deliver with a clear ambition for bringing the patient voice to the service supporting Quality, Care and Excellence.

See Appendix 1 for Patient Engagement Strategy.

2.2 **Operational**

1. **Delivering our Patient Engagement Strategy - establishing a new Patient Engagement Hub**

   We are pursuing plans to establish a Patient Engagement Hub at VCC that acts as a point of co-ordination, signposting and advice for our patient engagement activity. Hub staff will be responsible for the implementation and development of the Patient Engagement Strategy, the management of a new patient engagement panel and provide secretariat support for a refreshed Patient and Carer Group (Patient Engagement Group). The hub will provide a link between VCC operational teams, Velindre Futures and the Transforming Cancer Services (TCS) programmes and to the Executive (EMB) team for their functions. The Hub will sit within the VCC planning function and align with the Programme Management Office to ensure it is at the heart of all VCC activity.



For the provision of Patient Information, the current service and information produced is currently being reviewed and developed through the Velindre Futures Development and Delivery Group e.g. how we are covering patient and carer information needs from the first contact to the end of treatment. This is particularly important as many patients told us that following completion of their treatment, they felt like ‘they had fallen off the edge

of a cliff'. Aligning this work and the new Patient Engagement Hub will be key if both services are to ensure that patients receive the right information at the right time including post treatment, all for the benefit of their recovery.

The Hub team will report against a set of performance metrics to EMB through a governance pathway that will include the role of the Patient Engagement Group.

2. **Delivering our Patient Engagement Strategy – staffing the Patient Engagement Hub**

The only staff resource dedicated to aspects of patient engagement currently is a Band 6 Patient Experience Co-ordinator whose role is a composite of patient experience and engagement including the secretariat for the Patient and Carer Liaison Group. The post-holder is consistently considered as the lead for all VCC patient engagement including the delivery of patient engagement activity linked to the new Velindre Cancer Centre and TCS projects.

To establish an effective Patient Engagement Hub we will need to invest in two additional roles. They are:

A new ***Head of Patient Engagement (8A***) with responsibility for:

- oversight of the delivery of the Patient Engagement Framework and its development
- oversight of all systems relating to the delivery of the Patient Engagement Framework, including the Information Governance requirements;
- main liaison point for department leads regarding patient engagement asks e.g. input into focus groups, feedback, testing, clinical trials etc.
- oversight of an integrated communications and engagement plan to deliver the Patient Engagement Framework
- management of the Patient Leadership Group and its development, among other responsibilities.

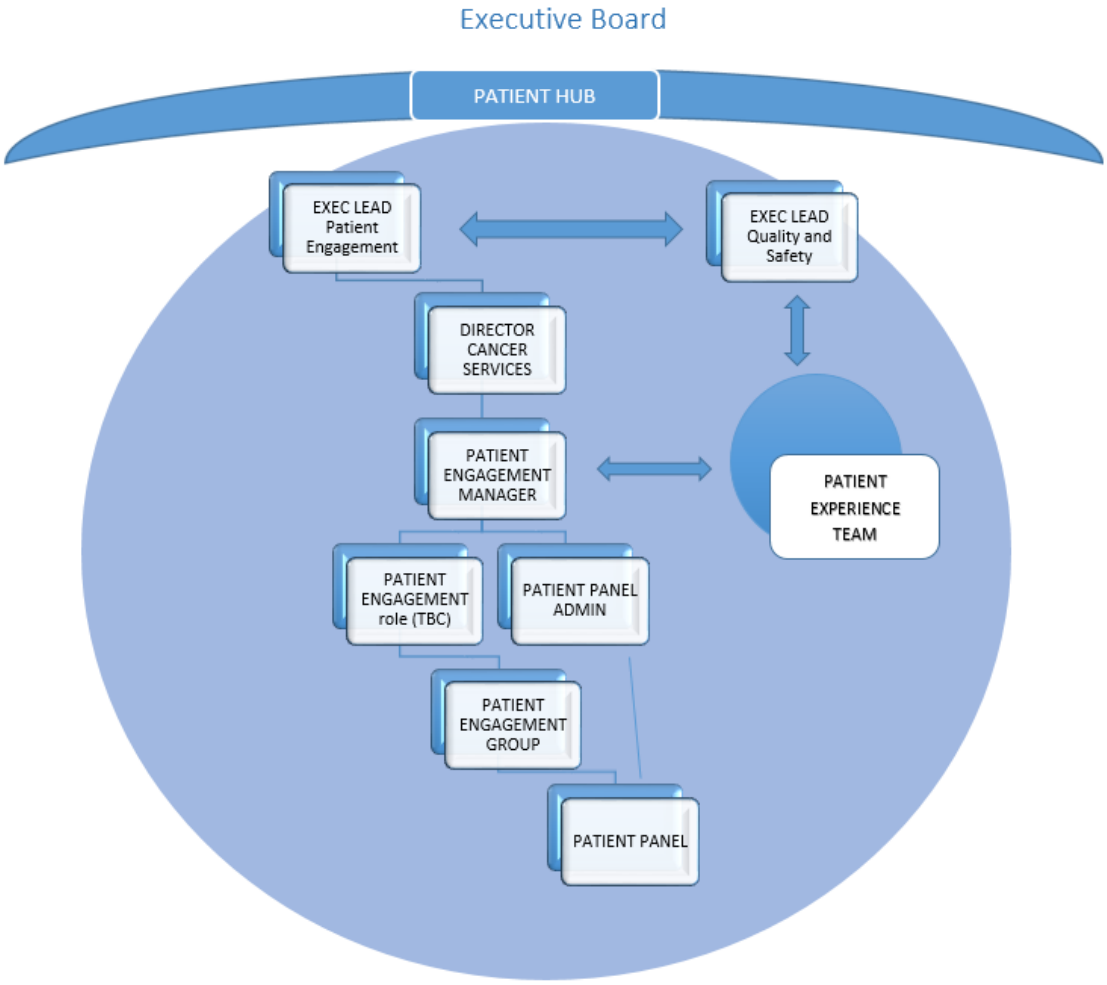
A ***new Patient Engagement Coordinator (B5)*** *to support.*

We propose to fund these two posts through a bid to Velindre Fundraising charitable funds. This will be for an initial 24 months with a view to review and ongoing funding.

3. **Delivering our Patient Engagement strategy - Executive Leadership**

It is clear from the list of areas above that these areas map to the responsibilities of each of the members of the Executive team and our ways of working have to create a way of supporting the various engagement activities to support all of these areas of work.

However, we propose that the executive lead for this work is the Director of the Cancer Centre reporting to the Chief Operating Officer. This aligns with the approach at WBS where the executive lead for Donor Engagement is the Director of WBS.



4. Priorities: establishing a new patient forum – Velindre Voices

We need to develop a means for making, maintaining and optimising our contact and engagement with the broad range of patients we support to deliver the strategic goals set out in the strategy. To do this, our initial task is to establish a means, compliant with all GDPR and Information Governance requirements, of allowing our patients to opt-in to a system that effectively maintains their contact details, areas of interest etc. and allows

us to communicate and engage with those who have opted into the system and potentially for patients to engage with each other.

5. Priorities: establishing a new Patient Leadership Group

The terms of reference of the Patient and Carer Liaison Group places them as the voice of the patient directly through the Patient Experience Coordinator. There is an opportunity to be more ambitious in terms of the representation of the Velindre patient community with the establishment a new patient forum and a refreshed Patient Engagement Group (PEG). There is appetite both within the VCC staff and the membership of the PLG for evolution and change within the current set up. A detailed transition plan is in development based on good practice elsewhere and the PLG's experience and ambition.

Among the key principles guiding the refresh are:

- Members of the PEG acting as the 'conscience' of patients ensuring that the patients' needs are at the forefront of any change or discussions.
- Group members to serve for a defined period rather than until they decide to stand down
- Members acing as the recruitment champions for the Patient Forum
- Provision of training and support for PEG members, building on work already undertaken in partnership with the Kings Fund and drawing on external expertise.
- Nominated members' continued attendance at Trust Board and specific committees.

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	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)

4. RECOMMENDATION

4.1 Trust Board is asked to APPROVE the final draft of the Patient Engagement strategy.

Appendix 1

Patient Engagement Strategy

Velindre University NHS Trust - Velindre Cancer Services

Gweithio gyda'n gilydd/ How we work together:

Our new patient, family and carer engagement strategy for Velindre Cancer Services.

May 2022

Velindre University NHS Trust has a proud, well-established history of providing cancer services, treatment and care for the patient population of south east Wales. We deliver our services at Velindre Cancer Centre in Whitchurch, Cardiff and other hospitals in the region. Over time, the services we deliver, the national and international healthcare landscape and cancer care network have changed significantly. In parallel, access to communications and technology with considerable potential to connect patients to clinicians and each other during their cancer journey continues to evolve.

Our new Velindre Cancer Centre patient engagement strategy has been developed to reflect these changes with one clear outcome in mind – to provide a strategy that that will allow us to embed an honest, trusting, respectful partnership with our patients at the heart of everything we do.

Introduction

Our patient engagement strategy has been developed working in conjunction with Velindre Cancer Centre patients, our volunteers, our staff, cancer charities and the Community Health Councils. It outlines how we will engage with our patients, their families, and carers in the future to ensure that their voices are at the heart of how we plan and deliver our services.

Why have we done this?

Velindre Cancer Centre is undergoing a period of unprecedented change. We are undertaking an exciting, ambitious programme of work to improve the cancer services we deliver for our patient population, building on our past achievements and learning from our experiences.

We are working from strong foundations, but our future success will be dependent on the strength of our partnerships with our patients, public and healthcare colleagues across South East Wales.

The focus of this strategy are the actions that we will take to achieve a step change in our partnership with our patients to improve what we do today and plan what we need for the future. Specifically, how we make sure that patient voices are threaded through our work from the outset and by adopting an accessible, innovative approach, guided by the Welsh Government's ambitions.[1]

Who is this Strategy for?

This strategy has been written for Velindre Cancer Centre patients, their families and carers, our staff, volunteers and other organisations that work with us to deliver cancer services. These organisations may be other NHS organisations, charities, other third sector organisations or healthcare providers.

In recognising that the focus of this strategy is patient, family and carer engagement, we will also align it with our emerging public involvement strategy and the Welsh Blood Service's (WBS) donor strategy. The donor strategy will include the way in which we recruit and engage, with the engagement aspect aligning with this document.

[1] The relevant Welsh Government documentation at time of publication is available as Annex A

Throughout this document, for simplicity we will refer to patients, however this should be read as patients, their families and carers. It considers engagement with patients, their families and carers as individuals and also as a group.

The context – national, regional and at Velindre Cancer Centre

Velindre University NHS Trust (the Trust) has a 10-year organisational strategy which outlines an ambition for the cancer services it delivers through the Velindre Cancer Centre and our partners. The strategy meets the aspiration of Welsh Government strategies and policies.

This patient engagement strategy outlines how we will empower the patient voice into the delivery of this aspiration and support the Trust's Purpose, Vision and Vales in its new ten year strategy.

Trust's Purpose:	To improve lives
Trust Vision:	Excellent care, Inspirational Learning, Healthier People
Trust Values:	Accountable, Bold, Caring, Dynamic

We will also ensure that this work aligns with our Strategic Equality Objectives to enhance our ability to meet the differing needs of all our communities and to ensure that the strategy aligns with our core objectives creating a culture of fairness and inclusion.

How was this strategy developed?

This Strategy was developed in partnership. We explored ideas from other organisations and reflected on their suitability for our work. We also undertook focus groups, individual meetings, drop-in sessions, and offered opportunities for staff to respond to a questionnaire to find out what we are doing well, what we could improve and to share ideas for consideration. We spoke to and heard from a wide range of voices including:

- Our patients, their families, and carers
- Our staff
- Our volunteers
- Our wider stakeholders

Our work has also been supported by a Steering Group, made up of patients, staff, and wider stakeholders with an excellent track record of either delivering cancer services, public engagement or in some instances, both. Crucially, patients from across the region shared their experiences with us. The group included representatives from our Patient Liaison Group, Community Health Councils, Wales Cancer Alliance, Wales Cancer Network, Diverse Cymru and Wales Cancer Research Centre. It also included members of our Digital Team. The steering group was chaired by an Independent Member of the Trust Board. The work was facilitated by the Wales Co-operative Centre.

What do our patients, their families and carers expect from us?

When we asked our patients, their families, and carers about their expectations they told us:

- Patients want to be seen, heard and recognised.
- Patients want to be treated as individuals, with respect and receive personalised care
- Patients want conversations about their treatments in language they understand.
- Patients expect our services to be accountable and transparent and provide treatment and care that they can trust.
- Patients want to be involved (volunteering, Patient Liaison Group, Focus Groups, Fundraising).
- Patients want to know about and be part of research opportunities.
- Patients wants modern digital ways of keeping in touch and updated.
- Patients want the right information, at the right time.
- Patients want to know about additional support after their treatment has been completed.
- Patients want to influence the services for others in the future

When we asked staff about their expectations they told us:

- Staff want patient engagement to be integrated across the departments, projects and service changes.
- Staff want an organised process about how to engage with patients.
- Staff want to use digital technology to record patient details.
- Staff want a large patient panel that they can ask for input on a wide range of activities
- Staff want patients to feel empowered to feedback.

What do we mean by patient engagement?

The terms patient engagement, patient experience and patient involvement are often used interchangeably in healthcare and can lead to confusion, both within and outside organisations. In delivering this Strategy we wanted to clarify what each of the terms means to us at Velindre:

Patient engagement

Patient engagement is the umbrella term we use to describe the wide range of activities and interactions we have with our patients and those who care for them. How we do this will differ, depending on our responsibilities, but we have a common aim - to benefit the treatment, care and well-being of our patients today and those we will engage with in future.

The spectrum of activities we include when we talk about patient engagement include:

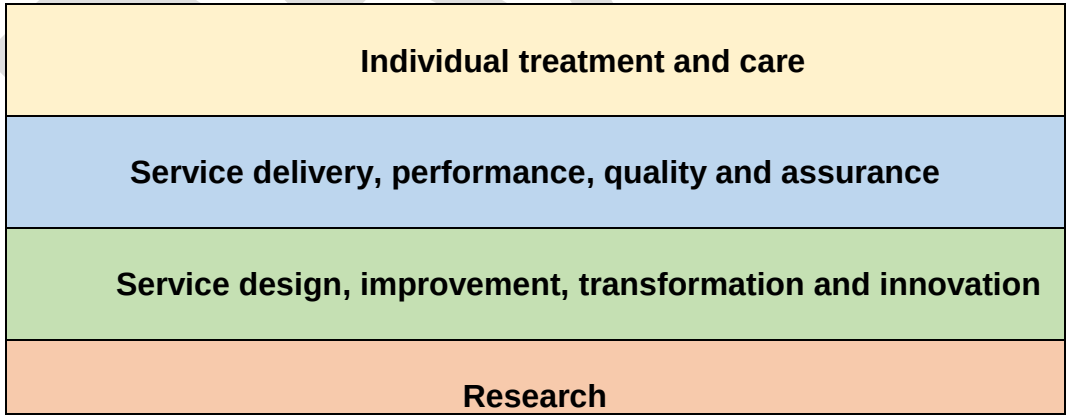
What we do	What it means
Informing	Sharing information effectively with our patients and providing the means for them to ask questions and feedback e.g., providing updates on our digital platforms or corresponding directly with individual patients.
Continuous Engagement	Gathering feedback on activity planned by Velindre and seeing the impact it had e.g., developing a new Velindre Cancer strategy and asking our patients what they think of the content.
Experience	Looking at and understanding what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing clinical excellence and safer care. It is about all of our cancer services, delivered across all of our healthcare settings. Ensuring that feedback from patients on their experience is acted upon and services improved.
Involving	Working directly with the patients on our future plans to ensure that their concerns and suggestions are understood and considered and demonstrating clearly how we responded e.g., inviting patients to focus groups to provide feedback on our future services.

Supporting	Providing wellbeing and welfare support for patients, their family and carers throughout their cancer journey e.g., signposting patients to our work with cancer charities, to financial services to support them along their journey or providing counselling services.
Collaborating	Contributing ideas and suggestions for improvements and in each aspect of the decision-making process, including developing alternatives and identifying the preferred solution e.g., patient forums or juries that enable us to work with patients to identify priority areas for improvement.
Empowering	Decision making power is in the hands of our patients, with the support of their family and carers e.g., creating the means for patients to make decisions on service priorities.

Which areas of Velindre Cancer Centre does the patient engagement strategy cover?

Velindre provides care for patients at the Velindre Cancer Centre, sometimes at other hospitals or mobile units in the south east Wales area. Everyone working at Velindre will play a part in the successful delivery of this Strategy.

There are six key areas of how we work that dependent on its success:



Strategy and Future Planning
Statutory Patient experience, citizen engagement, equality and Welsh Language

Our Ambition for Patient Engagement

We have developed our ambition in partnership with our patients, our staff, our volunteers and our partners.

We want to make sure that patient voices are threaded through Velindre Cancer Centre's work from the outset and partner with our patients to improve what we do today and plan what we need for the future.

Our Goals

Following the feedback from patients, staff and partners, we developed seven goals for our Strategy:

1. We will ensure that patient voices, both as individuals and as a group, are heard, listened to and have a visible impact.
2. We will ensure that all patients are enabled and empowered to engage with Velindre, including the voices of those that find it harder to be heard and those of our younger patients.
3. We will ensure that patient engagement is embedded into the way we work and at the heart of our organisational culture.
4. We will ensure that the reach of our engagement activities are maximised by implementing a range of tools and techniques, driven by evidence of our patients' preferences and choices.
5. We will signpost our patients, their families and carers to the right information, at the right time.
6. We will increase the opportunities for patients, their families and carers to take part in research and raise awareness of these opportunities.

7. We will excel in our statutory obligations including engagement with the Community Health Councils (and future successor organisations) and delivery of the NHS Strategy for Assuring Service User Experience and the Health and Care Standards (Wales Quality Standards).

By delivering these goals, we want our patients to:

- have the confidence and means to ask questions, make suggestions, collaborate and contribute to how we work together.
- feel listened to and valued as they progress on the patient pathway, and
- be empowered to contribute to Velindre' success today and help develop future services.

What will underpin our Goals?

Goal 1 – We will ensure that patient voices, both as individuals and as a group, are heard, listened to and have a visible impact

To achieve this we will:

- Outline our intentions and develop our approach and ways of working. This will include undertaking regular reviews and capturing feedback about how well we are doing and how we can keep improving. We will look at how we interact with each patient in providing them with information and an ability to feed back their experience, but also how we bring people together to share their views and ideas.
- Support patients to make shared decisions on their care with their care team.
- Create ways of working across the organisation, from front line service delivery to our strategic planning, to make sure that the patient voice is heard and that we work effectively in partnership, drawing on the experience of others and finding champions for our Patient Engagement Strategy from staff and patients.
- Create pathways to identify and recruit patients to join our patient voice groups.
- Work with Health Boards, to enable us to listen to the patient voice across the care pathway; recognising that people are often seen and treated in a number of different locations.
- Develop and use a range of training, information and tools to help patients work confidently with the service to provide their views, their experience and their thoughts and ideas in a range of ways recognising that people may want to have different opportunities and provide this information in a way that is easy to find and use.
- Work effectively with the third sector, Health and Care Research Wales and the Community Health Councils (and future successor organisations) to make the most of voices, skills and resources.

Goal 2 - We will ensure that all patients are enabled and empowered to engage with Velindre, including the voices of those that find it harder to be heard and those of our younger patients.

To achieve this we will:

- Make sure that the voices that we are hearing and people we are working with represent our patients in terms of their characteristics, where they live and the services and care that they receive. We will regularly review that we are achieving this.
- Set up a Patient Panel where we patients can be involved and input their feedback and thoughts
- Ensure patients are supported and signpost our services for well-being and after-care.
- Provide support for patients who help us by providing guidance and training. being

Goal 3 - We will ensure that patient engagement is embedded into the way we work and at the heart of our organisational culture.

To achieve this we will:

- Provide our staff with appropriate levels of patient engagement skills, training and information, starting at induction, so that they fully understand the importance and benefit of patient engagement and what we all need to do.
- Embed the patient voice in the ways we work throughout the organisation, across the spectrum of what we do; from strategic planning to service improvement.
- We will establish a patient engagement hub for the cancer service that provides a focal point for patients, staff and stakeholders to contact us and work with us.
- Ensure that our commitments are clearly visible to patients, staff and visitors.

Goal 4 - We will signpost or provide our patients, their families and carers to the right information, at the right time.

To achieve this we will:

- Review and revise the information that we currently provide to patients at the different stages of their treatment and recovery.

- Provide or signpost patients to relevant information at the start of their contact with us and this will include their treatment plan. We will make sure that patients, their families and carers know who they can speak to if, or when, they have any questions.
- Support patients, their families and carers to be able to ask us a question, raise a concern or provide us with feedback.

Goal 5 - We will ensure that the reach of our engagement activities are maximised by implementing a range of tools and techniques, driven by evidence of our patients' preferences and choices.

To achieve this we will:

- Make information, tools and resources available at the right time and in accessible ways.
- Continue to develop how we use our digital tools for patient experience feedback and provide more opportunities for feedback to be captured.
- Test and measure how effective we are at engaging and take any action, if needed, to improve. We will regularly review good practice examples and update our tools and techniques as necessary.
- Ensure that our ways of working include different ways of contributing, including making the most of what digital technology can offer for communicating, getting in touch, sharing feedback or ideas.
- Provide support for patients, families and carers who may need help with language, digital, cultural, geographical and any other barriers.

Goal 6 - We will raise awareness of and increase the opportunities for patients, their families and carers to take part in research.

To achieve this we will:

- Increase opportunities to take part in a wide range of research including treatments, support services, and how we work as an organisation.
- Ensure that research and research opportunities are accessible to appropriate patients and explained in a clear language to inform their decision making.
- Provide patient and family signposting on the organisational research and innovation opportunities available, including general information on research
- Seek appropriate patient /carer involvement in our research and innovation activities

- Ensure the patient voice is present (patient, public representative) in appropriate research governance and leadership groups that shape, drive and manage the Research &Innovation agenda of the organisation.
- Provide appropriate support and mentorship to patients and carers, facilitating engagement and/or involvement in Research and innovation.
- Better understand the patient/ carer experience surrounding research participation, engagement and involvement to improve our research service
- Communicate the impact of our research and innovation, recognising the input of patients and carers.
- Build on our strong relationships with organisations that undertake or commission research, such as our partner Academic Institutions, Health and Care Research Wales, National Institute for Health Research, CRUK, Macmillan, Tenovus and NICE.

Goal 7 - We will excel in our statutory obligations including engagement with the Community Health Councils (and future successor organisations) and delivery of the NHS Strategy for Assuring Service User Experience and the Health and Care Standards.

- We will make sure that we continue to be actively engaged with the Community Health Councils in the areas where we provide our patient services and grow and develop this where we can.
- We will support the work of Welsh Government to develop the Citizen Voice as introduced in the Health and Social Care (Quality and Engagement) Act 2020. The Citizen Voice will replace Community Health Councils in April 2023
- We will articulate and plan our ambition in delivering the Strategy for Assuring Service User Experience and integrate it into our ways of working, meeting the requirements set out in the Health and Care Standards.

How are we going to achieve these goals?

Culture, Process, People

We know that we have work to do if we are going to achieve our ambition and the goals we have set ourselves. We plan to adopt a phased approach to the implementation of this Strategy and will develop a detailed and dynamic action plan that will sit alongside it. We will monitor our achievements against this action plan and share what we achieve.

If we are going to deliver the goals outlined in this Strategy, in addition to our patients, our staff are key to our success. We must continue to keep them involved in the Strategy's implementation and keep them informed, involved and updated on progress made

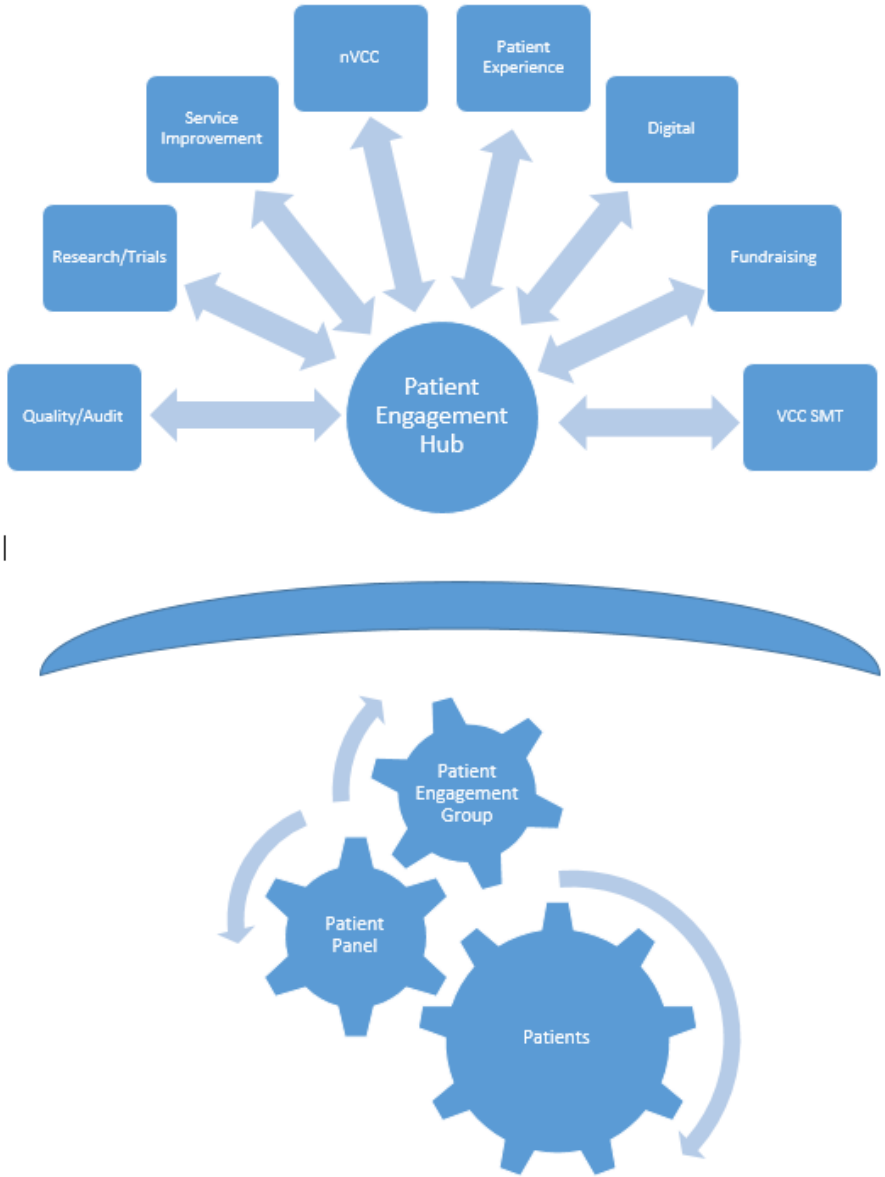
and how it develops in future. We need to work with them to develop a culture where engagement is embedded in our everyday activities. For many of our staff this is already the way that they work, and we need to give them the tools and techniques to build on the good practice that already exists. Our consultation with staff has also highlighted that many of our non-patient facing staff want to be able to engage with patients as they look to improve and develop functions, such as the information that they provide or the services that they offer. Again, we need to provide them with the tools and opportunities to be able to do this.

Co-ordinating and managing the work and the right tools and techniques

Engagement has to be an integral part of how we work so it needs to be embedded within the service. We will establish a patient engagement hub for the cancer service that provides a focal point for patients, staff and stakeholders to contact us and work with us. Together the Patient Hub will work with patients, colleagues, senior managers, the Executive team and Board to help us deliver our aspirations. It will work in collaboration with staff responsible for activities such as Communications, Clinical Audit and Patient Experience ensuring that the messages we hear and the lessons we learn things we learn are incorporated into the changes we plan and make their way through our work planning and programme office.

Sharing how we have listened and the difference the patient voice has made will be essential. Links with all of our communication channels will be used to provide ongoing feedback and share successes but we will also undertake periodic reviews of progress that will be reviewed by the Patient Engagement Group and provided to the Board as part of their assurance role.

PATIENT ENGAGEMENT HUB VISUAL



The Patient Experience function reaches out to gather details on experience, as outlined in the NHS Strategy for Assuring Service User Experience, which together with the work of the Trust Quality and Safety team in dealing with “concerns” under the *Putting Things Right* regulations i.e. how we manage complaints, provide two important sources of information and feedback. The patient engagement strategy will be aligned with these existing mechanisms.

How will the Strategy work?

Each of the members of our Executive Team increasingly require insight on the voice of our patients to fulfil their role. We know that we need to ‘join up’ how the work that happens. Our aim is that the Patient Engagement Hub acts as a single point of contact to drive and coordinate our engagement activities. This function will also have a key role in supporting our drive for equality in access to services, to participation and ultimately reducing health inequalities.

We also know that we will require new ways of identifying patients, reaching out and holding on to them in a range of ways that are accessible to them and efficient for us to manage. This will require some investment and increased training in new digital tools. The Patient Hub will lead on the development of a toolkit summarising the purpose, benefit and requirements of innovative ways of collating, analysing and sharing patients’ views and ideas working and learning with external partners, including Audit Wales’ Best Practice Unit.

To achieve our ambition we need to make changes to the way the organisation works – how we coordinate our activities and the tools, techniques and technology available to us to improve how we connect with our patients. The details on how we do this will be include in our delivery plan.

Oversight of the Strategy’s delivery

In summary:-

- The Strategy is owned by the Trust.

- Assurance for its delivery will be a matter for the Trust Board and Committees and they will be supported by patient representatives.

- Accountability and management of the Strategy's delivery will be shared by the Trust Executive Leadership, the Senior Management Team and the Velindre Cancer Centre Patient Engagement Team

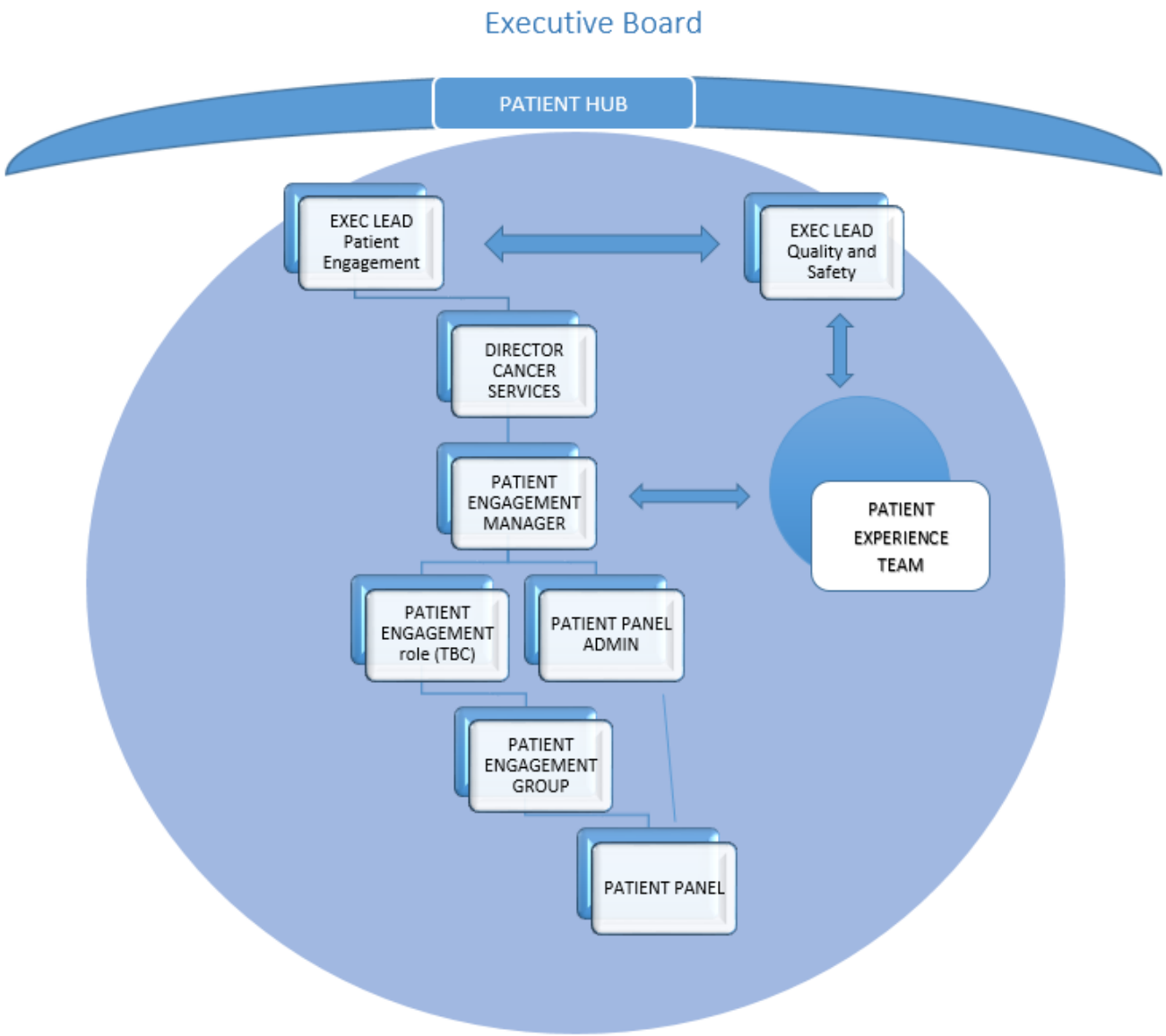
- Operational responsibility for the Strategy will be the Director of Velindre Cancer Services supported by the Chief Operating Officer

- The Executive Lead for ensuring the delivery of the Patient Engagement Strategy will be the Chief Operating Officer

- In addition, a newly reformed Patient Engagement Group (formally Patient Liaison Group) will also consider the role it will play in ensuring the delivery of the Strategy's goals, working with staff to support delivery and as patient engagement champions, and helping us review our progress and achievements.

- A new Patient Panel (a list of volunteers) will be set up, consisting of people who wish to share their views so that they can be involved in service changes, feedback, surveys etc.

- A new Patient Engagement Hub will be set up to support the coordination and alignment of current patient engagement with our patient experience duties, volunteers, Fundraising activity and involvement activities across the cancer centre.


Executive Board
PATIENT HUB
EXEC LEAD Patient Engagement
EXEC LEAD Quality and Safety
DIRECTOR CANCER SERVICES
PATIENT ENGAGEMENT MANAGER
PATIENT EXPERIENCE TEAM
PATIENT ENGAGEMENT role (TBC)
PATIENT PANEL ADMIN
PATIENT ENGAGEMENT GROUP
PATIENT PANEL

Bringing in Patient voices, a new patient engagement and leadership structure.

Our goal is to make sure that we have a wide range of patient voices. To do this we will establish a Patient Panel. By this we mean we will ask people to volunteer to give us their feedback and opinion from time to time. To help us do this we will ask them to register their interest and in doing so, they will become a member of our patient panel. This won't bring any obligation, other than for us to contact them, from time to time and offer an opportunity to become involved. This involvement will vary from a simple survey or focus group, to being part of a short-term working group to solve a problem or shape a change or improvement. Patients taking part in any activity for us will be reimbursed for out-of-pocket expenses such as travel and meals.

In addition to this, we need patients to be the champions of patient engagement and to work with us on a more regular basis. To do this we will create a Patient Engagement Group. This will replace our previous Patient Liaison Group, broadening its previous function.

The Patient Engagement Group will be made up of 12 people, who will be drawn from across the populations that we serve. Their role will be champions for patient engagement and promote the opportunities of being part of the Patient Panel with patients from all backgrounds and experiences. The group will work with us to review our achievements against this intent and Strategy. Its members will receive training and support to participate in a range of activities bringing the expert patient voice including attending various governance and planning activities within the Trust. The Chair of this group will attend the Trust Board with a specific focus on being the conscience and voice of the patient. Further members of the Patient Engagement Group will also attend other Trust Committees.

The design and development of the new Velindre Cancer Centre provides a once in a generation opportunity and will need the patient voice threaded through a myriad of activities starting on the appointment of the contractor and continuing till we open the doors to the first patients and beyond. Setting up a Patient Panel will be key to ensure we hear from patients as they help us to design a cancer centre fit for the future. There will be many opportunities for engagement as we move through the stages of the development and our transition to the new centre and also the changes in service that we anticipate across the region such as the development of the new radiotherapy centre at Neville Hall.

This Strategy gives us the opportunity to ensure that there is a collective process around patient engagement and to ensure that patients stay at the centre and at the heart of what we do.

Measuring our progress, our success and share the benefit this brings

A delivery and action plan will underpin this Strategy and work is being undertaken to shape this plan in parallel with the development of this Strategy.

As part of this delivery plan we will develop a set of indicators that we will use to measure our success. Our communication plan for Patient Engagement will include how we share our opportunities and successes with staff, patients and other stakeholders.

Our progress will be reviewed and monitored by the senior team at the cancer centre, the Executive team, the Patient Engagement Group and the Board with each making suggestions and proposals based on their role.

March 2022

Appendix 1

The legislative and policy context in Wales
Within the legislative and policy context in Wales, the patient voice and the recognition of the patient voice, is increasing in importance. The policies and legislation outlined below are all relevant to our services at Velindre and highlight the importance of patient engagement.

A Healthier Wales
A Healthier Wales builds on the philosophy of Prudent Healthcare and the central idea of the Quadruple Aim, focusing on:

- Improved population health and wellbeing.
- Better quality and more accessible health and social care services.
- Higher value health and social care, and
- A motivated and sustainable health and social care workforce.

A Healthier Wales highlights the need for the citizen and patient voice to be recognised and acknowledged, empowering people with the information and support they need to understand and manage their health and wellbeing and allowing them to make decisions about care and treatment based on 'what matters' to them. It also recognises the need for simple, clear, timely communication and co-ordinated engagement, appropriate to age and level of understanding.

National Clinical Strategy
The National Clinical Strategy sets out a coherent vision for the strategic and local development of NHS clinical services, and it is a vital part of a much broader approach, that was described in A Healthier Wales. Its purpose is to improve patient outcomes and support the planning and delivery of resilient clinical services.

The Strategy describes how clinical services should be planned and developed, based on an application of prudent and values-based healthcare principles, recognising the importance of co-production between health care professionals and patients. In doing so, it recognises the need to continue to shift focus from hospital-based care to person centred, community-based care.

There is also a broader challenge related to understanding what matters to the patient, in that treatment pathways can be recommended without fully comprehending what matters to the patient by a process of co-producing their care.
The emphasis should be on quality of life and what matters to the patient.

Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) are one of the important tools that we need to give us ways in which we can measure the effect of the services we provide and here again there is a need for developing our approach.

The Quality Statement for Cancer (Welsh Government)
This statement is part of the enhanced focus on quality in healthcare delivery that was described in A Healthier Wales and the Quality and Safety Strategy. In the future, quality statements will be integral to the future planning and accountability arrangements for the NHS in Wales.

The statement outlines the quality attributes for cancer services in Wales; equitable, safe, effective, efficient, person-centred and timely. It describes the need for person-centred cancer care to be culturally embedded, for patients to be involved in the co-production of their care and where eligible, that patients are offered the opportunity to take part in clinical trials.

Health and Social Care (Quality and Engagement) Act
This piece of legislation is likely to come into force in spring 2023. The Act has a number of purposes, one of which is to strengthen the citizen voice.

The drive towards closer integration of health and social services, with improved public engagement, is reflected in the aims of A Healthier Wales, which sets out the goal of ensuring citizens are placed at the heart of a whole-system approach to health and social care services and stresses the importance of listening to all voices through continual engagement. To realise this ambition, this piece of legislation replaces Community Health Councils (who currently represent the patient voice in the health service only) with a new national - the Citizen Voice Body ('CVB') - that will exercise functions across health and social care. The CVB will work locally, regionally and nationally.

The aims of the new body are to:

- strengthen the citizen voice in Wales in matters related to both health and social services, ensuring that citizens have an effective mechanism for ensuring that their views are heard.
- ensure that individuals are supported with advice and assistance when making a complaint in relation to their care, and
- use the service user experience to drive forward improvement.

Currently we do not know about the practical details of changing from Community Health Councils to the Citizen Voice Body, which will extend to include social care. We will be keeping up to date with consultations and keeping in contact with our Community Health Council representatives as the changes are planned and implemented.

We will adapt our patient engagement strategy and any associated actions necessary as soon as we have a better understanding about the role of the new body.

Quality and Safety Strategy: Learning and Improving (Welsh Government)
This Strategy states that organisations, at every level within the NHS, should function as a quality management system, to ensure that care meets the six domains of quality; care that is safe, effective, patient-centred, timely, efficient and equitable. This Strategy builds on the documents outlined above and the impact of the pandemic on out healthcare systems.

The Strategy outlines the importance of engaging and listening to patients in developing quality, person-centred care services that are continuously improving. One of the actions within the Strategy places a duty on NHS organisations to demonstrate, through their plans, that patient care and experience is central to their approach and delivery and that their governance arrangements support this requirement.

Health and Care Standards (2015)
The Health and Care Standards will continue to form the cornerstone of the overall quality assurance system within the NHS in Wales. There is a clear intent to revise the current standards and we will adapt our approach to meet these new criteria.

The standards highlight the importance of the patient voice and the coproduction of care outlining that co-production can support the delivery of person-centred care, which prioritises putting patients at the heart of all health care decisions and plans.

The standards also set out the criteria for health services to demonstrate how they respond to user experience to improve services and ensure feedback is captured, published and demonstrates learning and improvement

Strategy for Assuring Service User Experience (2018)
The NHS in Wales has adopted a service user experience Strategy which describes the evidence based key determinants of a good service user experience and identifies the key attributes and uses of a range of feedback methods.

Service user experience can be defined as ‘what it feels like to be a user of the NHS in Wales’. A service user can be defined as someone who uses or has access to health services in any setting, including their families and unpaid carers.

The Well-being of Future Generations Act 2015
The Well-being of Future Generations Act is a unique piece of legislation for the people of Wales.

We know that as a public body we have a number of duties relating to how we engage and involve our patients, their families and carers, for example to:

- Use a variety of accessible, inclusive engagement methods and formats
- Train relevant staff in principles and practices of public involvement
- Ensure patients are having ‘what matters’ conversations
- Involve people at the earliest possible opportunity
- Carry out a ‘you said, we did’ exercise

At Velindre we will continue to use the Wellbeing of Future Generations Act, the wellbeing goals and the five ways of working as the context in which we plan. This will ensure that how we work, who we involve and the decisions that we make will impact positively both now and in the future.

Appendix 2
VUNHST Mission and Vision – attached when it is completed

Canolfan Ganser Felindre
Velindre Cancer Centre

How we work together:

Our new patient, family and carer engagement strategy for Velindre Cancer Services.

What is patient engagement?

Patient engagement is the umbrella term we use to describe the wide range of activities and interactions we have with our patients; past and present, and those who care for them. How we do this will differ, depending on our responsibilities, but we have a common aim – to benefit the treatment, care and well-being of our patients today and those we will engage with in future.

Our Goals

Following feedback from patients (past and present), staff and partners, **we developed seven goals**.

Together, we will:

1 PATIENT VOICES

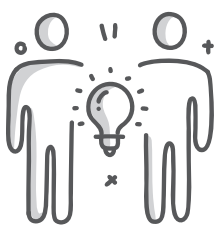
Ensure that patient voices, both as individuals and as a group, are heard, listened to and have a visible impact on the cancer services we deliver and patients receive.

2 PATIENT EMPOWERMENT

Enable and empower patients to engage with Velindre cancer services, including the voices of those that find it harder to be heard and those of our younger patients.

3 PATIENTS FIRST

Embed patient engagement into the way we work and at the heart of our organisational culture.



4 PATIENT CHOICES

Use a range of tools and techniques to maximise the reach of our activities, driven by our patients' preferences and choices.

5 PATIENT INFORMATION

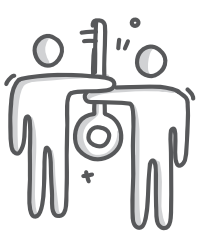
Signpost our patients, their families and carers to the right information, at the right time.

6 PATIENT INVOLVEMENT

Increase the opportunities for patients, their families and carers to take part in research and Trust business.

7 PATIENT PROMISE

Excel in our statutory obligations ensuring that patients are put first.



How to get involved

To make this work for us all, we need as many of you as possible to get involved!

You can do this by reaching out to us on our Velindre Cancer Centre social profiles, emailing us on **Velindre.PatientEngagement@wales.nhs.uk** or leaving your contact details with any of our staff at the centre.

Let's work together for the benefit of cancer patients today and tomorrow.

Patient Engagement Strategy – Velindre Cancer Centre
Trust Board May 2022

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Patient Engagement Strategy – Why?

To ensure that the voice of the patient, their families and carers are at the heart of shaping services, now and in the future

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Approach

- **Patient Engagement, Experience and Involvement - examples in other Trusts**

- **Extensive Stakeholder engagement**
  - Patients (including families and carers)
  - Patient Liaison Group
  - Clinical and Nursing Staff
  - Wider staff
  - Executive Staff
  - nVCC
  - Volunteers
  - Community Health Councils
  - Cancer Charities
  - Diverse Cymru
  - Health and Care Research Wales

Key Themes

- Information
- Communication
- The feedback loop
- Research
- Digital

- The patient voice
- Families
- Opportunities to engage
- Wider community (future patients)

Goals

Our Goals

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Patient Engagement Outputs

- Patient Engagement Strategy - ✓
- Patient Friendly Strategy - ✓
- Patient Engagement Hub
- Patient Engagement Panel
- Patient Engagement Group

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Next Steps

- Sign off Patient Engagement Strategy
- Share with patients
- Secure funding for Patient Engagement Hub Manager - ✓
- Set up Patient Panel
- Set up new Patient Engagement Group
- Embed in culture for all staff

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TRUST BOARD

QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	26th May 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	
SACT	Systemic Anti-Cancer Treatment Therapy
HIW	Health Inspectorate Wales
MHRA	Medicines and Healthcare Products Regulatory Agency
TCS	Transforming Cancer Services
IRMER	Ionising Radiation (Medical Exposure) Regulations

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Quality, Safety & Performance Committee at its meeting held on the 12th May 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. The Committee is continuing to embed and mature, actively seeking opportunities for continuous improvement together with the ongoing development of reporting formats, additional assurance mechanisms, including additional COVID-related matters as required.

3. HIGHLIGHT REPORT: 12th May 2022

3.1 Triangulated Theme

The Committee identified at the end of the meeting that the triangulated core theme arising from across a number of the papers was workforce, impacting on finance and operational delivery. It was concluded that workforce is emerging as the Trust's biggest risk due to a number of factors.

The Committee was also concerned about some of the inconsistencies in accurate data / figures across a range of papers and asked the Executive team to ensure a Quality Assurance process is undertaken prior to papers being published. The Committee was provided with **ASSURANCE** that the increasing workforce risk was currently being re-assessed and that there were plans underway to undertake a robust review of current Workforce (including skill mix review), development of a robust 5-year Workforce and recruitment plan to facilitate active and timely recruitment into hotspot areas and a number of continued support mechanisms and interventions to protect the wellbeing of staff.

3.2 Summary of Committee Highlights

The following areas were highlighted for reporting to the Trust Board from the meeting:

ALERT / ESCALATE	**Workforce and Organisational Development Performance Report/Financial Report** This was the second combined Workforce & Associated Finance Risks Report (under continual development). The following was highlighted: • *Workforce Supply and Shape* – Clear work plans and timelines are under development to help secure the necessary skills required to meet both current and future demand. This includes a review of all fixed term contracts and agency reduction plans. • *Wellbeing* – Aside from COVID-19 related sickness absence, the main reason for absence remains stress and anxiety. Targeted interventions and support continue, including supporting staff with adapting to a hybrid working model. • *Recruitment and Retention* – Increasing challenges due to NHS wide supply issues of critical clinical and scientific posts; this is requiring skill mix reviews to embed 'top of licence' principles across all areas of the Trust. • Work is underway to triangulate issues of staff sickness, maternity leave and other issues which may increase pressure on the Workforce. • *Outsourcing* – 10% of Trust capacity will require outsourcing during 2022/23, presenting financial risk due to premium costs standing at three times the Trust's own rates. • *Finance* - All operational financial risks identified during the year to 31st March 2022 were mitigated within the overall Trust budget for the year. The overall reported financial position for the Trust during 2021-2022 was breakeven. The Committee was provided with **ASSURANCE** that significant work is being undertaken to reduce workforce risks as quickly as possible across the Trust. The Committee will need to see the time specific measurable actions which have been agreed and the delivery of those before being assured. This will be closely monitored.
ADVISE	**GOLD Command Highlight Report** The Gold Command Highlight Report provided details of the key issues considered at Gold Command at its meetings held between 23rd March and 27th April 2022. The Committee was **ADVISED** that: • The COVID outbreak on the First Floor Ward at the Velindre Cancer Service was formally closed on 28th April 2022. The outbreak involved 5 patients (2 not acquired within VCC). No breaches in standards were identified. The 3 cases deemed to

have patient nosocomial reviews. No harm came to patients as a result of contracting COVID.

- Due to reduced COVID risk, Gold Command has progressed to the first phase of step down and from 27th April 2022 has been included as a designated part of fortnightly Executive Management Board meetings.

Trust 2021 – 2022 Annual Performance Report

The Committee received the first draft of the Annual Performance Report 2021-2022 (which follows the requirements set out in Welsh Government guidance (Chapter 3 of the NHS Manual for Accounts) and performance against the five harms arising from COVID) ahead of final submission to Welsh Government and Audit Wales on the 15th June 2022. Committee members had an opportunity to discuss the report, ask questions and suggest changes. The following was requested:

- Future reports to contain greater contextualisation (trend lines, % of activity).
- Further work to be undertaken in terms of triangulation of objectives, targets, performance, outcomes, benchmarking, learning and improvement.
- Further narrative in relation to key targets for VCC and WBS of interest to the public to be included in the report going forward.

Quality, Safety & Performance Report

The March 2022 overarching Trust performance report was discussed and the following key items were highlighted:

- *Staff Absence:* Sickness and absence (non COVID) has increased across both Divisions.

- *Brachytherapy breaches:* Service resilience remains challenging and it is anticipated that there will be further breaches in coming months. Executive led Improvements are underway that include an external peer review from the Clatterbridge during May & June 2022.

- *Radiotherapy Waiting Times:* A Pathway Lead has been identified to review breaches and improve processes to reduce time to treatment in addition to ongoing engagement with Health Boards to clarify their backlog clearance plans.

	• *SACT (chemotherapy):* The service remains under considerable pressure due to increasing demand and continued staff absences. A SACT Delivery Task Force is exploring all options available on the SACT treatment pathway, including identifying and securing the required staff resource and most efficient use of staff. It is the intention to double service capacity at the outreach unit at Prince Charles Hospital and provision at Neville Hall will become available following reconfiguration of the unit. • *Inpatient Falls:* 9 falls had been reported on the First Floor Ward of the Velindre Cancer Service during March 2022 involving 5 patients. All cases have been through a scrutiny panel and assessed as unavoidable. **Trust Risk Report** The report provided oversight of the March 2022 risk profile across the Trust as identified on the Datix system. The following was highlighted: • Of the 165 current risks, there is currently 1 level 20 risk (relating to Transforming Cancer Services (TCS)) and 9 level 16 risks (5 for Velindre Cancer Services, 3 for TCS and one for Corporate). There were no level 25 risks to report. 5 risks have closed since the previous reporting cycle. • An extensive review of Velindre Cancer Service risks had been undertaken in addition to recalibration of a number of COVID-related risks. • The Committee was **ADVISED** that current risks in relation to Workforce will now require inclusion in the next cycle of reporting. • All remaining elements for the development of the Risk Framework are on track to be delivered by the end of June 2022. The Committee **NOTED** that risk reporting will need to continue to mature and develop to provide sufficient detail for **ASSURANCE** to the Committee.
ASSURE	**Velindre Cancer Service (VCC) – Patient Story** A powerful story of a patient with head and neck cancer and his family's journey of care through VCC was received. The story detailed the difference the Supportive Care Team had made to this patient and his family, without which due to fear he may not have received his much needed treatment. The Committee COMMENDED the excellent work being undertaken by the Supportive Care Team that is often hidden but making a real difference to so many patients and their families.

NHS Wales Shared Services CIVAS@IP5 Report

The NHS Wales Shared Services CIVAS@IP5 Service Performance report was received, in addition to the findings of the MHRA (Medicines and Healthcare products Regulatory Agency) inspection which took place on the 15th and 16th February 2022 and resulting action plan. The following was discussed / agreed:

- A forensic investigation of the service was undertaken over 2 days, inspected against the Human Medicines Regulations 2012 and covering all licensed activity within the facility.
- The service was assigned low-risk status and no further inspections will take place until February 2024.
- Positive feedback was reported in relation to training of staff and good processes, no issues with vaccine packdown and good environmental control.
- No critical deficiencies were identified. Two major deficiencies (relating to documentation and contamination control) were identified, in addition to three 'other' (relating to product recall procedure).
- An action plan to address the above has been developed by the service and accepted by the MHRA, with a number of actions completed. The target date for outstanding actions is end of August 2022 with no issues for completion anticipated.
- It was agreed that the Board Assurance Framework within the NWSSP would be presented at a future Quality, Safety & Performance Committee and that the official letter received from the MHRA would be shared with Committee members.

Velindre Cancer Service Quality, Safety & Performance Divisional Report

The Velindre Cancer Service report provided an update on performance against key metrics for the period until the end of March 2022. The following areas were highlighted:

- Considerable progress has been made in relation to early resolution of concerns and improvement plans have been embedded.
- A Mortality and Morbidity pilot has been undertaken and all deaths occurring within 30 days of SACT will be discussed within a clinical governance meeting / mortality and morbidity meeting format.
- 11 compliments from patients had been captured via Datix during February 2022, one of which had been written in the form of a

poem. It was recognised that this is not a true reflection of the number of complements received and these require capturing in a timely manner.

Welsh Blood Service Performance Report

The Welsh Blood Service Performance report provided an update on outcomes and performance against key metrics for the period to the end of March 2022. The following was highlighted:

- Recruitment of bone marrow donors has been impacted by the COVID-19 pandemic, impeding the ability of the service to target schools, colleges and universities. The Committee was **ASSURED** that a review of the recruitment process, in particular increasing the number of young bone marrow donors, is underway.
- Serology remains an ongoing challenge due to sustained pressure compounded by staff sickness absence. An audit of out of hours referrals was undertaken and the findings are being reviewed. The Committee was **ASSURED** that referrals continue to be prioritised based on clinical need and are completed in a timely manner.
- The closure of quality incidents within 30 days remains below the 90% target for the period January – March 2022. The Committee was **ADVISED** that the majority of late closures relate to 'clip failures' (the clip on the donation bag is not fully engaged resulting in an amount of blood over the required limit). Although this renders the unit unusable, it poses no harm to the donor. The team is currently exploring a more appropriate method of reporting such incidents, outside of Datix.
- An agreed action to update the Chair and Committee on a transfusion Incident had not been provided and will be circulated after the meeting.

Trust Quarter 4 Putting Things Right Report

The Quarter 4 Putting Things Right Report, providing a summary of concerns, complaints and incidents received during the period 1st January 2022 and 31st March 2022 was discussed. The following was highlighted:

- Of the 46 concerns raised: 91% were graded level 1 (low level); 85% were managed as 'early resolution' (within 2 working days); 15% managed via the Putting Things Right process. No concerns related to the Pandemic. 100% of formal concerns raised were closed within the 30 working days; and top three themes were: appointments, communication, and clinical treatment.

- Of the 492 incidents raised during the Quarter; 403 related to VCC and 89 related to WBS. 97% were graded as no harm or low harm.
- There was one National Reportable Incident relating to an offsite storage contractor suffering major damage to one of its storage facilities and that hard copy Trust medical / clinical records may have been adversely affected.
- There were 10 Ionising Radiation (Medical Exposure) Regulations (IRMER) incidents reported to Healthcare Inspectorate Wales (HIW). All incidents were related to a nationally known equipment fault. The Committee was **ASSURED** that investigations had concluded and a review is currently looking at how / if other cancer centres using the same equipment are mitigating the known fault. Closure reports had been submitted to and been accepted by HIW.
- Formal investigation training has been provided to corporate and divisional staff.

Digital Service Incident Response Plans
Two reports were received to update the Committee on the current position in relation to the development of Trust IT and Cyber Security Incident Response Plans. The following was highlighted:

- Work has been undertaken to ensure that the Trust's local response plans now align with National response plans.
- A separate process for managing incident response outside of the general emergency planning and Business Continuity Plans within the Trust is not required and the IT incident response plan will utilise existing services.
- Operational implementation of finalised plans is now underway, beginning with a number of desktop testing exercises. This will be followed by routine testing of both plans on a 6 monthly basis.

The Committee was **ASSURED** of the work being undertaken and to test Trust plans robustly.

Review of Information Governance (IG) Toolkit
The Information Governance (IG) report provided **ASSURANCE** in relation to how the Trust manages patient, donor, service user and staff information in accordance with Information Governance legislation and standards, actions to improve management of IG risks and reporting IG incidents and actions from lessons learned. The Committee were advised of the following:

- *IG Toolkit self-assessment* – 22 of the 31 self-assessment

	questions apply to the Trust. The self-assessment had been undertaken and used to prioritise IG activity for 2022/23. • *Data Protection Impact Assessments (DPIA)* – 21 DPIAs have been undertaken since October 2021 which are fundamental to providing **ASSURANCE** regarding mitigation of risks. It has been identified that the Trust does not currently have a single visible Contracts Register (irrespective of the contract value) in place to support correct IG processes and documentation, which presents a risk; this is being prioritised for 2022 / 23. • *Data Protection Act (2018) requests / incidents and investigations* – Most incidents continue to be as a result of human error in relation to incorrect data handling. The Committee was **ADVISED** that training is now being targeted to all individuals involved as well as hot spot areas. All incidents were investigated within required timescales. **Trust Policy Compliance Report** The Trust Policy Compliance report provided **ASSURANCE** on progress since April 2022 to strengthen the Trust's policy and procedure governance including ensuring the review of all Trust policies and procedures where the review date has passed. The Committee was advised that: • 122 of the 157 Trust-wide policies fall within the oversight and remit of the Quality, Safety & Performance Committee. All have been audited and the status recorded within the report, including supporting risk assessment and any associated actions. • Work following the last Committee has focused on the 53 Workforce & Organisational Development policies. • The next phase of work will focus on policies which fall within the remit of the Trust's other Board Committees, reporting to each Committee as appropriate. The Committee commended the significant work undertaken to enhance policy and procedure governance and to reduce the number of policies overdue for renewal.
INFORM	The Committee **APPROVED** the following revised policy: • IPC07: Policy for the Prevention and Control of Methicillin Resistant Staphylococcus Aureus (MRSA).
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 12th May 2022.

TRUST BOARD

MARCH PERFORMANCE MANAGEMENT FRAMEWORK COVER PAPER

DATE OF MEETING	26/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Wayne Jenkins, Head of Planning and Performance Alan Prosser, Director WBS Sue Thomas Ass Director WOD
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer Sarah Morley, Director WOD
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim 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	13.4.22	Reviewed and Noted
VCC SLT	20.4.22	Reviewed and Noted
WBS PERFORMANCE REVIEW	20.4.22	Reviewed and Noted
VCC PERFORMANCE REVIEW	21.04.22	Reviewed and Noted
EMB RUN	27.4.22	Reviewed and Noted

QSP COMMITTE	12.5.22	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
SPC	Statistical Process Control

1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports provide an update to the Trust Board with respect to Trust-wide performance against key performance metrics through to the end of March

2022 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 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.

2.2 Velindre Cancer Centre:

Covid continues to impact our service planning and delivery – positive cases on wards impacts our ability to flexibly use our staff capacity to support SACT and maintain all services.

Radiotherapy Waiting Times

Referral volumes were at a high of 383 in March.

As a result of breaches primarily reflecting issues in areas of the patient pathway and not necessarily linac capacity, the Medical directorate has identified a pathway lead to review all breaches with the SSTs responsible and look at where there are process variations that can be resolved to improve the time to treatment. This has commenced with the March data.

Brachytherapy surge due in May- capacity to meet demand remains limited- this is under active surveillance.

SACT Waiting Times

We are reporting the lowest performance in the last twelve months due to increasing demand and nurse staffing absences.

A Task and Finish Group was established in late March to create a specific focus on identifying a range of actions to address all aspects of the service that enable patients to receive their SACT treatment. This includes addressing workforce shortage, the physical limitations of capacity for SCAT delivery chairs and increasing capacity in pharmacy and pre-SACT assessment clinics. The EMB received a presentation at their meeting on 27th April to outline the actions taken to date as well as those planned in forthcoming week. A

number of actions have been identified and work is currently ongoing to identify the additional capacity that these will create in the forthcoming months. We are still likely to have to make use of third party provision once contractual arrangements are in place. This work is ongoing and likely to come online in May.

Outpatients

Data collection paused during December to February due to operational pressures and staff absence as manual collection of individual patient attendances is required. We are actively considering new ways of assessing patient experience in clinics as part of the development of the new performance framework.

Therapies

Therapy targets primarily being achieved. The one exception being a dietetic patient seen outside of the two week target.

Other areas

Falls

During March 2022, 9 falls were reported on first floor ward involving 5 patients, 4 of whom fell twice. During this period all patients admitted to the ward were cared for in a single room pending COVID screening results and there was a high patient complexity and acuity. There was no harm or injuries to any patients due to the falls.

All incidents have been fully investigated and been discussed at Scrutiny Panel with independent (Corporate Nursing) scrutiny and all were deemed unavoidable. Although all standards were followed there was some additional learning was identified by the scrutiny panel that could further improve standards. An additional paper on the falls was presented at EMB Run in April.

Pressure Ulcers

One Velindre acquired pressure ulcer was reported in March 2022. The patient's mobility was subject to deterioration due to disease progression. The ulcer was deemed unavoidable by the VCC Pressure Ulcer Scrutiny Panel.

No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).

Healthcare Acquired Infections

There was one instance of *C.diff* infection reported in March 2022.

A Root Cause Analysis was undertaken. The infection was deemed to have resulted from extended antibiotic usage and was deemed unavoidable.

SEPSIS bundle NEWS score

6 patients met the criteria for administration of the sepsis treatment bundle in March 2022. All patients received all elements of the bundle within one hour. 2 of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.

Delayed Transfers of Care (DTOC's)

One Delayed Transfer of Care was reported in March 2022.

A patient admitted to ensure appropriate nutritional support while undergoing radiotherapy could not be discharged in accordance with the repatriation plan which had been developed because of health board capacity issues.

Further detailed performance data is provided in Appendix 1

2.3 Welsh Blood Service

Supply Chain Performance

WBS continued the monthly trend of meeting demand for red cells with demand for O, A and B groups continuing to be maintained above 3 days in line with the performance for the year.

3 specialist rare patient specific pheno-typed units were requested from NHSBT as part of our mutual aid agreement.

On March 21st the service issued a Blue alert notice to NHS Wales regarding pressure on O group red cells. A number of factors affected this position and included increased demand on common blood groups during the period, high sickness absence rates in collections, vacancy factor and COVID restrictions.

2.3.1 Recruitment of new bone marrow volunteers

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) improved again in March. It remains below the annual target of 4000 p/a standing at 2,582.

The reduction is due to fewer 17-30 year old blood donor donating red blood, from which bone marrow donors are recruited. This significant reduction can be aligned to COVID 19 Pandemic and the service not being able to target schools, colleges and universities.

The service has recognised this challenge and is in the process of reviewing its approach to recruiting bone marrow donors and identifying how to increase the number of young bone marrow donors. An action plan has been agreed and a business case is being prepared to address this issue. Improvements anticipated Q2 2022.

2.3.2 Reference Serology

Turnaround times have reduced to 65% in March and the service is under sustained pressure. Work continues to be prioritised based on clinical need, and all compatibility testing (>55% of referrals) is completed to the required time/date. The complexity of referrals continues to impact performance in March.

The service advised pathology labs across Wales that due to increased staffing pressures all out of hours referrals should be triaged by them to ensure that only those tests that required out of hours provision of results should be sent to WBS for out of hours action.

In addition, following an audit of out of hours referrals these findings are being communicated to Health Board laboratory service leads.

A report on key issues is being prepared which will consider options to improve service provision in the short to long term. In addition, automated analysers are being introduced in Q1 2022 which will enable efficiencies to be realized in some elements of the service.

2.3.2 Quality

Incidents reported to Regulator/Licensing

There was no Serious Adverse Events (SAE) reported to regulators during March.

Incidents closed within 30 days

This measure has not met target (90%) for the period January to March with an increase of incidents not closed within timeframe increasing from 8 to 24.

Of the 16 Datix incidents, 8 were closed in March but exceeded closure timelines. Remaining incidents open in Datix are at the initial reporting stage (4) or remain under investigation (4). Of the remaining incidents, 4 remain open because they are awaiting completion of investigation process which does not permit closure until it has been

completed. The remaining 4 incidents were closed late, and the reasons for late closure are currently being compiled.

It should be noted that thirteen of the 16 incidents closed late relate to 'clip failures'. This means that the clip on the donation bag is not fully engaged and as a result the bag has an amount of blood over the required limit. As a result, the donated unit cannot be used but does not reflect actual or potential harm to the Donor, or risk to patients.

Historically these events were not reported in Datix prior to May 2021 and investigations only completed if an adverse trend outside of normal process variation was detected. Work is nearing completion to revert to monitoring clip failures as a process deviation using Q-pulse, and not to treat them as incidents in Datix.

Whole Blood Collection Productivity

The collection productivity for March continues to be below target. This target will not improve under Covid restrictions as the additional resources to operate in this environment are included in the productivity data.

Risk assessments have been undertaken for reducing social distancing to 1m and for the removal of the triage resource at donation clinics from April to support increased capacity at community-based clinics through the reintroduction of additional donation chairs and screening booths and the introduction of self-service triage for donors.

Number of Concerns Received

There were 8 concerns received in March and all were managed within timeline as 'Early Resolution'.

Donor Satisfaction

Continues to perform strongly at a national level despite the COVID restrictions in place.

3. WORKFORCE

3.1 PADR

Trust wide performance shows compliance levels at 66.86%

WBS PADR compliance is reported at 78.44% for March 2022.

VCC PADR compliance is reported at 65.96% for March 2022. This is a slight increase on the previous month. March has seen an increase across a number or areas within VCC (only 1 area now appearing as 'red'), and Radiotherapy have plans in place to further increase compliance, with the plan looking forward to the next 12 months.

Sickness Absence

Rolling absence levels are 6.07%.

WBS sickness absence (in month) has increased, reporting at 7.62%. Short term sickness absence has increased to 4.37%, with long term absence slightly decreasing to 3.25%

VCC sickness absence (in month) has increase in March 2022, reporting at 7.77% from 5.81% in February 2022. Some areas have reported an increase in Covid related absences, which has resulted in some service pressures. SACT/Pharmacy have a number of staff on long term sickness absence, these are being managed in line with the managing Attendance at Work Policy.
Both Short- and long term sickness absence has increased this month, 3.24% and 4.53% respectively.

3.2 **Statutory & Mandatory Compliance**

Compliance with the 10 subjects of the Core Statutory Training Framework is at 85.77%.

WBS's Statutory and Mandatory Compliance is 92.30%.

VCC's Statutory and Mandatory Compliance is 84.75% for March 2022, which is a slight increase from the previous month.

4.0 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.

5.0 RECOMMENDATION

5.1 Trust Board is asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC December PMF Report
2. WBS December PMF Report
3. Workforce KPI data

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (March 2022)

			Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 8)	Actual	89%	95%	94%	97%	96%	97%	96%	92%	78%	92%	92%	92%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 10)	Actual	85%	95%	85%	82%	82%	82%	82%	74%	84%	90%	90%	81%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 12)	Actual	97%	100%	100%	97%	100%	97%	100%	85%	89%	100%	93%	88%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 14)	Actual	98%	98%	98%	99%	99%	98%	99%	99%	99%	94%	91%	71%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page 15)	Actual	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%	100%	83%
		Target	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 19)	Actual	66%	79%	76%	76%	53%	53%	65%	65%	Data collection paused between December and March due to operational pressures.			
		Target	100%	100%	100%	100%	100%	100%	100%	100%				

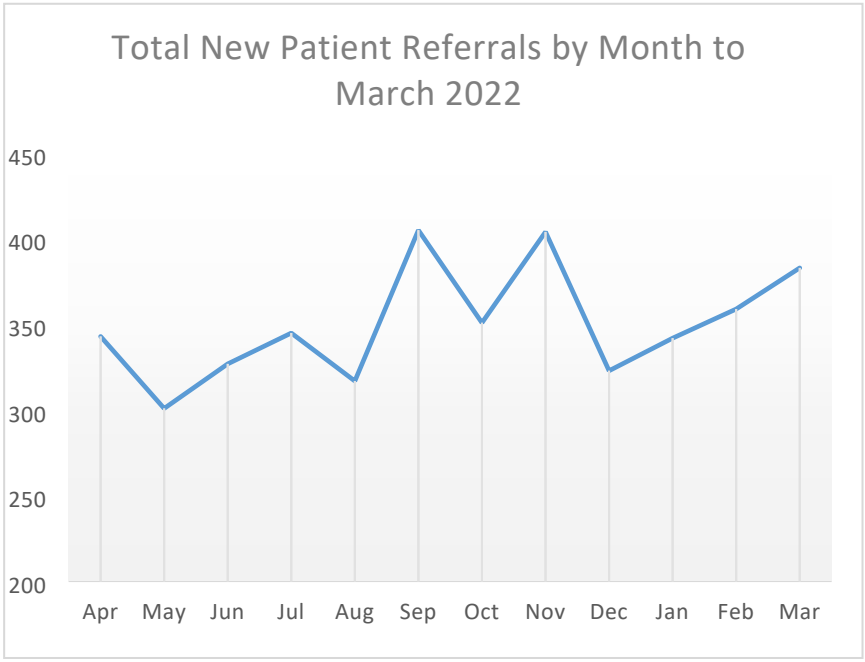
			Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
	Did Not Attend (DNA) Rates	Actual	3%	4%	4%	5%	5%	5%	5%	5%	3%	3%	3%	3%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	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%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page 22)	Actual (Dietetics)	100%	100%	84%	94%	94%	98%	97%	100%	95%	98%	100%	98%
		Actual (Physiotherapy)	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%
		Actual (Speech and Language Therapy)	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%

			Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
	Routine Therapies Outpatients Seen Within 6 Weeks (page 22)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	96%	33%	78%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	96%	100%	100%	96%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page 24)	Actual	1	0	0	0	2	1	1	0	1	0	1	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	1	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page 26)	Actual (Total)	2	3	1	3	4	2	3	1	4	3	2	9
		Unavoidable	1	3	1	3	4	1	3	1	4	2	2	9
		Avoidable	1	0	0	0	0	1	0	0	0	1	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	0	0	1	0	4	0	0	1	4	1

			Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
		Target	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
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater to or Equal to Three Who Receive all 6 Elements in Required Timeframe (page 28)	Actual	100%	100%	100%	80%	100%	75%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections (page 29)	Actual	0	0	0	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)	0	1 (*C.diff*)
		Target	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%	%
		Target	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



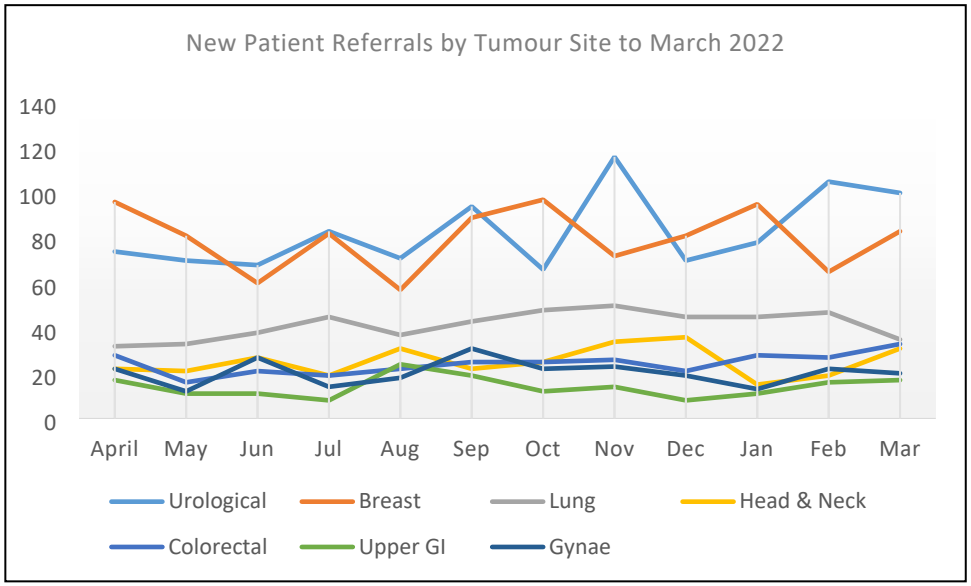
Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (March 2022)
357	315	383

The total number of referrals received in March 2022 (383) represented an increase on the number received in February 2022 (359). The number of referrals considerably exceeded the average number received in any month, on average, during 2020-21.

Areas of risk:
Brachytherapy surge due in May- capacity to meet demand remains limited- this is under active surveillance and active engagement with WHSSC on increased capacity.

Radiotherapy – Operational Context

Referral Trends - Tumour Site

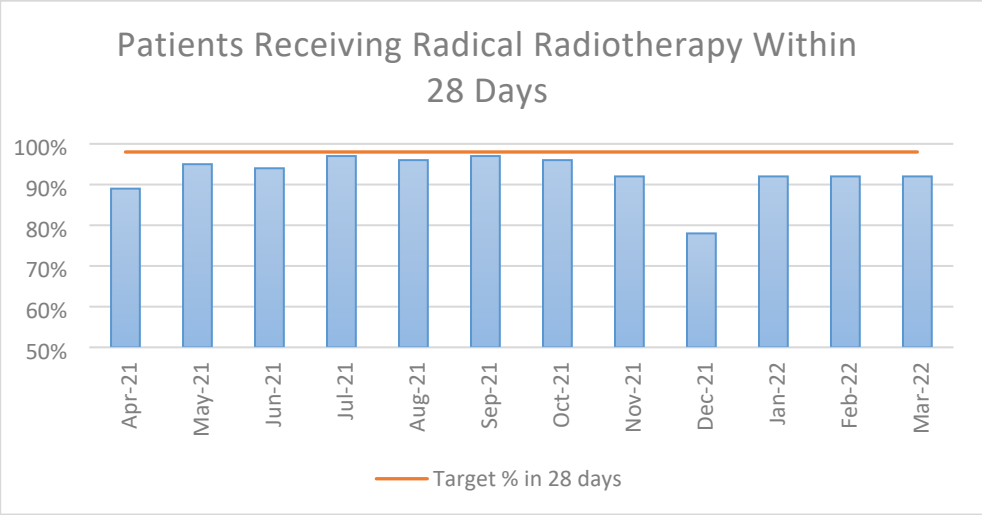


Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patients (March 2022)
Breast	**88**	**60**	**-32%**	83
Urology	**82**	**82**	**0%**	100
Lung	**47**	**38**	**-19%**	35
Colorectal	**20**	**22**	**+10%**	33
Head and Neck	**23**	**23**	**0%**	31
Gynaecological	**18**	**18**	**0%**	20
Upper Gastrointestinal	**16**	**13**	**- 19%**	17
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**82%**	**81%**		83%

The graph and table show the number of patients scheduled to begin treatment in February by the tumour sites most commonly referred for radiotherapy treatment.

- Referrals overall and across some tumour sites now returning to pre Covid levels.
- Demand up from 82% to 84% against the 2019/20 baseline (in the tumour sites most commonly referred for radiotherapy, with maximum 80% capacity due to IP&C measures. Prior to staff absences rising during 4th COVID wave.
- Weekly variation in referrals from health boards, across individual tumour sites, is impacting on our ability to meet demand in a timely fashion. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by SSTs to meet short term surges and to respond to health board backlog clearance.

Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



The number of patients scheduled to begin radical radiotherapy treatment in March 2022 (236) was considerably greater than the monthly average observed in 2020-21 (150) and was larger than the number scheduled to begin treatment in March 2021 (208).

18 patients referred for Radical radiotherapy did not begin treatment within the 28 day target constituting an overall performance rate of 92**%.**

All 18 patients have now commenced treatment and breaches due to capacity constraints followed an approved clinical prioritisation process, to ensure risk to patients and outcomes is minimised.

Breakdown of Breach length of waits:

Treatment Intent	29-35 days	Over 35 days
Radical (28-day target)	12	6

Most of the breaches were due to planning/re-planning/re-scanning issues, however the 3 longest waits above were prostate patients (53-75 days) who had their treatment paused during the omicron wave and commenced treatment in month. Everyone now has commenced treatment.

Opportunities for improvement:
Escalation process continues to monitor predicted breaches and prevents breaches where possible through weekly capacity meeting
Delays and cancellations monitored weekly and reported back to Radiotherapy Management Group and the pathway sub group.
Outsourcing of RT for Breast and prostate patients to RCC continues with 5 prostate and 14 breast patients being referred in March.

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (March 2022)
Radical	167	150	236
	Patients Scheduled to Begin Treatment (March 2020)	Patients Scheduled to Begin Treatment (March 2021)	
	194	208	

As a result of breaches primarily reflecting issues in areas of pathway not necessarily linac capacity, the Medical directorate has identified a pathway lead to review all breaches with the SSTs responsible and to target the areas where there are process variation. This has commenced with the March data.

Medium Term Actions

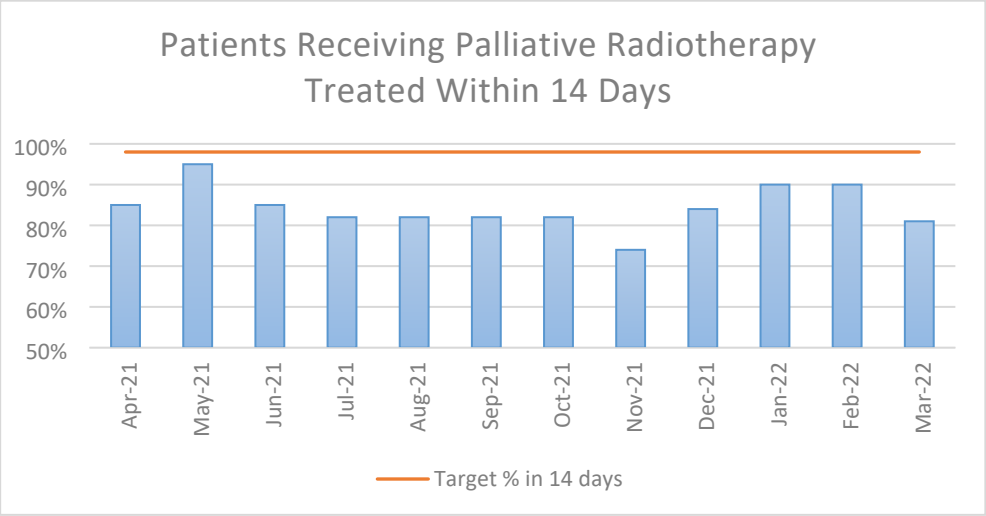
- We are working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options e.g. Brachytherapy, molecular radiotherapy.
- Recruitment and appointments in progress for additional front line resources, however this will not create capacity increases until 2nd half of 2022 due to lead in time, but we will be maximising capacity from Sept-Dec 2022.
- Peer review with Clatterbridge Trust underway April 2022 to identify options/service models to put service demand and capacity in balance for Brachytherapy.
- Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC. submission Apr 2022
- Assess the options to escalate some or all of the longer term capacity solutions. April 2022.

Patients Receiving Palliative Radiotherapy Within 14-Days

Target: 98%

SLT Lead: Radiotherapy Services Manager

Trend



The number of patients scheduled to begin palliative radiotherapy treatment in March 2022 (110) was above the monthly average observed in 2020-21 (74), but was marginally fewer than the number scheduled to begin treatment in March 2021 (112).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (March 2022)
Palliative	82	74	110
	Patients Scheduled to Begin Treatment (March 2020)	Patients Scheduled to Begin Treatment (March 2021)	
	110	112	

Current Performance

21 patients referred for radiotherapy treatment with palliative intent were scheduled to begin treatment in March and did not begin treatment within the 14 day target constituting an overall performance rate of **81%.**

Additional staffing pressures due to sickness during March as a result of Omicron variant resulted in a reduction of the service.

Breakdown of Breach length of waits:

Treatment Intent	Under 21 days
Palliative (14-day target)	21

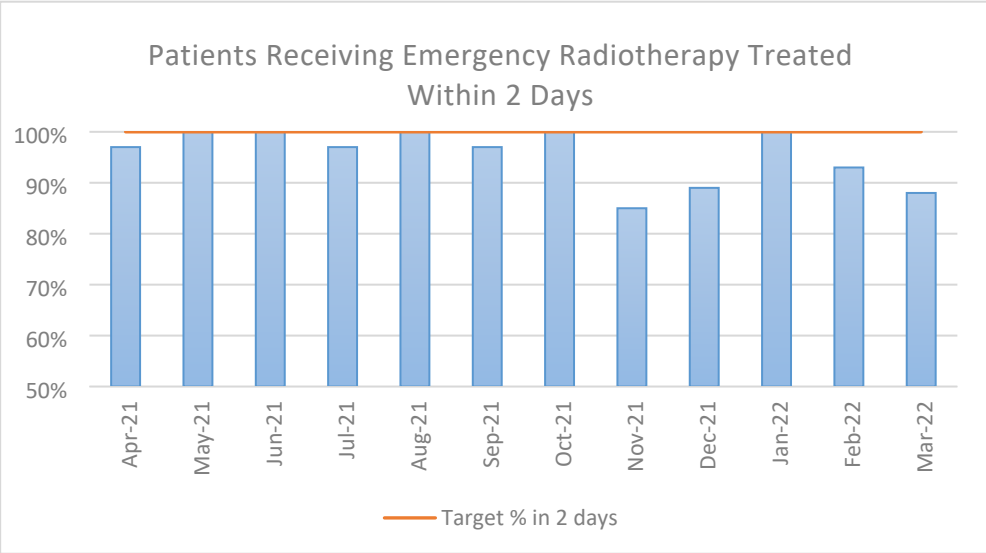
3D Planning was the primary cause of breach delays, as it is not possible to produce these within the 14 day targets due to medical physics capacity.

Outsourcing of RT for Breast and prostate patients to RCC continues with 5 prostate and 14 breast patients being referred in March.

As a result of breaches primarily reflecting issues in areas of pathway not necessarily linac capacity, the Medical directorate has identified a pathway lead to review all breaches with the SSTs responsible and to target the areas where there are process variation. This has commenced with the March data.

	Medium Term Actions
	• Refer to 28 day medium term actions.

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 March 2022 (17) was lower than the monthly average observed in 2020-21 (27) and was lower than the number scheduled to begin treatment in March 2021 (29).

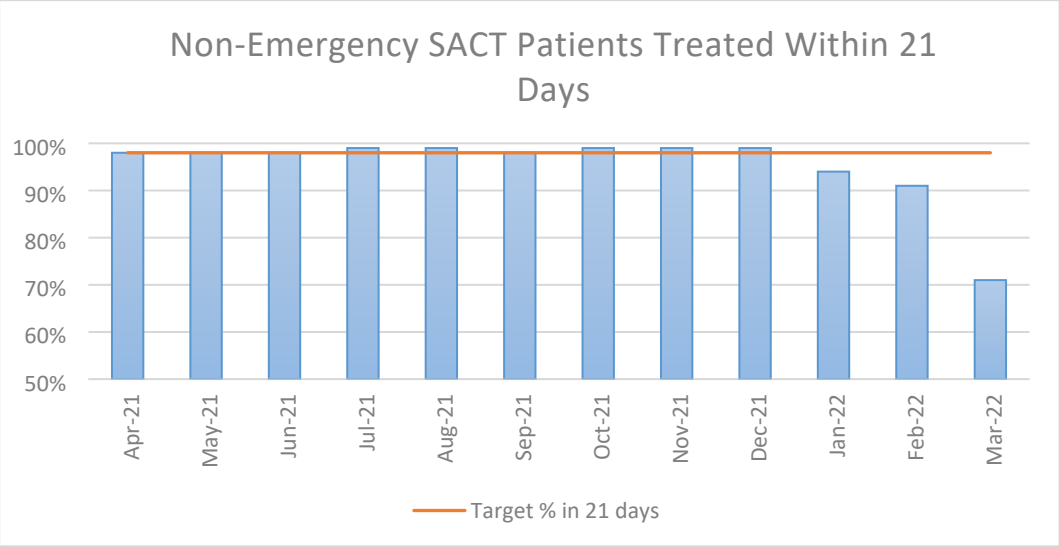
Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (March 2022)
Emergency	25	27	17
	Patients Scheduled to Begin Treatment (March 2020)	Patients Scheduled to Begin Treatment (March 2021)	
	33	29	

17 patients referred for radiotherapy treatment with emergency intent were scheduled to begin treatment in March. Of these 2 and did not begin treatment within the 2 day target constituting an overall performance rate of **88%.**

Both patients were treated on day 3. Transport delays at the local health boards in transferring both patients from their local hospitals was the cause of both delays.

Wider Actions as above for 28 and 14 day targets

Non-Emergency SACT Patients Treated Within 21-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend



The number of patients scheduled to begin non-emergency SACT treatment in March 2022 (400) was considerably larger than both the monthly average observed in 2020-21 (298).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (March 2022)
Non - emergency	328 Patients Scheduled to Begin Treatment (March 2020)	298 Patients Scheduled to Begin Treatment (March 2021)	400

400 patients were referred for non-emergency SACT treatment scheduled to begin treatment in March. Of this total, 118 patients did not begin treatment within the 21 day target, constituting an overall performance rate of 71%.
Of the 118 patients who did not begin treatment within 21-days

Treatment Intent	≤ 28 days	≤ 35 days	≤ 42 days
Non-emergency (21-day target)	61	47	10

All patients within a Clinical Trial are booked within the trial timeframes.
Due to current capacity constraints within SACT & Medicines Management team, all new patients & urgent patients are prioritised using Welsh Cancer Network guidance and available clinical information. Escalation & capacity needs are continually reviewed and change frequently throughout the day. The Clinical Priority process commenced 20/12/22.
VCC has not reduced social distancing to 1m due to the high community prevalence of COVID. Reduction of social distancing to 1m will enable VCC SACT daycase unit to increase the number of chairs overall by a small margin (yet to be defined). This will aid patient flow. However, the primary capacity challenge of the service is related to staffing resource and thus increase in chair capacity will not facilitate increased capacity without resolution of staffing challenges.

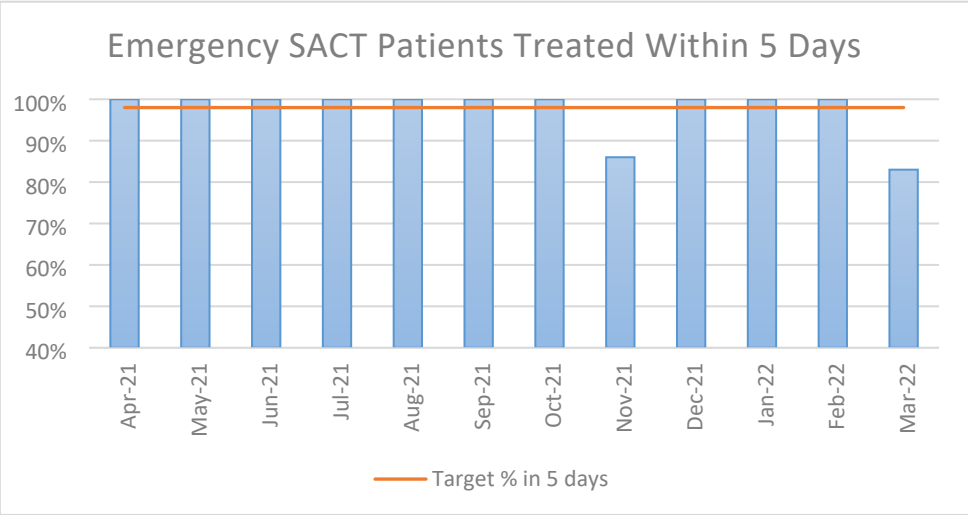
	329	351	

All options to address workforce challenges are being considered.
Daily SACT Escalation meetings continue to be held with senior clinical SACT team leads who actively manage this prioritisation process and endeavour to ensure that all patients are treated in as timely a manner as possible according to their clinical prioritisation category and date of referral to the service.

Actions

- Weekend clinics and mutual aid from other parts of the centre are being utilised.
- Additional capacity being secured from Rutherford cancer centre. May 2022 is the predicted commencement, however discussions have commenced to try and bring this forward.
- All treatment regimens that can be delivered in other clinical areas are being explored and actioned to release capacity in the SACT clinic area.
- A task and finish group has been established to identify solutions to support the service in increasing capacity, productivity, sustainability. Commenced March 2022 and ongoing.
- Discussions are being escalated to prioritise the Neville Hall provision, which is the medium term plan for increasing capacity. We expect a progress report in May.

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend



The number of patients scheduled to begin emergency SACT treatment in March 2022 (6) was higher than the monthly average observed in 2020-21 (4).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (March 2022)
Emergency	4	4	6
	Patients Scheduled to Begin Treatment (March 2020)	Patients Scheduled to Begin Treatment (March 2021)	
	3	8	

6 patients referred for emergency SACT treatment were scheduled to begin treatment in March 2022. 1 patient did not begin treatment within the 5-day target.
The patient was treated on day 10.

- Ring fencing of emergency chair capacity has allowed us to improve the compliance in this area. This took a number of months until the correct balance between ring fencing and chair utilisation was achieved.

Actions

- Continue to balance demand and ring fencing with capacity.

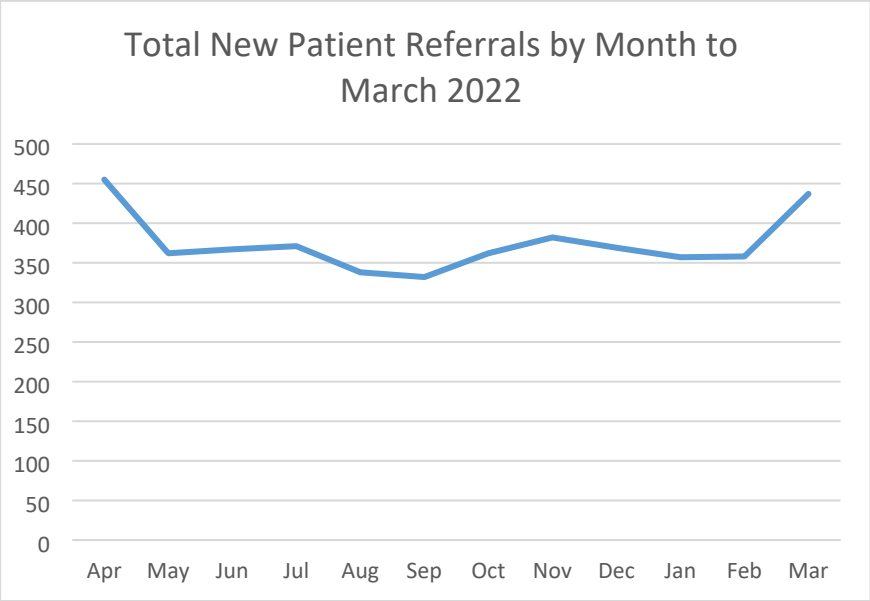
SACT – Operational Context

Current Performance Consolidated

Measure	Target	Mar-22
Non-emergency (21-day target)	98%	**71%**
Emergency (5-day target)	98%	**83%**

The table shown here sets-out performance relative to the extant time to SACT targets.

Referral Trends - Overall



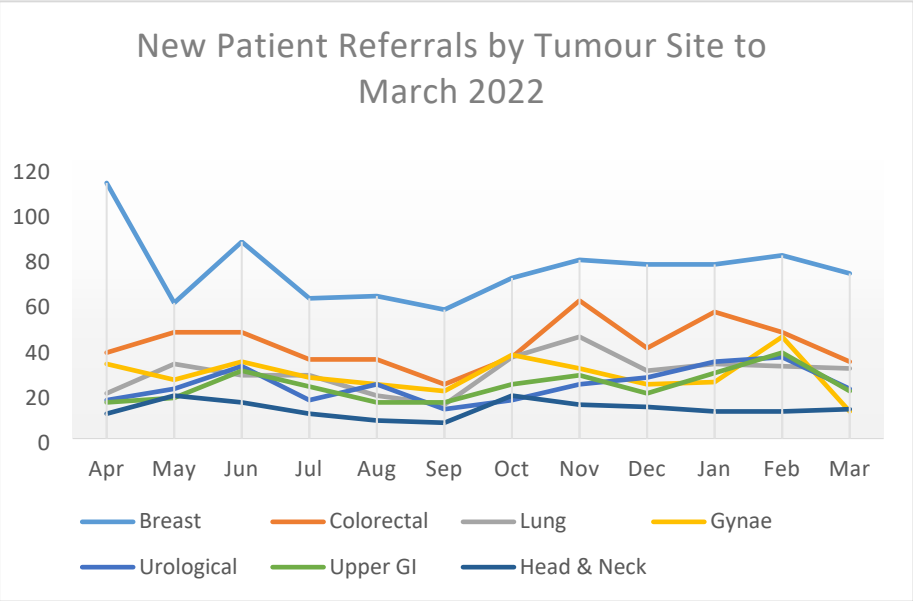
Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (March 2022)
325	301	437

The total number of referrals received in March 2022 (437) was markedly greater than the average number received in any given month during 2020-21 (301) and greater than the number received in February 2022 (358). The number of referrals received in March also greatly exceeds the average number received on average, per month in 2019-20.

Referrals fell dramatically following the first national lock-down in March 2020. Subsequently, referrals have returned to pre-pandemic levels.
Referrals include new patients for 1st definitive treatment and repeat treatments for patients mid cycle or on a revised treatment cycle.

SACT – Operational Context

Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patient Referrals (March 2022)
Breast	**92**	**76**	**-17%**	73
Colorectal	**54**	**55**	**+2%**	34
Lung	**33**	**32**	**-3%**	31
Gynaecological	**31**	**31**	**0**	12
Urological	**36**	**26**	**-28%**	22
Upper Gastrointestinal	**18**	**26**	**+44%**	21
Head and Neck	**16**	**14**	**-12%**	13
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**86%**	**87%**		47%

The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.
SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

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

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

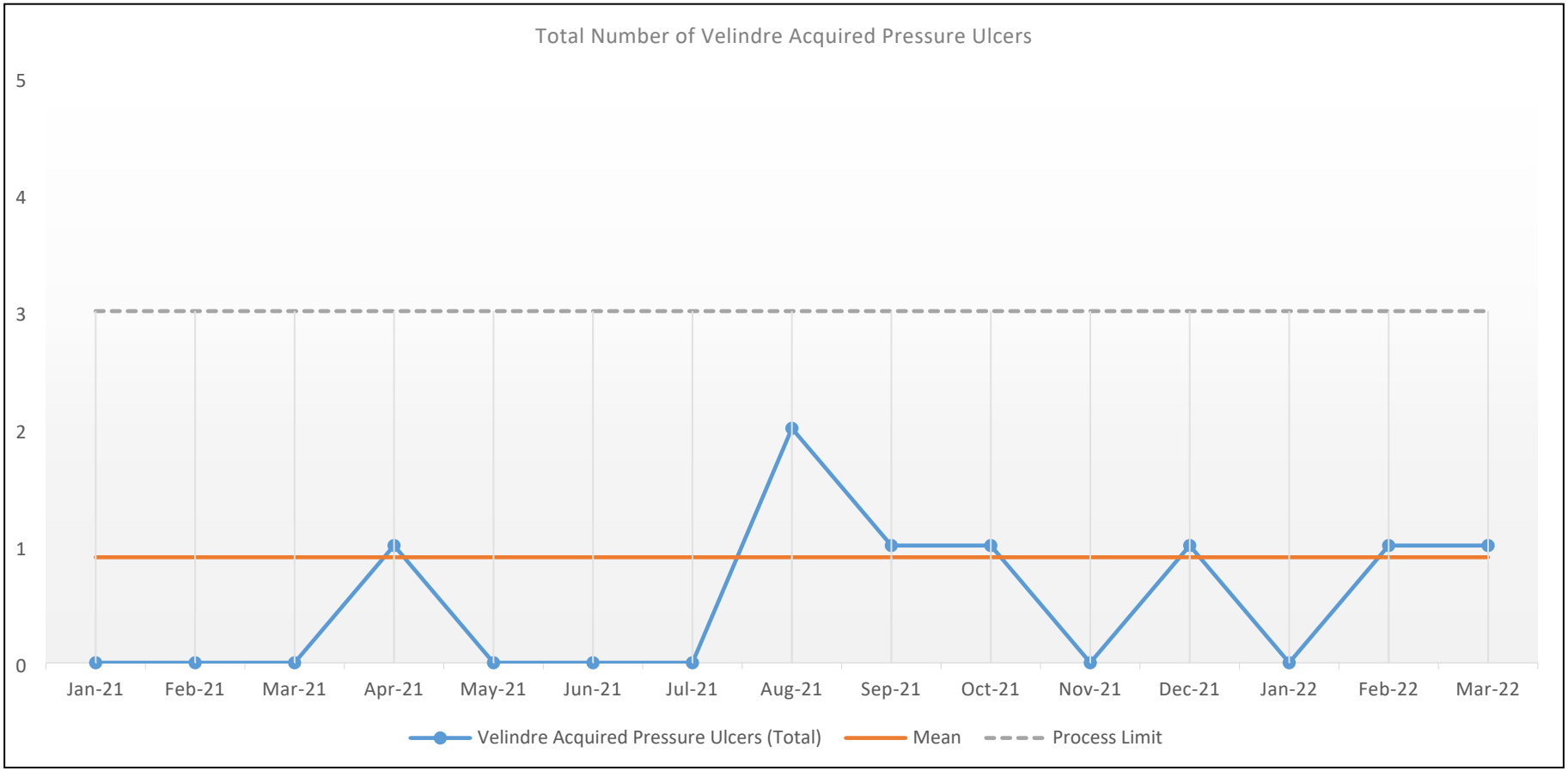
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Dietetics	100%	100%	84%	94%	94%	98%	97%	100%	95%	98%	100%	98%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	86%	100%	100%
OT	100%	100%	100%	100%	96%	33%	78%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	96%	100%	100%	96%	100%	100%	100%	100%	100%

One dietetic outpatient was not seen within target. The patient was seen one day after the stipulated target. No harm was reported.	No specific actions required.

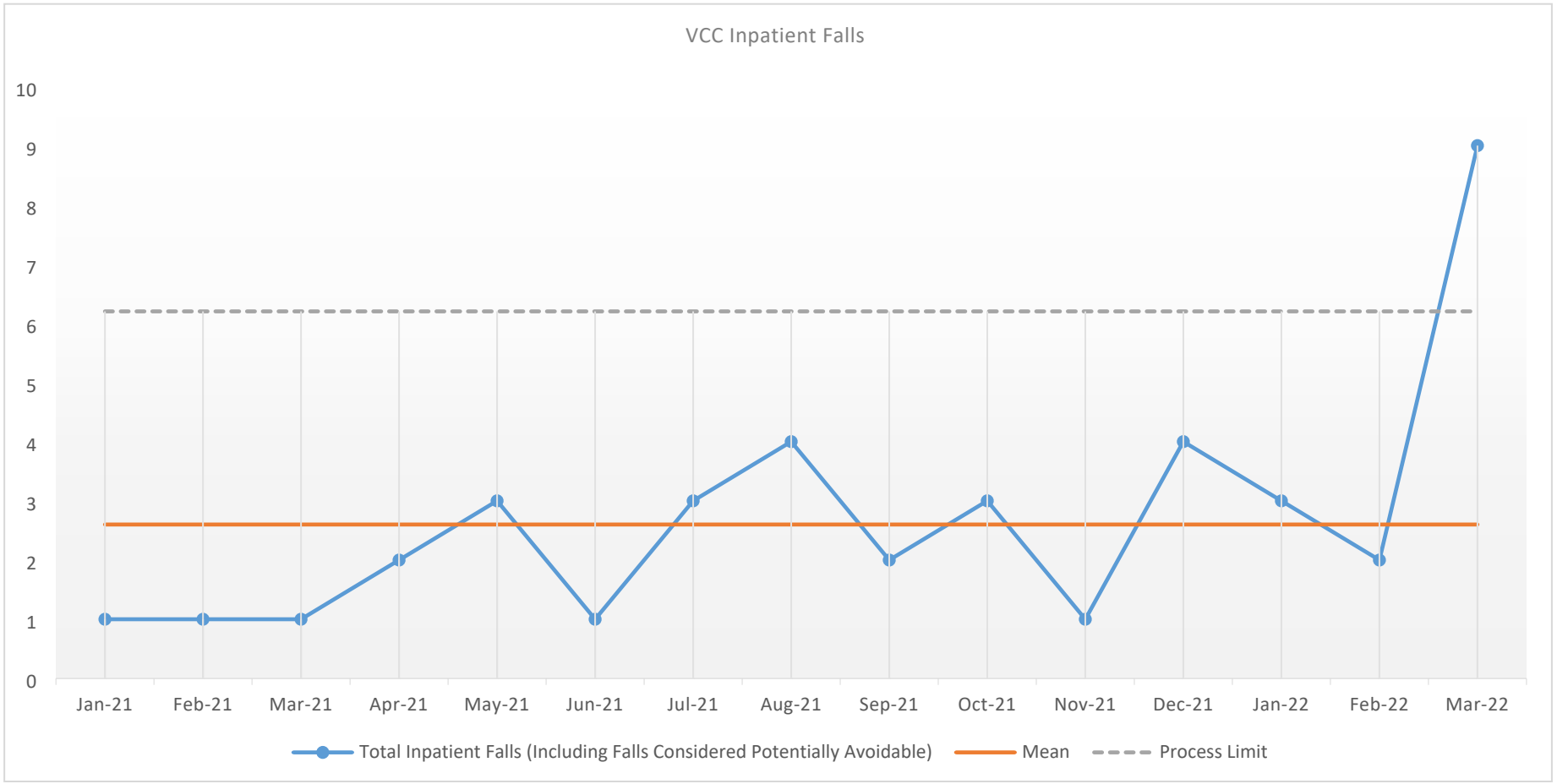
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Velindre Acquired Pressure Ulcers (Total)	0	0	0	1	0	0	0	2	1	1	0	1	0	1	1
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0

Trend	Action
1 Velindre acquired pressure ulcers was reported in March 2022. • The patient's mobility was subject to deterioration due to disease progression. The ulcer was deemed unavoidable by the VCC Pressure Ulcer Scrutiny Panel. A risk assessment was undertaken on admission and app • Appropriate interventions put in place. No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).	• No further action required.

Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov -21	Dec -21	Jan -22	Feb -22	Mar -22
Total Inpatient Falls	1	1	1	2	3	1	3	4	2	3	1	4	3	2	9
Potentially Avoidable Inpatient Falls	0	0	0	1	0	0	0	0	1	0	0	0	1	0	0

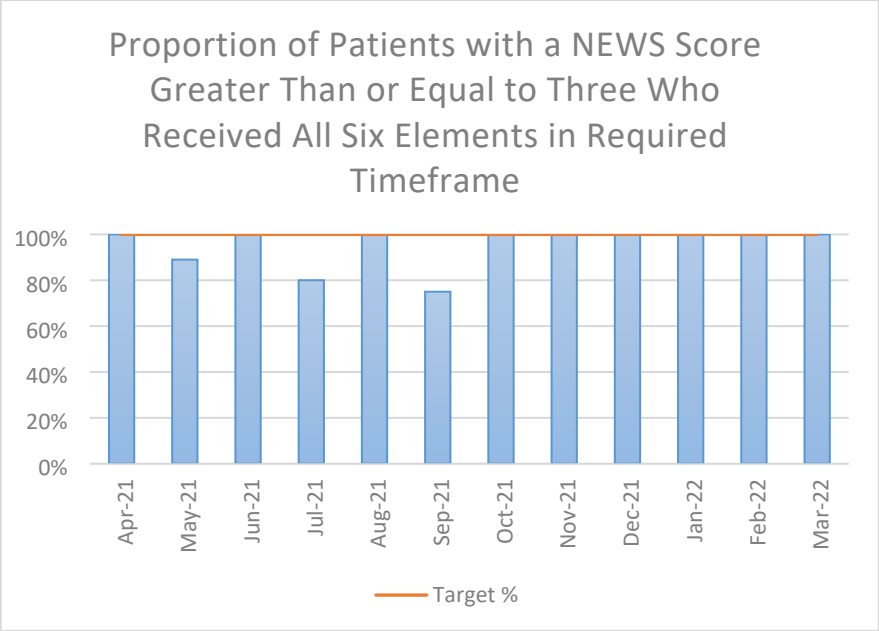
Trend	Action
During March 2022, 9 falls were reported on first floor ward involving 5 patients, 4 of whom fell twice. During this period all patients admitted to the ward were cared for in a single room pending COVID screening results and there was a high patient complexity and acuity. There was no harm or injuries to any patients due to the falls. All incidents have been fully investigated and been discussed at Scrutiny Panel with independent (Corporate Nursing) scrutiny and all were deemed unavoidable. All assessments were completed in line with standards and appropriate post fall care adjustments made and medical review undertaken. The circumstances and mechanics of each fall varied. Two of the patients were experiencing a degree of cognitive impairment and some of the falls occurred when staff were also present with the patient but could not prevent the descent to the floor. Following one of the patient's second fall 24/7 one to one nursing care was put in place.	Although all standards were followed there was some additional learning was identified by the scrutiny panel that could further improve standards. • All patients to have a baseline lying / standing blood pressure reading taken on admission • Staff to liaise with all-Wales Falls Team and local neurological teams at district general hospitals in order to identify specific measures which might be implemented to support patients subject to altered mental capacity.

Delayed Transfer of Care	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	

1 Delayed Transfers of Care was reported in March 2022.

A patient admitted to ensure appropriate nutritional support while undergoing radiotherapy could not be discharged in accordance with the repatriation plan which had been developed because of health board capacity issues.

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



6 patients met the criteria for administration of the sepsis treatment bundle in March 2022. All patients received all elements of the bundle within one hour. 2 of the patients subsequently received a diagnosis of sepsis or neutropenic sepsis.

Actions

No specific action required.

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**
Current Performance	

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
C.diff	0	0	0	0	1	0	0	0	0	1	0	1
MRSA	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
E.coli	0	0	0	0	0	0	0	0	0	0	0	0
Klebsiella	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

Trend	Action
There was one instance of *C.diff* infection reported in March 2022.	A Root Cause Analysis was undertaken. The infection was deemed to have resulted from extended antibiotic usage and was deemed unavoidable.

Welsh Blood Service Monthly Report

March 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

- WBS monitors the availability of blood for transfusion through its daily 'resilience groups' and plans its collection model to meet demand. In March, WBS continued the monthly trend of meeting demand for red cells with demand for O, A and B+ group c ontinuing to be maintained above 3 days in line with the performance for the year. Covid related sickness has been particularly challe nging during March within the Collection Teams, which has impacted the Services' ability to collect blood. On 21/03/2022 the se rvice issued a blue alert to NHS Wales highlighting pressure on O blood groups. There were three red cell units imported during March as a result of a request for a rare blood group (phenotype) not available at WBS.

- The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) remains below the annual target of 4000 p/a at 2582, continuing the upward trend in numbers recruited from December 2021 into March 2022. The reduction is due to fewer 17-30 year old blood donors donating red blood, from which bone marrow donors are recruited. This significant reduction can be aligned to COVID 19 Pandemic. The service is currently reviewing its approach to recruiting bone marrow donors and identifying how to increase the number of young bone marrow donors, which are the preferred demographic of donors due to the fact there is an improved outcome rate. An action plan and a supporting business case has been developed to formally raise awareness of the 'SWAB' test to determine potential bone marrow donors in addition to capturing individuals already don ating red blood cells in place. In the meantime two University donor recruitment sessions took place in March which resulted in a higher than average conversion rate for registrations of 17-30 year olds, and the registration of 21 SWAB donors in March.

- There continues to be an upward trend for stem cell collections in Wales. However, the service has seen a higher cancellation rate (30%) compared to that pre pandemic (15%). This is due to patient fitness and the requirement for collection centres to'workup' two donors simultaneously in order to ensure sufficient number of donors available at the required point of a patient's treatment . The apheresis stem cell collection service commenced in VCC in October 2021 and is providing additional capacity to support st em cell collections. There are plans to open the bone marrow collection service at VCC later in the year.

- Red Cell Immunology staffing related pressures resulted in the Service advising pathology labs across Wales to triage out of hour referrals. At 65% turn around times for March were impacted significantly by key staff absences, with the Service receiving the highest ever number of referrals (272) in March. An audit has been undertaken, and the findings accepted. These recommendations will be introduced with Health Boards and improvements in performance are anticipated.

- At 0.99 the Collection Productivity Rate continues the trend for the year and is below the target of 1.25. Whilst the service continues to operate under COVID19 conditions it is limited in being able to improve the performance which based on a pre Covid19 operating model. For the majority of March, donor sessions operated at 2m distancing, and it is expected that the change to 1 m physical distancing from April will help improve this performance figure by increasing the number of donation chairs available at collection sessions.

- At 85% the performance against the 'Incidents closed within 30 days' measure has not met target (90%) for the three month r olling period to March. In this period the number of incidents not closed in the required timeframe increased from eight in t he previous reporting period to 24. Thirteen of these relate to clip failures at the end of the donation process leading to collection of an excess quantity of blood, reported as incidents in Datix and granular data has only just been made available. These incidents do not reflect harm to the Donor, or risk to patients, but the blood collected would be discarded as a manufacturing loss. Prior to the int roduction of Datix Once for Wales these were not recorded in Datix but were tracked through manufacturing losses. The current nu mber of reports remains within the normal variations and tolerances for blood donation. Reporting of these incidents will be removed to Q-Pulse to reflect the need to monitor trends without an investigation of each individual occurrence.

There were no Serious Adverse Events (SAE) reported to regulators during March.

- In March 2022, 7,415 donors were registered at donation clinics. Eight (8) concerns were reported and managed within the required timeline and 692 new donors completed a donation. Attending University venues has resulted in the increase in new donors whilst donor satisfaction continues to exceed target at 95.7%.

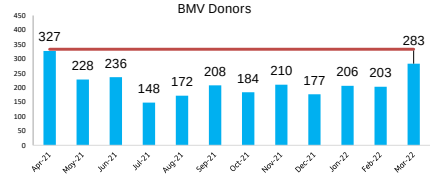
Reference Table

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

Equitable and Timely Access to Services

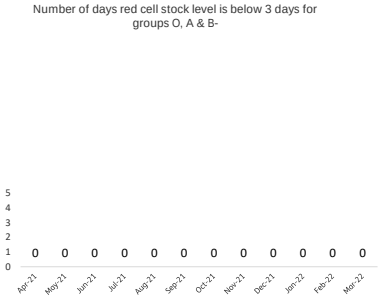
Mar-22



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) reached 283 in March compared to 203 the previous month. There were two University sessions in March which were attended by two Subject Matter Experts (SMEs) from the WBMDR to engage with potential donors. This resulted in a higher than average conversion rate for registrations of 17-30 year olds. This coupled with the registration of 21 SWAB donors contributed to the higher number of BMV registrations.	The Service is taking a two-pronged approach to improve the performance against this measure: 1.) promoting 'SWAB' kits and 2.) supporting the Service to increase the number of younger donors donating blood. The proposed action plan will focus on promotion at Universities and Colleges and on social media, as well as improving content and visibility of information on the WBS website.	Reviewed weekly

Safe and Reliable Service

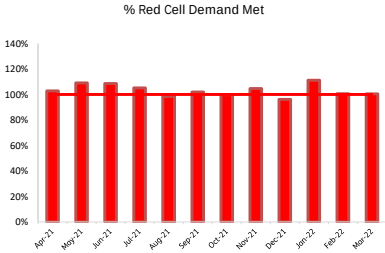
Mar-22



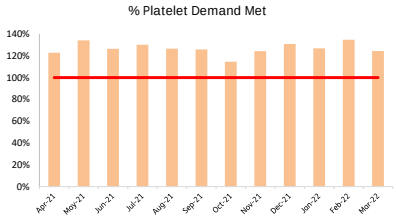
Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
O, A and B+ blood groups continue to be maintained above 3 days. Collections of blood from volunteers are sufficient to maintain stock levels above the 3 day target. This is core business and is reviewed on a daily basis at resilience meetings and any concerns are escalated via WBS Senior Management Team (SMT) leads for immediate action.	The Welsh Blood 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' and include the Collections, Manufacturing, Distribution and Blood Health teams. At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at each daily review. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages. On March 21st the Service issued a Blue Alert for blood group O to NHS Wales and indicated that this will be for a prolonged period. In addition regular Demand Planning meetings take place to consider the more strategic aspects of blood supply.	Business as Usual, reviewed daily

Safe and Reliable service

Mar-22



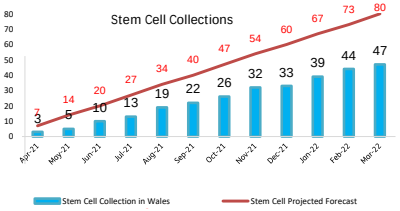
Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All hospital demand for red cells was met. Collections and Issues were effectively balanced meaning a steady stock position for March, and factors continuing to affect the supply chain include Covid restrictions and staff absence. Stock management is closely monitored and discussed at daily resilience meetings with immediate escalation to SMT if required. Demand in March (full weeks) averaged at 1423 units per week, in line with the year average. There was however a considerable weekly variance (1211 - 1632 units per week) 3 red cells were imported for a specific blood type (phenotype) not available at the Welsh Blood Service was requested and approved by Medical staff.	The Welsh Blood 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' and include the Collections, Manufacturing, Distribution and Blood Health teams. At the meetings business intelligence data is also reviewed and facilitates operational responses to the challenges identified at each daily review. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages. In addition regular Demand Planning meetings take place to consider the more strategic aspects of blood supply.	Business as Usual, reviewed daily



Safe and Reliable service

Mar-22

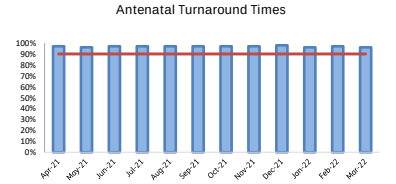
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All clinical demand for platelets was met. Platelets are produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, they provide the total number of units available each month. 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. For March 2022 platelet demand was 197 units per week on average. A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets.	The Ambient Overnight Hold (AONH) production process allows flexibility in the production plan for platelets. Adjustments on the weekly production continue to be made to align with demand.	Reviewed daily



Safe and Reliable service

Mar-22

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
The pandemic has impacted on unrelated donor stem cell transplants globally, which has resulted the number of stem cell collection requests. In addition the Service is experiencing a cancellation rate of around 30% compared to 15% pre COVID pandemic levels. This is due to patient fitness and the need for collection centres to 'work up' two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.	The move to Velindre Cancer Centre (VCC) has enabled WBS to offer more options for collections, moving to four day availability compared to two previously available at Nuffield. A five year strategy is being developed which will seek to enhance the Donor Panel and offer potential collaborations with other Donor registry partners.	30/06/2022



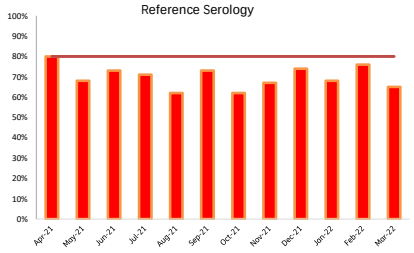
Safe and Reliable service

Mar-22

Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 96%, the turnaround time for routine Antenatal tests in March remains above the target of 90% Continued monitoring and active management remains in place.	Efficient and embedded testing systems are in place. Continuation of existing processes are maintaining high performance against current target.	Business as Usual, reviewed daily

Safe and Reliable service

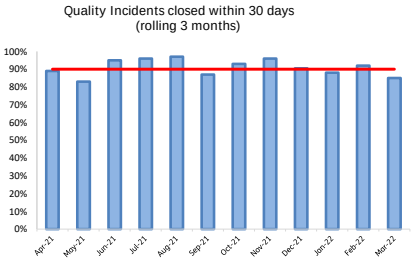
Mar-22



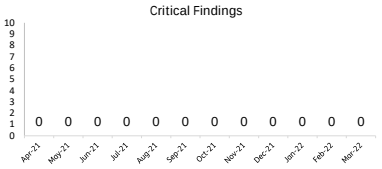
Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 65% turn around times for March were impacted significantly by key staff absences. The number of samples referred in March (272) was the highest number of referrals ever referred to RCI. Work continues to be prioritised based on clinical need, and all compatibility testing (>54% of referrals) is completed to the required time/date. Whilst the complexity of referrals continues to impact performance in March the more significant impact has been as a result of unavoidable staff absences. As previously stated, there were 272 hospital patient referrals in March, with the average number of Hospital Patient referrals at 226/month for 2021, compared to 181 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 and all Compatibility Testing (>52% of referrals) is completed to the required time/date. These requests are time critical and require provision of blood for transfusion, the tests are prioritised and patient care was not affected. There were 272 hospital patient referrals in March , with the average number of Hospital Patient referrals at 226/month for 2021, compared to 181 in 2020. Staffing pressures caused by COVID absence have delayed the validation the new automated analyser which will now begin in April. However the testing strategy for patient samples suitable for automated testing has been completed and the findings of the recent Out of Hours Referrals Audit are being reviewed for implementation. On 29/03/2022 the Service advised pathology services across Wales on service referral pressures, asking for out of hours cross matching referrals to be triaged. The service is preparing a paper for May 2022 regarding service pressures and will consider short and long term solutions for maintaining service delivery.	Quarter 1

Safe and Reliable service

Mar-22



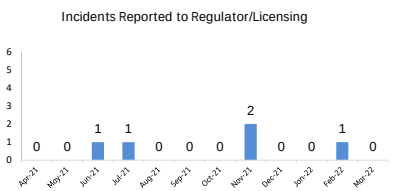
Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 85% the performance against this metric has not met target (90%) for the three month rolling period to March, with the number of incidents not closed in the required timeframe increasing from eight in the previous reporting period to 24 (8 QPulse and 16 Datix) All 8 QPulse incidents have been risk assessed and investigated. Four QPulse incidents remain open because they are awaiting completion of CAPA (the system does not permit closure of the incident until all CAPA has been completed). The remaining 4 incidents were closed late, and the reasons for late closure are currently being compiled. Of the 16 Datix incidents, 8 were closed in March but were late having exceeded the 31 day criteria requirement. Thirteen of these relate to clip failures at the end of the donation process leading to collection of an excess quantity of blood, reported as incidents in Datix and granular data has only just been made available. These incidents do not reflect harm to the Donor, or risk to patients, but the blood collected would be discarded as a manufacturing loss. Prior to the introduction of Datix Once for Wales these were not recorded in Datix but were tracked through manufacturing losses. The current number of reports remains within the normal variations and tolerances for blood donation. Reporting of these incidents will be removed to Q-Pulse to reflect the need to monitor trends without an investigation of each individual occurrence. There remaining 8 incidents open in Datix are either at the initial reporting stage (4) or remain under investigation (4). All 16 Datix incidents have exceeded the 31 day criteria requirement. The performance for incidents reported via QPulse is at 94% and 73% for Datix .	The revised process for managing low-impact incidents within QPulse was implemented on 1st June, new reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The QA team send weekly updates alerting owners of incidents recorded within QPulse that are likely to breach close-out deadlines. Datix User Access for QA Systems Triage team has been granted and allows visibility of progression of incidents through the system and any which are overdue for completion. Moving forward, close attention will be paid to the progression of these incidents and the QA triage team will run weekly reports to ensure early recognition of those requiring attention. Details regarding the specific incidents that need to be progressed shall be reported to the relevant managers and SMT Leads.	Continue with close monitoring and early recognition of potential timeline breaches.



Safe and Reliable service

Mar-22

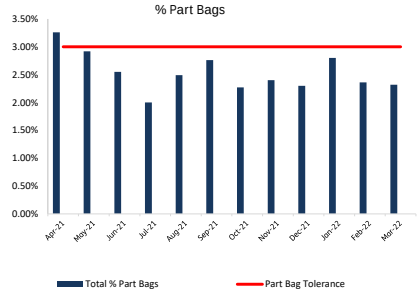
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There was one external audit undertaken in March. UKAS assessment of compliance of WASPS (Welsh Serological Proficiency Scheme) against ISO 17043. There were 7 mandatory findings and 2 recommendations.	The UKAS findings are being managed via an action plan and the formal response and submission of evidence (being actioned by Section leader, WASPS) is required by 17/04/2022. Actions from previous MHRA inspections are being managed as business as usual via action plans. One action remains open and is within the revised completion date (revised date has been accepted by MHRA)	SABRE 98 completed 11/03/2022



Safe and Reliable service

Mar-22

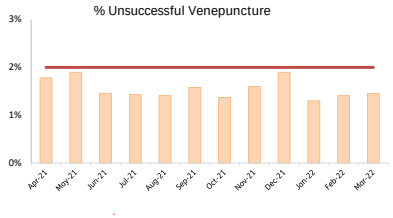
Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were no Serious Adverse Events (SAE) reported to regulators during March.	The confirmation report for SABRE 98 (raised and reported February 2022) was submitted to MHRA via the SABRE portal, within the required timescale, and a SHOT near-miss questionnaire was also completed. There are no further actions arising from this. Long-term preventive action for SABRE 98 is being managed and monitored via QPulse.	SABRE 98 completed 11/03/2022



Spending Every Pound Well

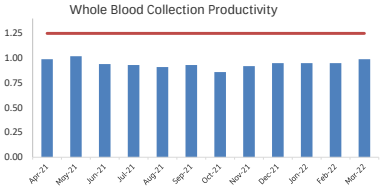
Mar-22

Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The combined 'Part Bag' rate remains within the required tolerance level at 2.32% in March 2022. The overall trend on all teams is stable with all teams being under tolerance except the Stock building team (3.4%) -but this associated with low numbers (2 events). East B and East C teams are both close to tolerance at 2.9%. Causes of Part Bag are various and include: needle placement, donor is unwell, donor request to stop donation, and equipment failure. This is a separate factor to FVPs.	Analysis of venepuncturist performance on East B and C teams will be undertaken to ensure no repeat venepuncturist issues. Operation Managers & the Training Team will be provided with the outcome of the analysis and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned.	Continued close monitoring and intervention where required



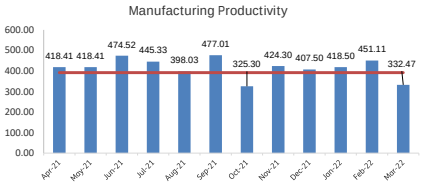
Spending Every Pound Well — Mar-22

Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The combined Failed Venepuncture (FVP) rate for all whole blood teams for March 2022 remains within the required tolerance at 1.45%. The only team to be over tolerance for this factor in March 2022 is Bangor team - but this is associated with low numbers. (2.4% - 9 FVP events). East A Team is at the threshold of tolerance (2.0% - 27 events).	A review of the Bangor and East A team venepuncturist performance will be undertaken to determine if there are any trends linked to individual venepuncturists. Operation Managers & the Training Team will be provided with the outcome of the analysis and should it be required further interventions (I.e. Individual Support Plans and or Additional Training /Supervision) can be actioned.	Continue with close monitoring and intervention where required



Spending Every Pound Well — Mar-22

Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 0.99, collection productivity for March has improved marginally. For the majority of March, donor sessions operated at 2m distancing with Covid and Infection Prevention Control (IPC) measures continuing to limit donation centre capacity. Clinics continue to operate on an appointment only basis, which disables the ability to backfill on the day 'non attendance' with walk in Donors. There are regional variations in productivity across collection teams, ranging from 0.68 in Bangor to 1.07 for one of the three East teams which warrant further investigation	A review of donation clinic social distancing (SD) has taken place that has resulted in a reduction of SD from 2metres to 1 metre from April 2022. This will enable an increase in appointment capacity, however this can only be realised if appropriately safe resourcing can be maintained to match increases in donor attendance. The Service is reviewing clinic practice, layout, processes and 'capacity to viable donation' data, to understand the regional productivity variation.	Quarter 1 2022

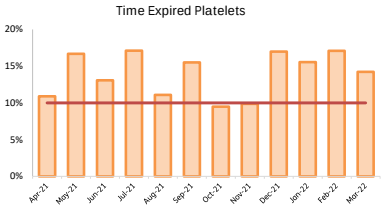


Spending Every Pound Well

Monthly Target 392	SMT Lead: Tracey Rees	
What are the reasons for performance?	Actions(s) bring taken to improve performance	By When
The lower Manufacturing Efficiency performance for March is attributed to staff returning from sickness and completing training. Manufacturing Efficiency is calculated by dividing working time available by the amount of work completed. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department..	This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured. This target is based on the Pre COVID operating model and is due to be reviewed as part of the review of this reporting framework.	Quarter 1 2022

Spending Every Pound Well

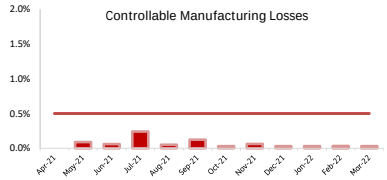
Mar-22



Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Platelet expiry was above target for March and a review of expiry against and demand production was undertaken. Average platelet issue for March was at 197 units per week and production at 215 units per week. On two occasions in March platelet production increased due to expected demand, leading to an excess of approx. 20 units per week. Planned platelet production does not include apheresis platelets donated for neonatal use. There were 91 units bled for neonatal use of which 5-6 would be used per week leading to an excess of approximately 60 units. Units not needed for neonatal use would enter general platelet supply.	Platelets are being produced by two different methods: Donor Apheresis and Manufactured Pools from whole blood. In combination, the methods provide the total number of units available each month. The introduction of Ambient Overnight Hold process for the manufacturing of blood components has increased flexibility in production of pooled platelets. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. Adjustments to the platelet manufacturing targets are made in the laboratory to better align with demand, and take into account the apheresis appointments and donor attendance. Although it should be noted that demand can fluctuate significantly on a daily basis. Given the variability of expired platelets over the past 12 months the Service is carrying out a review to look at improving wastage rates. NB: All demand continues to be met without the requirement to import routine stock.	Ongoing and reviewed daily

Spending Every Pound Well

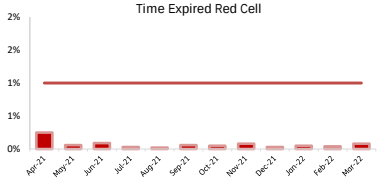
Mar-22



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 for March were extremely low at 0.03% and remain within tolerance to be below 0.5%. The losses were (units): M&D Operator - Operator : 1 unit M&D Operator - Packing : 1 unit 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

Spending Every Pound Well

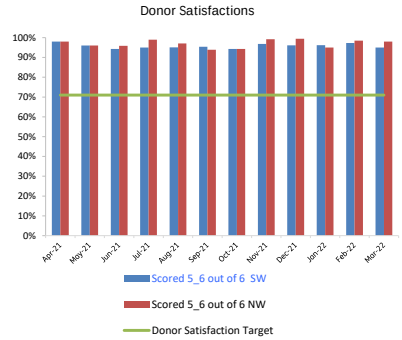
Mar-22



Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Red cell expiry for March remains negligible at 0.08% and significantly lower than the 1% target. The Covid 19 challenges continue to affect the blood collection numbers resulting in faster stock turnover preventing red cells stocks from ageing in storage. This metric is well within the target and there are no concerns around expiry of red cells.	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

First Class Donor Experience

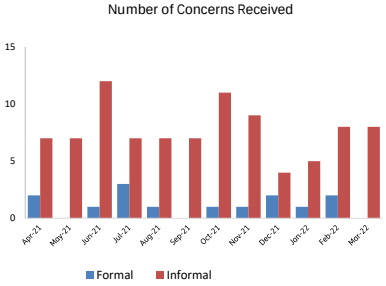
Mar-22



Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In March overall donor satisfaction continued to exceed target at 95.7%. In total there were 1,199 respondents, who had made a full donation and shared their donation experience (some of which are non attributable), 201 were from North Wales and 974 were from South Wales (where location was able to be defined).	Findings are reported to Management at Collections meeting to address any actions for individual teams.	Business as usual, reviewed monthly

First Class Donor Experience

Mar-22



Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In March 2022, 7,415 donors were registered at donation clinics. 8 concerns (0.11%) were reported within this period, all eight concerns were managed within timeline as 'Early Resolution' 1. 3 x donors raised concerns around staff attitude and behaviour: -Donor late for appointment -Donor unhappy felt venepuncturist was dismissive -Donor felt like he was being told off by staff member 2. 3 x donors raised concerns around the appointment system -2 x Donors unhappy session had been cancelled -1 x Donor unhappy last appointment had been taken whilst donor was on phone with call handler wanting to book appointment 3. A Donor raised concern around the amount of plastic/PPE being used on session 4. A Donor raised concern around being to help her son complete the Self Administered Health History (SAHH) questionnaire and social distancing measures whilst on clinic	Actions taken to address concerns: 1. Operation Managers have discussed each concern raised with Clinical Lead Registered Nurses (RN) and Supervisors to monitor and support staff members, with an action plan prepared to support staff if necessary. 2. Apologies and a full explanation have been provided to each donor regarding their concerns with the appointment booking system -2 x donors were unable to be informed of session cancellation prior attendance despite attempts to reach them. - The donor was offered alternative venue/date to donate 3. A full explanation was provided to the Donor upon Government guidelines for use and disposal of PPE in Health Care settings. The donor was also informed of the WBS work to reduce use of plastic, and of a trial at collections events on the use of biodegradable plastics and waste bags. The trial is due to end in April 2022. 4. The Clinic Lead Registered Nurse RN provided a full explanation of current guidelines for assisting donors to complete the SAHH questionnaire and explained required social distancing measures whilst attending collections sessions	Business as usual, reviewed daily

% Responses to Concerns closed within 30 Working Days

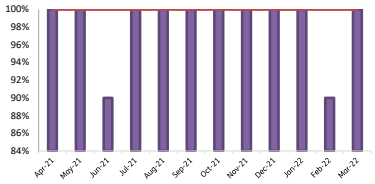
First Class Donor Experience

Mar-22

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
During March 2022 there were no formal concerns to report. * Under PTR, 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, reviewed daily

First Class Donor Experience

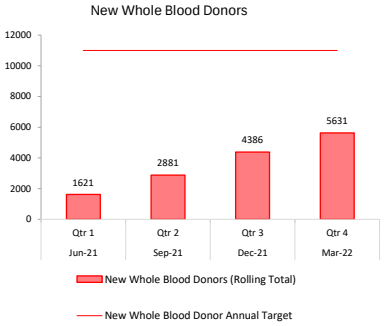
% Concerns Acknowledged within 2 Working Days



Mar-22

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Initial responses to all eight concerns in March 2022 were managed within timeline.	Continue to monitor this measure against the 'two working day' target compliance. Monitoring communications e-mail receiving concerns inbox made aware of the importance for such concerns being directly entered into Datix or passed through the usual concerns route to avoid delays in reporting and possible breach of timeline.	ongoing, reviewed daily

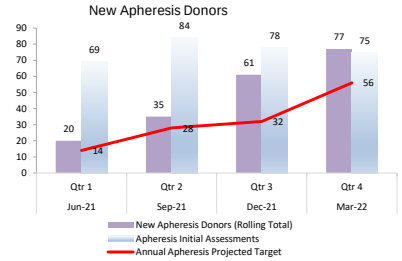
Quarterly Reporting



Equitable and Timely Access to Services

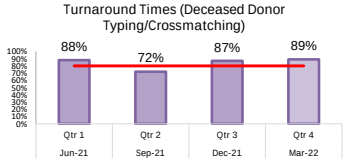
Mar-22

Quarterly Target: 2750. Annual 11000	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
692 new donors completed a donation in March, 10.0% of the total donations received in the month. Attending more University venue has resulted in the increase in new donors. During Covid-19, appointment slots have been reduced to match hospital demand. The reduction has resulted in fewer available opportunities for new donors to donate. The current demand for blood is being sustained despite the decrease in new donors. Appointment slots have reduced, resulting less available opportunities for new donors to donate. As new donors' blood type is unknown, reserving slots for new donors is not prudent as this will increase the number of unknown blood types bookings and decrease the efficiency of blood collection.	The ability to recruit new donors has also been complicated by the reduction of post-5pm donation slots, by the inability to use donation vehicles and the pause on the majority of venues with high numbers of new donors (e.g. Universities). The feasibility of reintroducing universities and school venues is continually reviewed. School venues (used prior to Covid 19) are now being contacted to reintroduce the sessions once schools return in Sept 2022. The next monthly review is due w/c 14 April 2022.	w/c 14 April 2022.



Mar-22

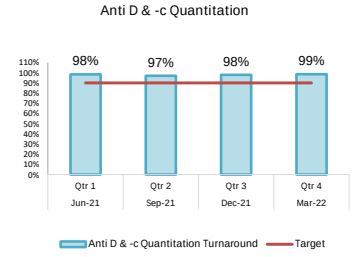
Quarterly Target: 14	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 8 new apheresis donors in March 2022, reaching 16 donors for the quarter and exceeding quarterly target of 14, and annual target of 56	Continue to recruit new apheresis donors.	N/A



Safe and Reliable service

Mar-22

Quarterly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Performance is above the target of 80%	Continue to monitor performance	30/06/2022



Safe and Reliable service

Mar-22

Quarterly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
data for March not yet available	Whilst continued monitoring and active management remains in place, application of the recently introduced British Society of Haematology guidelines has doubled the workload in the last two months. The service is preparing a paper for May 2022 regarding service pressures and will consider short and long term solutions for maintaining service delivery.	Quarter 1

Workforce Monthly Report

February 2022

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, PADR, Statutory and Mandatory training;
- Hotspots identified, with in month actions to explain improvement trajectory work. Hotspots defined as areas where KPIs are not met and there has been a downward trend over the last three months;
- In month Job Planning figures with narrative to notify areas of improvement;
- Usage of Work in Confidence platform.

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Feb-22	Jan-22	
PADR	69.75	69.21	85%
Sickness	5.76	5.73	3.54%
S&M Compliance	85.26	85.97	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	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Corporate	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69	46.58	44.59	45.64	44.08	50.33
Research, Development & Innovation	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67	72.09	90.91	88.37	84.09	80.00
Transforming Cancer Services	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25	43.75	62.50	75.00	63.16	57.89
Velindre Cancer Centre	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40	73.77	70.90	67.61	65.16	65.25
Welsh Blood Service	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93	77.52	82.19	83.06	83.73	81..75
Velindre Organisations	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67	71.69	72.11	70.83	69.21	69.75
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)	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Corporate	70.62	69.47	69.06	70.08	69.08	69.26	70.45	71.36	74.54	72.32	74.40	72.17	73.64
Research, Development & Innovation	82.50	83.73	82.59	83.08	85.69	86.00	85.80	86.25	84.89	84.58	85.83	84.26	80.42
Transforming Cancer Services	69.38	64.12	65.29	70.00	76.00	76.84	85.26	82.50	82.86	83.33	81.43	77.86	77.39
Velindre Cancer Centre	81.53	81.57	80.98	81.77	82.45	82.70	83.16	82.89	83.11	84.91	84.93	84.73	84.18
Welsh Blood Service	89.54	90.90	90.43	92.23	92.39	93.38	92.66	92.21	92.54	93.36	93.56	93.78	92.02
Velindre Organisations	83.06	83.39	82.92	84.09	84.59	84.97	85.24	84.95	85.10	86.06	86.40	85.97	85.26

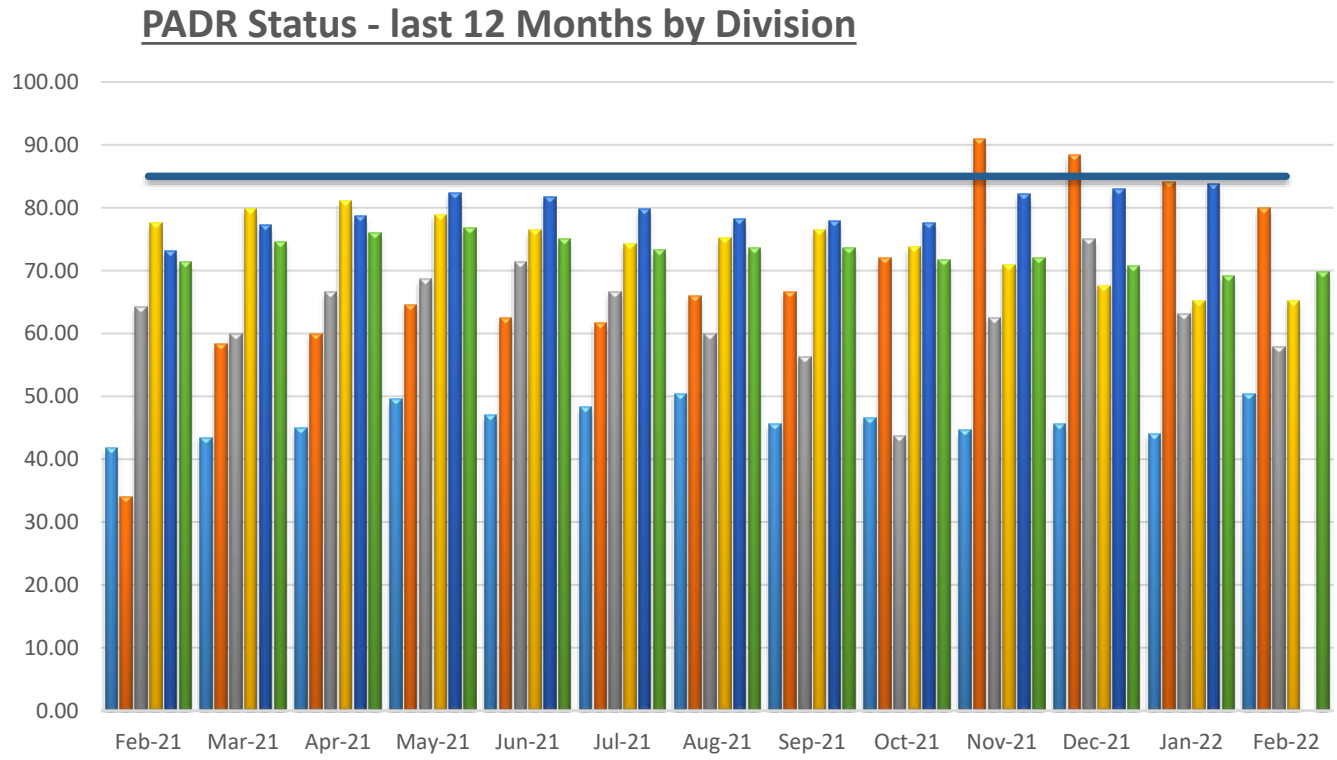
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Corporate	5.13	4.94	4.74	4.70	4.68	4.64	4.49	4.58	4.67	5.00	5.32	5.40	5.36
Research, Development & Innovation	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.96	4.29	4.41	4.31	4.49	4.72
Transforming Cancer Services	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.40	0.86	1.27	0.99	0.95	1.02
Velindre Cancer Centre	5.97	5.77	5.40	5.38	5.41	5.47	5.47	5.52	5.57	5.64	5.53	5.57	5.58
Welsh Blood Service	4.38	4.24	4.19	4.37	4.58	4.82	5.11	5.42	5.72	5.99	6.27	6.45	6.52
Velindre Organisations	5.29	5.11	4.85	4.87	4.94	5.05	5.13	5.28	5.43	5.59	5.64	5.73	5.76
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%		0.01% - 0.49%		0.50 % & Above								
Sickness Leave Covid Related	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Corporate	0.60	0.68	0.69	0.78	0.88	0.99	1.16	1.34	1.46	1.56	1.64	1.70	1.70
Research, Development & Innovation	0.46	0.42	0.35	0.44	0.45	0.45	0.43	0.43	0.43	0.42	0.37	0.40	0.39
Transforming Cancer Services	0.26	0.21	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	1.44	1.31	0.96	0.89	0.86	0.87	0.88	0.84	0.86	0.83	0.72	0.79	0.87
Welsh Blood Service	0.44	0.39	0.31	0.29	0.28	0.29	0.29	0.36	0.39	0.38	0.36	0.39	0.41
Velindre Organisations	1.00	0.92	0.70	0.67	0.66	0.67	0.69	0.71	0.75	0.74	0.68	0.74	0.79

Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Non Covid Related	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Corporate	0.23	0.17	0.11	0.05	0.04	0.06	0.05	0.03	0.09	0.09	0.09	0.09	0.09
Research, Development & Innovation	0.65	0.50	0.46	0.42	0.51	0.60	0.74	0.92	1.08	1.26	1.38	1.54	1.55
Transforming Cancer Services	0.51	0.51	0.51	0.51	0.51	0.53	0.56	0.55	0.54	0.40	0.24	0.07	0.07
Velindre Cancer Centre	0.43	0.43	0.41	0.41	0.42	0.44	0.47	0.49	0.54	0.57	0.62	0.66	0.65
Welsh Blood Service	0.61	0.62	0.58	0.59	0.58	0.60	0.61	0.63	0.65	0.64	0.62	0.60	0.58
Velindre Organisations	0.48	0.47	0.44	0.43	0.44	0.46	0.49	0.51	0.55	0.57	0.59	0.60	0.59

Monthly Special Leave Absence Rolling %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Covid Related	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Corporate	0.57	0.48	0.32	0.25	0.18	0.11	0.03	0.01	0.00	0.00	0.00	0.00	0.00
Research, Development & Innovation	1.95	1.45	1.04	0.76	0.49	0.21	0.13	0.13	0.15	0.10	0.15	0.23	0.23
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	2.36	2.09	1.67	1.35	1.09	0.91	0.80	0.79	0.80	0.73	0.74	0.82	0.88
Welsh Blood Service	1.75	1.65	1.33	1.06	0.83	0.68	0.62	0.67	0.68	0.68	0.65	0.63	0.61
Velindre Organisations	1.96	1.75	1.39	1.12	0.89	0.73	0.64	0.64	0.65	0.61	0.61	0.64	0.67

PADR – The Figures



	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Corporate	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69	46.58	44.59	45.64	44.08	50.33
Research, Development & Innovation	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67	72.09	90.91	88.37	84.09	80.00
Transforming Cancer Services	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25	43.75	62.50	75.00	63.16	57.89
Velindre Cancer Centre	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40	73.77	70.90	67.61	65.16	65.25
Welsh Blood Service	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93	77.52	82.19	83.06	83.73	0.00
Velindre Organisations	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67	71.69	72.11	70.83	69.21	69.75
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

PADR – The Narrative

Performance Indicator	RAG / change from previous month	December Figure	Hotspot Areas	%	Comment to include reasons for change / rates high or low
PADR Compliance (85%)	**69.75%** ↑	69.21%	**Welsh Blood Service (81.75%)**		
			Directors	25%	Decrease from previous month (50%)
			General	65.52%	Decrease from previous month (85.71%)
			Clinical Services	68.18%	No change from previous month (68.18%)
			Velindre Cancer Centre (65.25%)		
			Medical Staffing	49.09%	Increase on previous month 47.27% however, it must be noted that the 'approved missed appraisal' status continues until April 2022 for all medical staff.
			Radiotherapy	47.96%	Increase from previous month 44.44%. Significant workforce challenges over absence, recruitment and turnover currently impacting radiotherapy KPI's.
			Cancer Services Management Office	53.85%	Targeted interventions have improved figures from 34.48%
			Corporate Areas (69.15%)		
			Clinical Governance	22.5%	Significant increase from previous month (12.50%)
			Fundraising	14.29%	Inability to complete due to long-term sickness and complex ER cases ongoing in the department.
			WOD	58.82%	Significant increase from previous month (26.32%). Due to significant turnover within the department and appointment of new employees in the past 12 months. Action plan in place to complete by March 2022 (this will be available for May EMB report).
Action/initiatives:					

Velindre University NHS Trust

The WOD operational team has a number of vacancies (in progress of being filled) which has meant monthly 1-2-1's on compliance has dipped across the Trust, however it is anticipated that number will improve as the team returns to regular 1-2-1's with service leads.

Welsh Blood Service

Overall slight decrease this month in PADR compliance. Compliance rates slightly decreased but still high overall compliance. Some work to do in the hotspot areas.

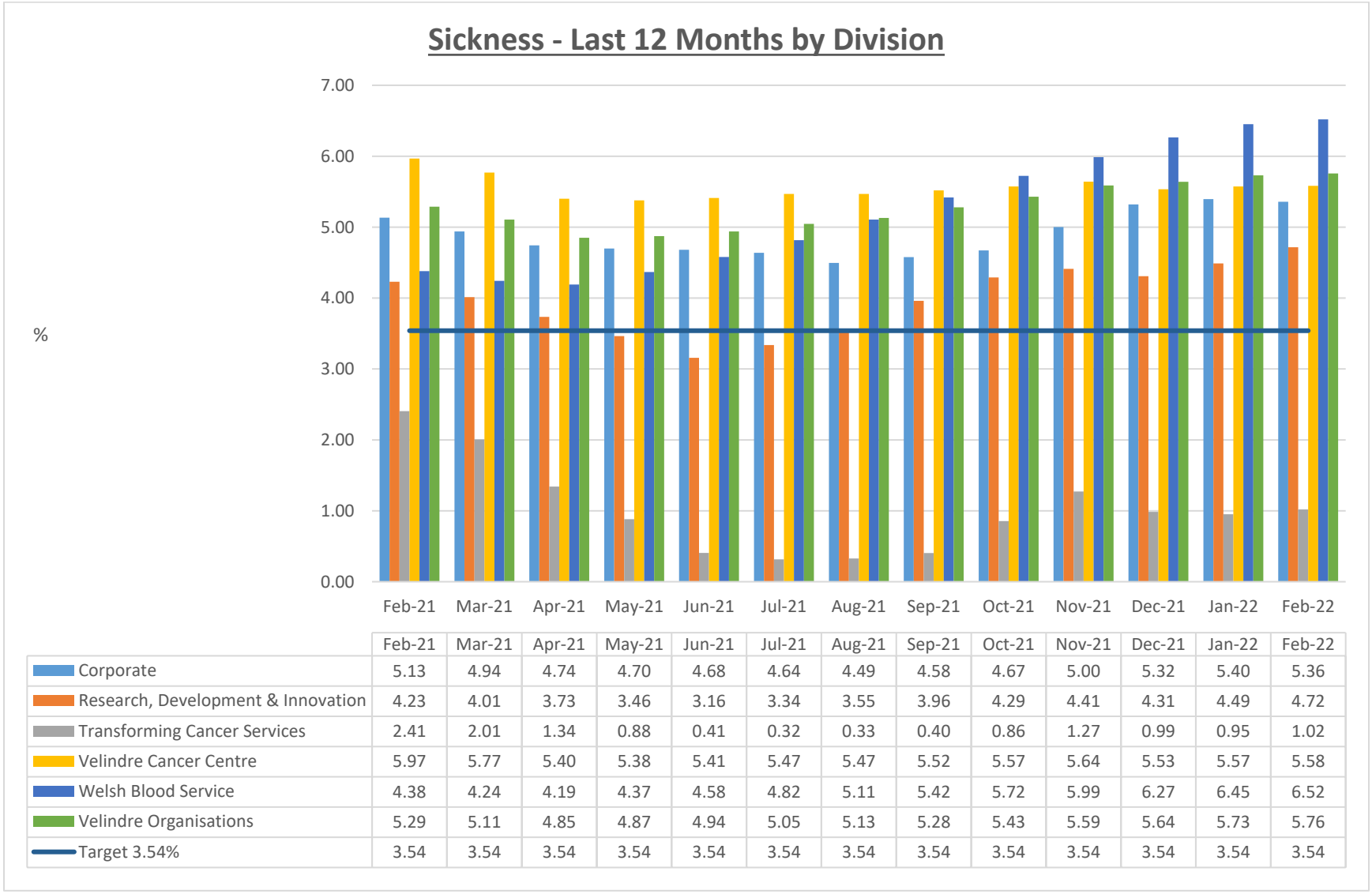
VCC

WOD Business Partner for VCC has worked closely at targeting hotspot areas, and KPI's have improved where this work is able to be supported. The continuation of VCC deep dive and planning of key WOD concerns will continue to improve these figures over the coming months.

Corporate Areas (including RD&T, HTW & TCS)

WOD Business Partner for corporate services has worked closely at targeting hotspot areas, and increases seen in areas where this work is able to be supported. This targeted intervention will continue in March and April.

Sickness Data – The Figures



	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Corporate	5.13	4.94	4.74	4.70	4.68	4.64	4.49	4.58	4.67	5.00	5.32	5.40	5.36
Research, Development & Innovation	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.96	4.29	4.41	4.31	4.49	4.72
Transforming Cancer Services	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.40	0.86	1.27	0.99	0.95	1.02
Velindre Cancer Centre	5.97	5.77	5.40	5.38	5.41	5.47	5.47	5.52	5.57	5.64	5.53	5.57	5.58
Welsh Blood Service	4.38	4.24	4.19	4.37	4.58	4.82	5.11	5.42	5.72	5.99	6.27	6.45	6.52
Velindre Organisations	5.29	5.11	4.85	4.87	4.94	5.05	5.13	5.28	5.43	5.59	5.64	5.73	5.76
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	August Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Sickness absence (3.42%)	**5.76%** ↑	5.73%	**Welsh Blood Service (5.72%)**		
			Collection Services	8.5%	Same as previous month
			Laboratory Services	7.31%	Same as previous month
			Quality Assurance	9.02%	Same as previous month
			Velindre Cancer Centre (5.81%)		
			Nuclear Medicine	7.77%	Decrease from previous month 11.66%. As a small team 1 absence can cause significant rise in absence %
			Outpatients	20%	Significant increase from previous month 13.71% with no identified reason for increase. WOD to provide targeted support to managers in March and April.
			Operational Services	9.31%	Increase from previous month's 8.44%. WOD to provide targeted support to managers in March and April.
			Corporate Areas (5.4%)		
			Corporate Management Section	8.29%	Increase from previous month 7.44%
			Fundraising	27.24%	Increase from previous month 16.3%. Continued targeted intervention from WOD for management facilitate returns alongside management of complex WOD cases.
Action/ initiatives: **<u>Velindre University NHS Trust</u>**					

The WOD department sent a Wellbeing letter to all staff at the end of February, to remind colleagues of the wellbeing support we offer as a Trust and to offer thanks and recognition for everyone's effort during the pandemic. This message has been regarded as well-received and appreciated by staff.

An all Wales working group to review the Managing Attendance at Work policy is underway and WOD have representatives to ensure the policy remains fit for managers and staff during the course of this review. The senior BP's are supporting this interaction by feeding back divisions concerns or improvements.

WBS

Long-term sickness absence has decreased in February to 3.31%, short term sickness absence has marginally increased to 2.41%. There is a continuing downward trend for long-term sickness absence it is tracking 1% higher than compared with a year ago. The decrease in long-term sickness absences can be attributed to some cases reaching the final absence management stage or being managed out of the business.

Stress Related absence continues to be the highest reason for absence at 30.4% of all absences over the last 12 months, followed again by back problems at a fairly static figure of 8.4%.

VCC

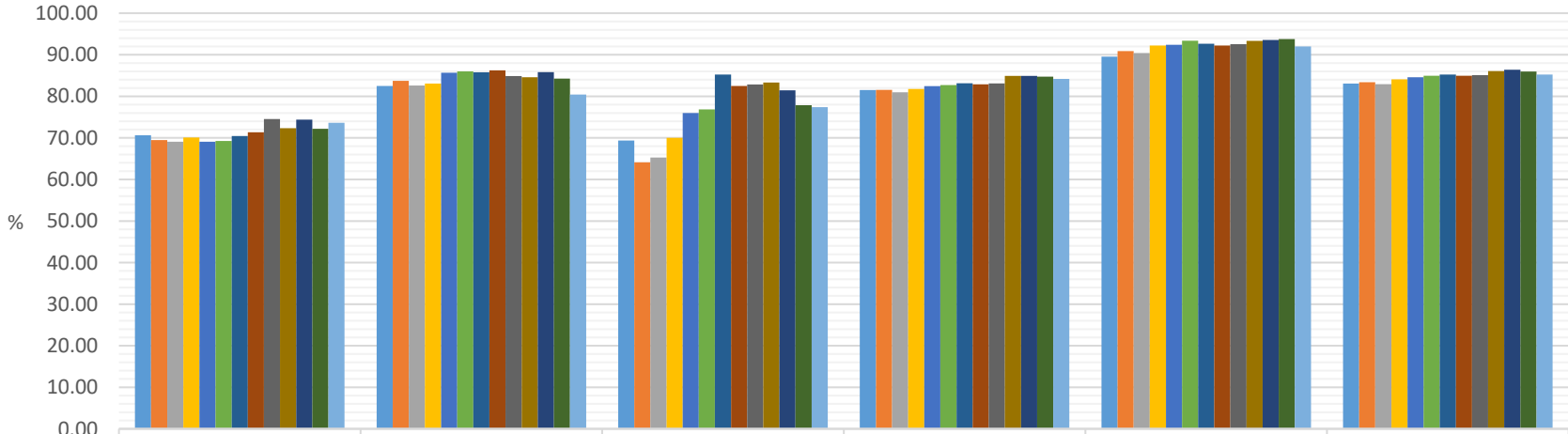
Short-term sickness is 2.42% (decrease from last month) and long-term sickness absence is at 3.40% (increase from last month).

WOD senior BP to support SLT in understanding underlying concerns and attributes for these figures through the ongoing VCC deep dives.

Corporate Areas (including RD&T, HTW & TCS)

A significant rise in absence from previous month report of 3.39% has occurred however on analysis of figures it appears not all absence information has been inputted into ESR and therefore the corrected figure for January 2022 is 5.18% for Corporate Services.

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Feb-21	70.62	82.50	69.38	81.53	89.54	83.06
Mar-21	69.47	83.73	64.12	81.57	90.90	83.39
Apr-21	69.06	82.59	65.29	80.98	90.43	82.92
May-21	70.08	83.08	70.00	81.77	92.23	84.09
Jun-21	69.08	85.69	76.00	82.45	92.39	84.59
Jul-21	69.26	86.00	76.84	82.70	93.38	84.97
Aug-21	70.45	85.80	85.26	83.16	92.66	85.24
Sep-21	71.36	86.25	82.50	82.89	92.21	84.95
Oct-21	74.54	84.89	82.86	83.11	92.54	85.10
Nov-21	72.32	84.58	83.33	84.91	93.36	86.06
Dec-21	74.40	85.83	81.43	84.93	93.56	86.40
Jan-22	72.17	84.26	77.86	84.73	93.78	85.97
Feb-22	73.64	80.42	77.39	84.18	92.02	85.26

Statutory and Mandatory Figures – The Narrative

Performance Indicator	RAG/ Change from previous month	August Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Stat & Mand Training (85%)	**85.26%** ↓	86.40%	**Welsh Blood Service (92.25%)**		
			All areas above 90% compliance		
			Velindre Cancer Centre (84.18%)		
			Palliative/Chronic Pain	55.42%	Decrease on previous month 61.30%
			Medical Staffing	54.92%	Decrease on previous month 60.76%
			Cancer Services Management Office	74.83%	Continued slight increase month on month. Previous month 74.70%
			Corporate Areas (85.26%)		
			Significant improvement in Stat. and Mandatory training made in all areas of Corporate services bringing compliance back within target from 72.84% in January.		

Action/ initiatives:

<u>Velindre University NHS Trust</u>

Statutory and Mandatory compliance has reported over target for 5 consecutive months within the Trust despite the restrictions on face to face training. Through the COVID pandemic the education and training department have worked on the virtual offering and continue to develop this alongside divisions.

<u>WBS</u>

To continue to maintain target compliance across WBS.

VCC

Stat and Mandatory training has dipped within VCC with no identified reason for these changes. The WOD senior BP has escalated to SLT in February's divisional performance report for consideration of next steps.

Corporate Areas (including RD&T, HTW & TCS)

Appointment of WOD senior BP has helped support targeted interventions in Corporate Services and the plan is to continue this support to maintain compliance.

Job Planning Figures – VCC & WBS combined

Combined

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	63	25	39.68%	13	20.63%	25	39.68%
Medical Director	2	0	0.00%	0	0.00%	2	100.00%
Specialty Doctor	13	12	92.31%	0	0.00%	1	7.69%
Grand Total	**78**	**37**	**47.44%**	**13**	**16.67%**	**28**	**35.90%**

NB

Data on the job plans associated with other 'medical' posts within the Trust have not been included in the above; this is due to the relatively small numbers involved and therefore the immediately identifiable nature of this information.

Narrative

Job plans continue to increase across the Trust (up from 35.90% in January and 20.78% in December) as the process continues to be rolled out with the support of the Medical Directorate at VCC. These figures are expected to continue to rise over the coming months.

The implementation of the new SAS contract has also improved the specialty doctor job plans as these roles develop and are utalised under the new contract.

Work In Confidence (WIC)

No detail has been provided this month in terms of the number of staff who have accessed the WIC platform, or categorisation of the type of conversations that have taken place; this is primarily the result of low usage of the platform over the last month and therefore the potential to identify those who have made contact.

In all contacts with staff, staff are encouraged, where appropriate, to share their concerns with their Line Manager (or next appropriate Manager), in order to achieve an early, informal resolution. The WOD Team have also been previously involved in facilitating discussions between the Manager and member of staff.

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31 MARCH 2022 (M12)

DATE OF MEETING	26 May 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris, Financial Planning & Reporting Manager
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**
Quality, Safety & Performance Committee	12.05.2022	NOTED

ACRONYMS	
IMTP	Integrated Medium Term Plan
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of March 2022.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £000	Total Actual 2021-22 £000
Revenue	Variance	23	28
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	6,020	12,426
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	90.7%	94.3%

2.2 Revenue Budget

The overall position against the profiled revenue budget for 2021-22 was an underspend of **£28k**, with a large pay underspend due to the Trust carrying a large number of vacancies being throughout the year, which offset a non-pay overspend and underachievement on income.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid.

Cost pressures which surfaced during the year, were in line with normal budgetary control procedures, and were managed by budget holders to ensure the delegated expenditure control limits were not exceeded for 2021-22.

The Trust overachieved against the savings target during 2021-22 which is due to increased vacancy factor which was above the target that was held within the divisions.

All Covid related expenditure requirement was funded by WG during 2021-22

2.3 PSPP Performance

PSSP performance for the whole Trust was 95.7% against a target of 95%, however the performance against the Core Trust excluding NWSSP fell just short at 94.3%.

PSPP compliance levels had significantly recovered following a temporary dip in performance, however since December performance levels have again fallen. Following investigation, it appears to be largely the result of reduced levels of receipting on orders which is most likely due to the high levels of sickness which currently being experienced throughout the Trust. Finance have been working with service colleagues to put measures in place to help rectify this issue.

The finance teams continue to work with the service and NWSSP colleagues with a view to improve performance on the core Trust during 2022-23.

2.4 Covid Expenditure

Covid-19 Revenue Spend/ Funding			
	Total Actual 2021/22 £000	Total Funding Received £000	Variance to Funding allocated £000
Mass & Booster Covid Vaccination	392	392	0
Cleaning Standards	831	769	62
PPE	195	226	(31)
Covid Recovery	3,098	3,479	(381)
Other Covid Related Spend & Cost Reduction	1,624	1,274	350
BFWD Savings Loss	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	0
Annual Leave Provision & Sell Back Scheme	332	187	145
SDEC Emergency Care Funding	77	77	0
Total Covid Spend /Funding Requirement 2021/22	**7,166**	**7,021**	**145**

The overall gross funding requirement related to Covid for 2021-22 was £7,021k which included £6,217k of directly associated expenditure or cost reduction, £700k in relation to the non-achievement of savings carried forward from 2020/21, the return of surplus NHS bonus payment £(83)k, and the costs associated with the Annual leave sell back scheme £187k.The £145k annual leave provision was met through the Trust savings plans and additional vacancy factor.

2.5 Reserves

The financial strategy for 2021-22 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 522k.

2.5.1 Recurrent Reserves (budget unallocated):

The unspent recurrent reserve balance of £766k will be carried forward for utilisation during 2022-23 against previously agreed commitments.

2.6 Financial Risks

All operational financial risks that emerged during the year were mitigated within the overall Trust budget for 2021-22.

2.7 Capital

a) All Wales Programme

The total cumulative spend on the All-Wales Capital Programme schemes was £10,525k for 2021-22. As previously highlighted, there were several challenges last financial year which was a combination of procurement capacity constraints, the impact of the pandemic on supplier lead times, and current market conditions where costs have significantly increased. All this resulted in movement and variances being reported in actual spend against approved funding against some of the all Wales schemes, however following discussions with WG this was managed across the whole of the All Wales Programme to ensure that the CEL was achieved for 2021-22.

The Trust discretionary actual spend for 2021-22 was £1,901k against an approved CEL of £1,911k leaving a balance of £10k on the overall Capital Programme.

Other Major Schemes in development that will be considered during the remainder of 2021/22 and in 2022/23 in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, VCC Ventilation & Infrastructure/ Outpatients, and WBS Plasma fractionation (for medicines).

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 reported a financial position of **£28k** for 2021-22 which is in line with the IMTP

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the contents of the March financial report and in particular the financial performance for 2021-22.

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 MARCH 2021/22

TRUST BOARD
26/05/2022

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 2021-22.

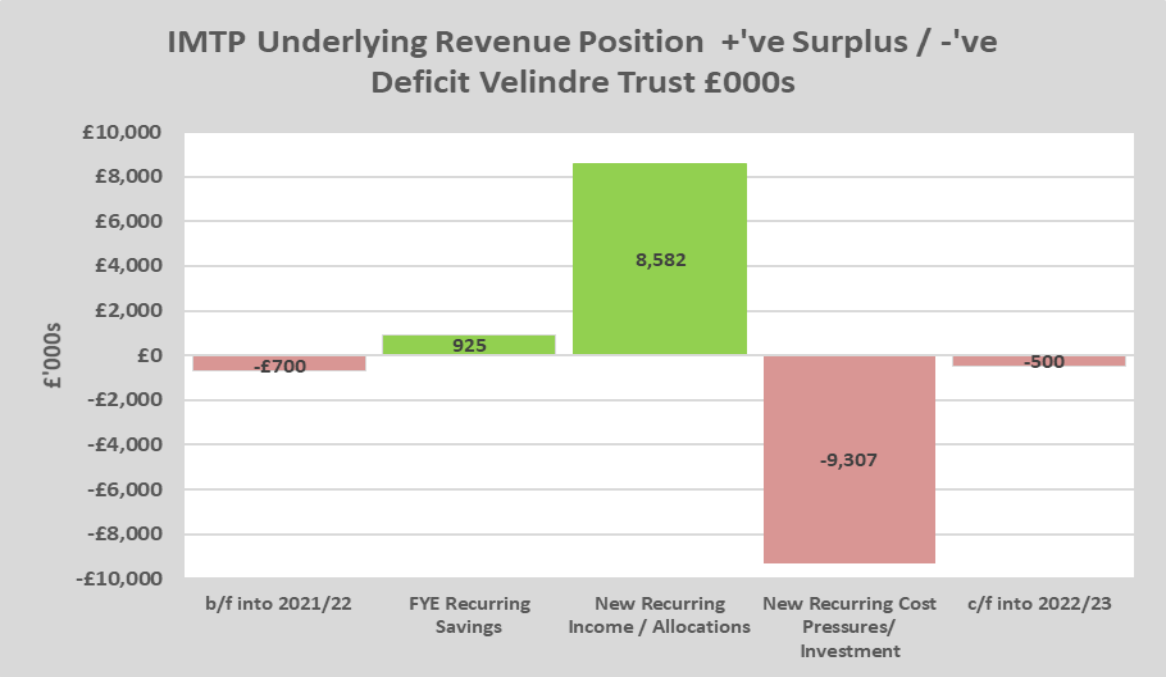
2. Background / Context

The Trust Financial Plan for 2021-22 was set within the following context.

- The Trust submitted a balanced one-year financial plan, covering the period 2021-22 to Welsh Government on the 30 June 2021.

- For 2021-22 the Plan (excl Covid) included;
  - an underlying **deficit of -£700k brought forward from 2020-21,**
  - FYE **of new cost pressures / Investment** of **-£9,307k,**
  - offset by **new recurring Income** of **£8,582k,**
  - and Recurring FYE **savings schemes** of **£925k.**

- Due to the ongoing pandemic and the inability to fully enact savings schemes & cost reduction, the Trust is not expecting to be able to fully eliminate the underlying deficit during 2021-22, however in line with the submitted financial plan the Trust will be aiming to reduce the deficit by £200k to carry forward an underlying position of £500k into 2022-23.
- **To reduce the underlying deficit, the savings target set for 2021-22 must be achieved.**



Underlying Position +Deficit/(-Surplus) £000s	b/f into 2021/22	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2022/23
Velindre NHS Trust	- 700	925	8,582	- 9,307	- 500

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 £000	Total Actual 2021-22 £000
Revenue	Variance	23	28
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	6,020	12,426
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	90.7%	94.3%

Performance against Planned Savings Target

Efficiency / Savings	Variance	0	145

Revenue

The Trust reported a **£23k** in-month underspend position for March '22, with a cumulative final position for the core Trust of **28k** underspent for 2021-22.

Capital

The final approved Capital Expenditure Limit (CEL) for 2021-22 was £12,436k. This represented all Wales Capital allocation funding of £10,525k, and Discretionary funding of £1,911k**.** The Trust reported a total capital spend of **£12,426k** for 2021-22 leaving a remaining balance of **£10k**.

PSPP

During March '22 the Trust (core) achieved a compliance level of **90.7%** (February 22: 93.7%) of Non-NHS supplier invoices paid within the 30-day target, which gave a cumulative core Trust compliance figure of **94.3 %** for 2021-22, and a final total Trust position (including hosted) of **95.7%** compared to the target of 95%.

Since December the PSPP compliance levels in have experienced a dip in performance which is following recovery being produced in the previous quarter. Urgent measures are being put in place to improve performance which has been significantly impacted by the ongoing pandemic and reduced levels of receipting on orders which is due to the high levels of sickness which currently being experienced in the Trust. The finance teams continues to work with the service and NWSSP colleagues with a view to improve performance on the core Trust during 2022-23.

Efficiency / Savings

The Trust overachieved against the savings target during 2021-22 which is due to increased vacancy factor which is above the target that is held within the divisions.

Revenue Position

2021/22 Financial Position			
£27,695 Underspent			
Type	**Full Year Budget (£'000)**	**Full Year Actual (£'000)**	**Full Year Variance (£'000)**
Income	(172,310)	(171,622)	(688)
Pay	76,945	75,592	1,353
Non Pay	95,365	96,003	(637)
Total	**(0)**	**(28)**	28

The overall final position against the profiled revenue budget for 2021-22 was an underspend of **£28k.**

4.1 Revenue Position Key Issues

Income Key Issues

- Income underachievement for 2021-22 largely related to activity being lower than planned on Bone Marrow and Plasma Sales in WBS which resulted in income loss above Covid support received during the period.
- Income underperformance was partly offset within VCC via an increase in VAT savings from providing additional SACT Homecare, and over performance of Private Patient income.

Pay Key Issues

The Trust has reported a final year end underspend of **£1,353k** on Pay for 2021-22.

Significant vacancies carried throughout the year resulted in a large underspend being reported against Pay.

The total Trust vacancies as at 31st March 2022 is 144wte, VCC (79wte), WBS (37wte), Corporate (1wte), R&D (19wte), TCS (1wte) and HTW (7wte).

The WTE by pay category is provided within the table below:

Pay WTE By Category			
Pay Type	WTE Budget	WTE Actual	WTE Variance
ADD PROF SCIENTIFIC AND TECHNICAL	58.40	51.20	(7.20)
ADDITIONAL CLINICAL SERVICES	257.04	233.83	(23.21)
ADMINISTRATIVE & CLERICAL	535.63	491.64	(43.99)
ALLIED HEALTH PROFESSIONALS	136.21	126.31	(9.90)
ESTATES AND ANCILLIARY	64.81	65.52	0.71
HEALTHCARE SCIENTISTS	165.26	155.51	(9.75)
MEDICAL AND DENTAL	99.49	68.94	(30.55)
NURSING AND MIDWIFERY REGISTERED	226.02	204.94	(21.08)
STUDENTS	2.47	2.93	0.46
Total Pay by Category	**1,545.33**	**1,400.82**	**(144.51)**

Non Pay Key Issues

The Trust reported a **£(637)k** overspend on Non-Pay for 2021-22.

- Large underspend experienced in WBS due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services.
- Release in year of dilapidations provision on Wrexham and Bangor sites due to new accounting treatment and introduction of IFRS 16.
- There are underspends on general drugs in VCC from reduced activity and temporary closure of outreach clinics.
- Other underspends within VCC includes release of accountancy measures, and unallocated reserves to fund overall position.
- Overspends in VCC on facilities management, canteen refurbishment and other site improvements, along with a rise in both consumable cost and usage.
- Printing / Stationary & Postage underspend across Trust due to a reduction in office-based activity and paper-based communications given the increased homeworking. A proportion of this underspend is anticipated to be permanent and will be taken as recurrent saving once the Trust has agreed the operating model of future working arrangements.
- The increase in energy prices has resulted in an overspend being reported against utility budgets. The exceptional cost pressures which include energy prices have been included within the Trust IMTP with reassurance form WG that these costs will be funded.
- Significant pressure on the Estates function to maintain and improve Trust sites especially within VCC.
- Divisional Savings targets met through additional Vacancy factor within Pay.

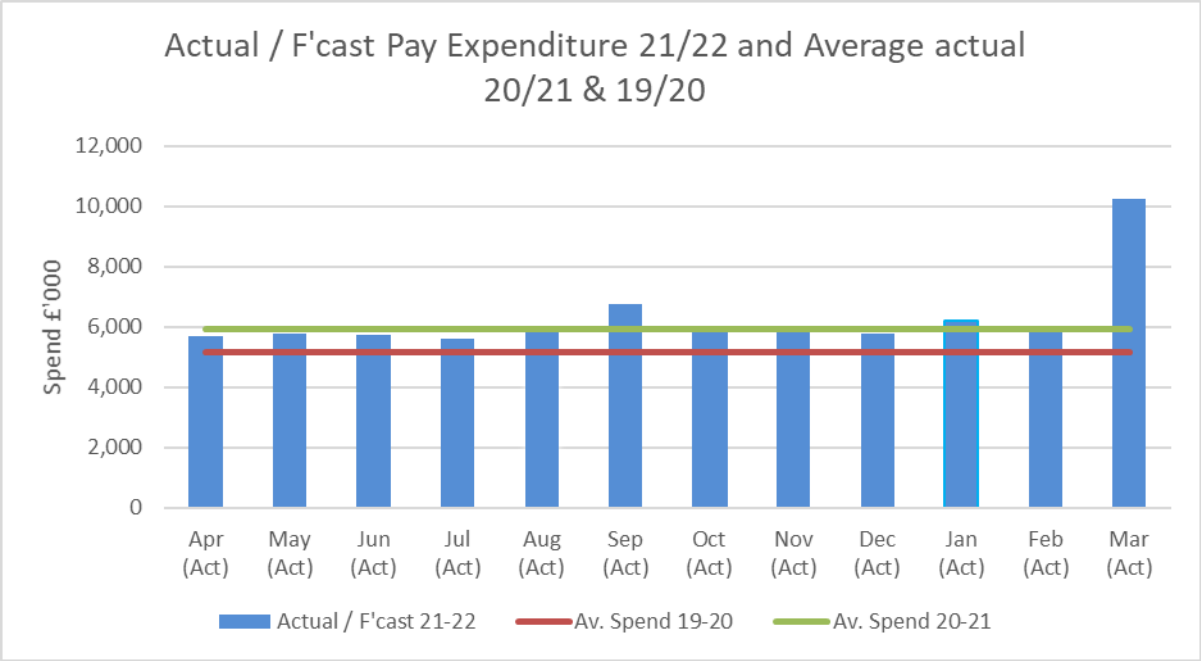
Further details on performance against Income, Pay and Non-Pay is provided within the Divisional analysis later in the paper.

4.2 Pay Spend Trends (Run Rate)

The pay spend for 2020/21 was 14.82% above av. pay in 2019-20. 3% was accounted for by the pay award, 1.14% can be accounted for by an increase in use of agency, 2.3% related to the NHS Bonus Payment with the remaining being the additional staff recruited over the course of 2020/21 (c. 126 wte), and the pay costs associated with Covid.

Staff received the 2021/22 pay award of 3% and arrears dated back to April 2021 in their September pay. Excluding the Pay award, spend is still increased throughout the year with the

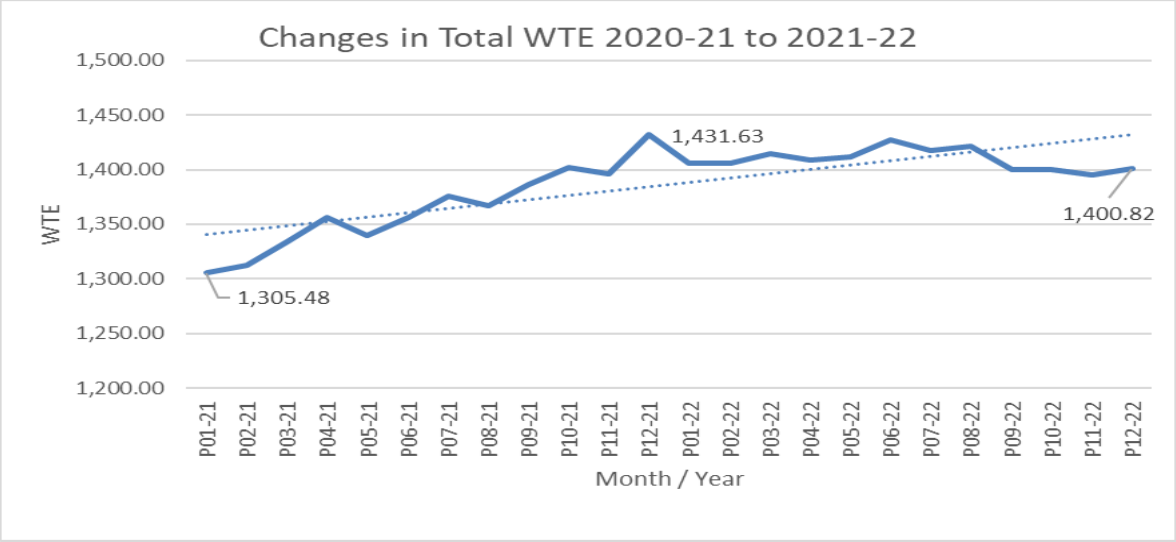
recruitment of additional posts to meet 'surge' capacity in both VCC and WBS which is in response to Covid recovery. Whilst the plan was to reduce agency costs within the Trust Core staffing structure, due to the difficulty being experienced in recruitment, the agency staff replaced with substantive recruits will now be utilised as part of the Covid recovery.



*Sep costs include Pay Award (3%) backdated to April.

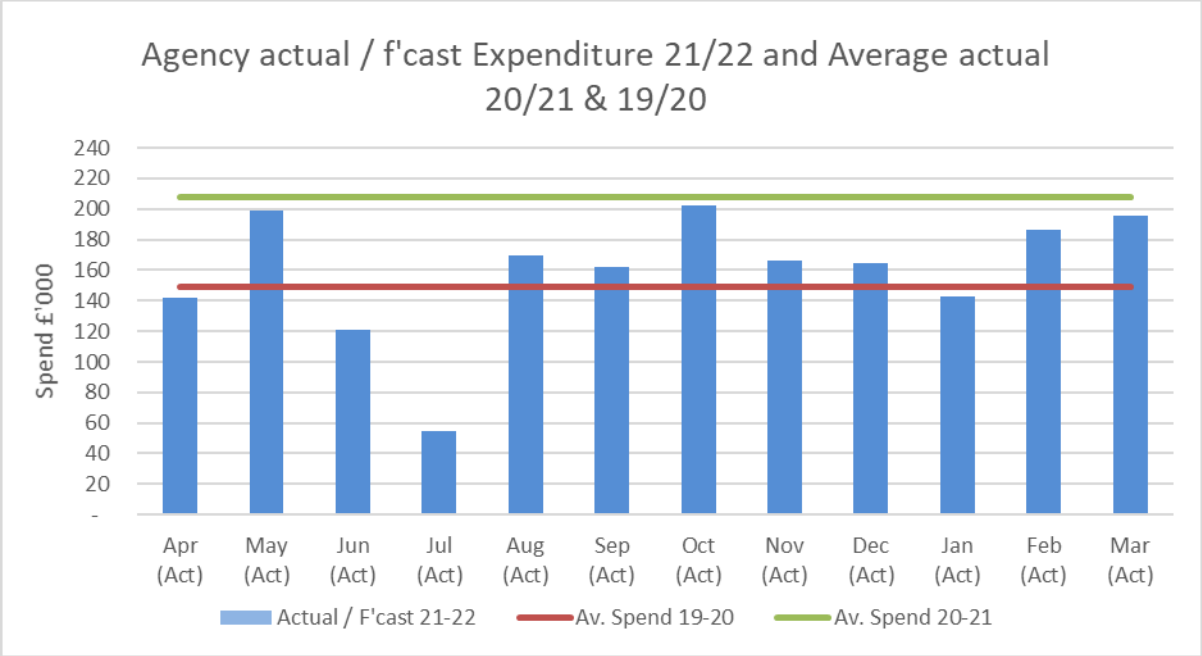
*During January Staff who were on bands 1-5 received a 1% non consolidated pay award.

*March pay includes the 6.3% notional pension award funded via WG. and annual leave sell back and carry forward provision.



* Reduction in WTE since March 21 is largely due to ceasing of the Patient Vaccination programme.

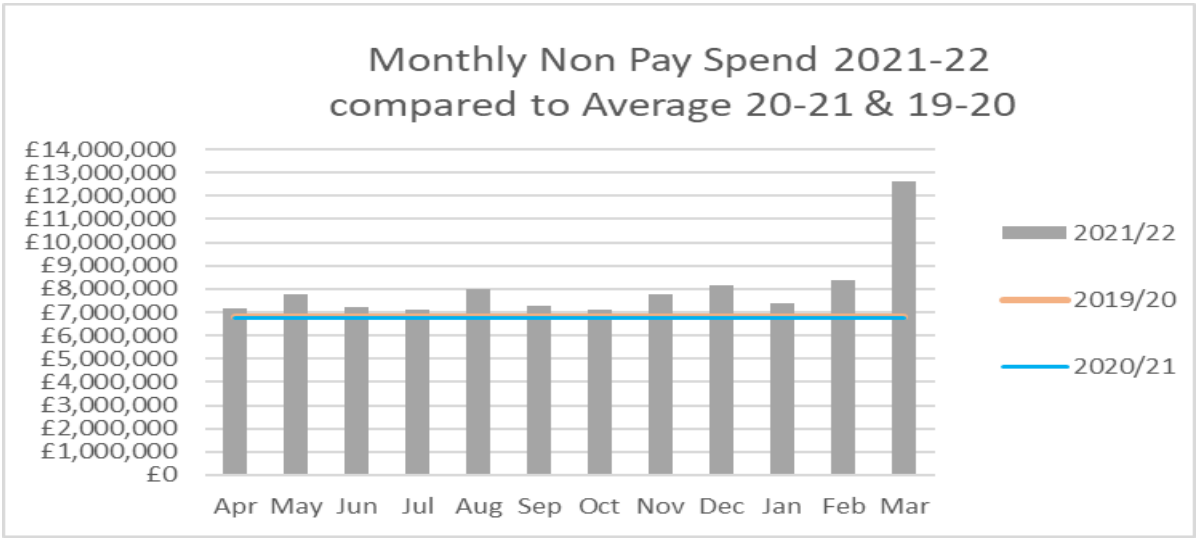
The spend on agency for March was £196k (February £186k), which gives a cumulative total for the year of **£1,906k.** Of these totals the year to date spend on agency directly relating to Covid was **£826k.**



*The increase in May costs has been reviewed and corrected in July following a full review of agency invoices received against orders raised within VCC.

4.3 Non Pay

Non-pay 20/21 (c£81.2m) av. monthly spend remained static between 19/20 and 20/21 at £6.8m. The average monthly spend for 21-22 is was £1,200k (15.4%) more than 20/21, which is largely due to the increase NICE / High-Cost drug usage following the recovery and surge related to Covid along with the surge on Blood wholesaling which is demand led.



*March spend includes £2m additional drug spend about annual average, £0.7m of WBS blood wholesaling which is demand led, bad debt provision £0.3m, along with spend on investment decisions previously agreed.

4.4 Covid-19

Covid-19 Revenue Spend/ Funding			
	Total Actual 2021/22 £000	Total Funding Received £000	Variance to Funding allocated £000
Mass & Booster Covid Vaccination	392	392	0
Cleaning Standards	831	769	62
PPE	195	226	(31)
Covid Recovery	3,098	3,479	(381)
Other Covid Related Spend & Cost Reduction	1,624	1,274	350
BFWD Savings Loss	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	0
Annual Leave Provision & Sell Back Scheme	332	187	145
SDEC Emergency Care Funding	77	77	0
Total Covid Spend /Funding Requirement 2021/22	**7,166**	**7,021**	**145**

All Covid related expenditure requirement was funded by WG during 2021-22

Covid recovery funding in agreement with WG was flexibly managed with Covid response requirements, whilst delivering the capacity intended by the funding. This maintained the overall funding envelope though recovery has been re-categorised to £3,098k via a reduction in outsourcing.

The Trust received £187k from WG which related to the annual leave sell back scheme, with the remaining £145k provision for untaken leave being managed through the overall Trust position through increased vacancies above the vacancy factor target.

The Trust received £4.5m of Covid funding to support the Hospices during 2021/22. Following discussions with WG and Audit at the last financial year end it was agreed that the Trust should not include the Hospice income and expenditure within the Velindre accounts, and therefore they have also been excluded for reporting purposes from the Trust Financial ledger and the tables above. Following a recent request from WG the figures were included within the Trust monthly financial monitoring returns and the total Covid funding envelope.

Vaccinations

The Trust is spent £392k on the Covid Mass & Booster Vaccination programme during 2021/22. The £392k revenue spend requirement largely related to the WBS storage and distribution for NHS Wales (£297k), delivery of vaccinations to front line staff in both Velindre and WAST, and the rollout of the Patient Vaccination programme (£63k), with the balance being spent against the booster programme (£32k).

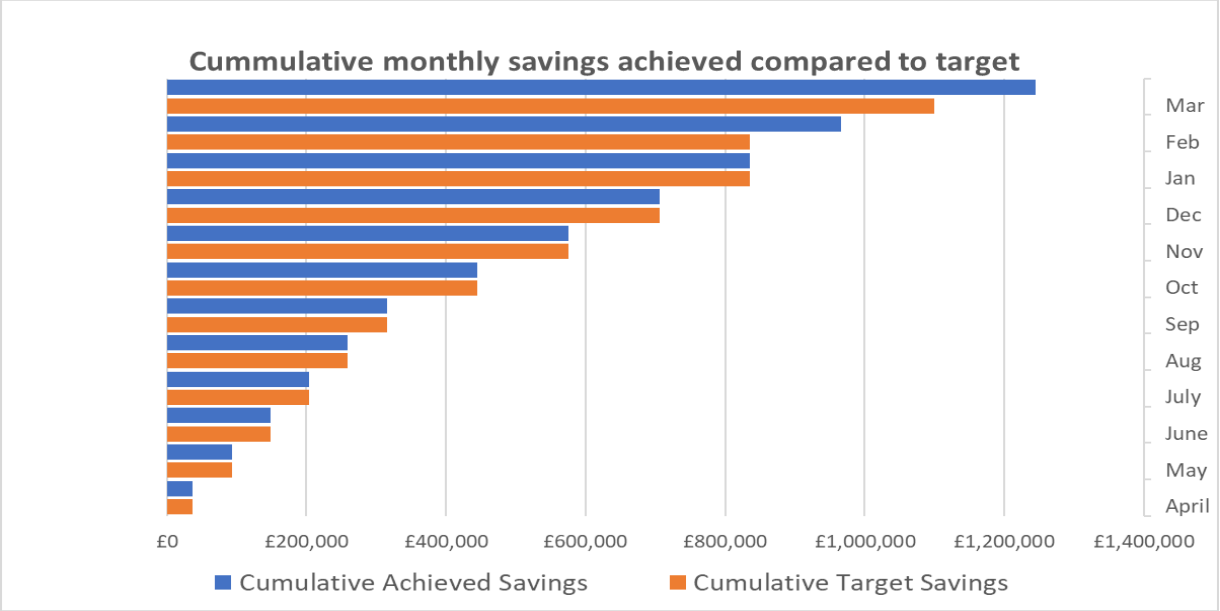
4. Savings

The Trust established as part of the IMTP a savings requirement of £1,100k for 2021-22, £525k recurrent (£925k full year recurrent) and £575k non-recurrent, with £1,050k being categorised as actual saving schemes and £50k being income generating schemes.

The 'Post Covid' Savings of £90k are not reflected in the tables below as they were netted of against Covid Spend during 2021-22, with agreement from WG that the income cannot be drawn down whilst still in the pandemic. The Trust is expected to realise the benefit of these savings post Covid following the new ways of working such as reduced Travel expenses and office consumable spend. These savings were replaced with non-recurrent vacancy factor during 2021-22, which realised a benefit of £145k above the planned target. This was utilised against the annual leave provision which will be carried into 2022/23.

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	**413**	**300**	**300**	**0**	**300**	**(113)**
			100%		**73%**	
WBS TOTAL SAVINGS	**368**	**300**	**300**	**0**	**300**	**(68)**
			100%		**82%**	
CORPORATE TOTAL SAVINGS	**119**	**100**	**100**	**0**	**100**	**(19)**
			100%		**100%**	
TRUST TOTAL SAVINGS IDENTIFIED	**900**	**700**	**700**	**0**	**700**	**(200)**
TRUST ADDITIONAL NON-RECURRENT SAVINGS	**200**	**400**	**545**	**145**	**545**	**345**
TRUST TOTAL SAVINGS	**1,100**	**1,100**	**1,245**	**145**	**1,245**	**145**
			113%		**113%**	

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							
Premium of Agency Staffing	Green	150	150	150	0	150	0
Premium of Agency Staffing	Green	100	100	100	0	100	0
Post Covid Savings (VCC)	Red	113	0	0	0	0	(113)
Blood Supply Chain 2020	Green	75	75	75	0	75	0
Blood Supply Chain 2020	Green	25	25	25	0	25	0
Stock Management	Green	200	200	200	0	200	0
Post Covid Savings (WBS)	Red	68	0	0	0	0	(68)
Establishment Control	Green	100	100	100	0	100	0
Post Covid Savings (Corporate)	Red	19	0	0	0	0	(19)
Total Saving Schemes		**850**	650	650	0	650	(200)
Income Generation							
Maximinsing Income Opportunities	Green	50	50	50	0	50	0
Total Income Generation		**50**	50	50	0	50	0
TRUST ADDITIONAL NON-RECURRENT SAVINGS - VACANY FACTOR		**200**	**400**	**545**	**145**	**545**	**345**
TRUST TOTAL SAVINGS		**1,100**	**1,100**	**1,245**	**145**	**1,245**	**145**
				113%		**113%**	



5. Reserves

The financial strategy for 2021-22 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 522k.

The unspent recurrent reserve balance of £766k will be carried forward for utilisation during 2022/23 against previously agreed commitments.

6. End of Year Forecast / Risk Assessment

All operational financial risks that emerged during the year were mitigated within the overall Trust budget for 2021-22.

7. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme			
VCC - Transforming Cancer Services	3,711	3,673	38
NVCC - Enabling Works	1,786	1,786	0
VCC Radiotherapy Procurement Solution	312	312	0
IT - WPAS (CANISC replacement phase 2)	993	1,056	(63)
Fire Safety	600	559	41
National Programmes - Decarbonisation	109	111	(2)
National Programmes - Imaging	1,020	1,003	17
Covid Recovery	675	699	(24)
DHCW - NDR Funding	350	350	0
DHCW - VCC Careflow	60	60	0
HTW Capital	5	5	0
Linc ETR Funding	25	24	1
Additional DPIF Capital Allocations	41	41	0
End of Year Capital		0	
Multileaf Collimator (MLC) Motor Replacements	120	164	(44)
(CDR) function within the WBS.	83	82	1
Patient Specific Quality Assurance (PSQA) Phantom	100	62	38
Digital IT Client tech refresh	450	450	0
Digital Server Infrastructure Tech refresh	85	89	(4)
Total All Wales Capital Programme	10,525	10,525	(0)
Discretionary Capital	1,911	1,901	10
Total	12,436	12,426	10

The approved Capital Expenditure Limit (CEL) for 2021-22 was £12,436k. This includes All Wales Capital allocation funding of £10,525k, and discretionary funding of £1,911k.

The Trust previously received confirmation of £675k funding from WG towards Capital related Covid recovery. This was used to support additional donor chairs in WBS, urgent ventilation work, and increased capacity in VCC such as improvements to the outpatient area and Bobarth building.

In addition, following a communication from WG of the availability of additional end of year capital monies, the Trust was successful in receiving £838k of funding against the £1,396k of schemes it submitted. The request was based on prioritised divisional bids as provided for in the table above.

Yearend performance

The total spend on the All-Wales Capital Programme schemes was £10,525k. As previously highlighted, there were several challenges last financial year which was a combination of procurement capacity constraints, the impact of the pandemic on supplier lead times, and current market conditions where costs have significantly increased. All this resulted in movement and variances being reported in actual spend against approved funding against some of the all Wales

schemes, however following discussions with WG this was manged across the whole of the All Wales Programme to ensure that the CEL was achieved for 2021-22.

The Trust discretionary actual spend for 2021-22 was £1,901k against an approved CEL of £1,911k leaving a balance of £10k on the overall Capital programme.

Major Schemes in Development

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

Other 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 £'000	23/24 £'000	24/25 £'000	25/26 £'000
1	VCC Outpatients	1,250	Feasibility & design study currently being undertaken although unlikely to gain WG funding to supprt during 2022/23	625	625		
2	WBS HQ	22,500	PBD approved by WG OBC end of February. FBC to be developed 22/23	550	8,854	6,810	3,143
3	Ventilation	2,490	BJC to be submitted (paused during pandemic)		1,868	623	
4	IRS	37,929	OBC & PBC approved by WG, FBC under development (Phasing of costs under review)	8,953	8,033	22,832	7,103
5	Plasma Fractionation	TBC	Feasibility study to be developed				

*Cash flow of these schemes is still under review in conjunction with WG.

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.

The Trust formally removed DHCW from the Trust SoFP during 2021-22, following the transfer of assets and liabilities which took place on the 31 December 2021.

The SoFP is based at a point in time with the Trust submitting draft accounts to WG on the 29th April so is subject to change.

Non-Current Assets

The balance on PPE and intangible assets will move up and down depended on the agreed purchases from the Trust Capital programme (including hosted), offset against the depreciation charges on owned assets.

Trade debtors and receivables will move up and down each month depending on timing of when invoices are raised and consequently paid by organisations.

Current Assets

Discussions between WG and NWSSP have agreed that additional stock to BAU still needs to be maintained. Therefore, cash that is still held for stock held in relation to both Covid and Brexit will be repaid during the next financial year.

The balance on receivables will move up and down each month depending on the timing of when invoices are raised, and when the cash is physically received from debtors. The Trust actively chases its debts to ensure prompt payment.

Current Liabilities & Non-Current Liabilities

Liabilities will move up and down each month depending on timing of when commitments are made, and invoices are received and paid.

Taxpayers Equity

The movement on PDC and revaluation reserves relates to the transfer of Capital assets relating to DHCW.

	Opening Balance Beginning of Apr 20	Closing Balance End of Mar-22	Movement from 1st April Mar-22
Non-Current Assets	**£'000**	**£'000**	**£'000**
Property, plant and equipment	136,558	143,999	7,441
Intangible assets	20,821	7,803	(13,018)
Trade and other receivables	817,142	1,087,814	270,672
Other financial assets	0	0	0
Non-Current Assets sub total	974,521	1,239,616	265,095
Current Assets			
Inventories	95,564	65,208	(30,356)
Trade and other receivables	548,836	501,352	(47,484)
Other financial assets	0	0	0
Cash and cash equivalents	43,263	30,388	(12,875)
Non-current assets classified as held for sale	0	0	0
Current Assets sub total	687,663	596,948	(90,715)
TOTAL ASSETS	1,662,184	1,836,564	174,380
Current Liabilities			
Trade and other payables	(353,136)	(240,722)	112,414
Borrowings	(8)	0	8
Other financial liabilities	0	0	0
Provisions	(316,959)	(347,664)	(30,705)
Current Liabilities sub total	(670,103)	(588,386)	81,717
NET ASSETS LESS CURRENT LIABILITIES	992,081	1,248,178	256,097
Non-Current Liabilities			
Trade and other payables	(7,301)	0	7,301
Borrowings	0	0	0
Other financial liabilities	0	0	0
Provisions	(818,782)	(1,088,795)	(270,013)
Non-Current Liabilities sub total	(826,083)	(1,088,795)	(262,712)
TOTAL ASSETS EMPLOYED	165,998	159,383	(6,615)
FINANCED BY: **Taxpayers' Equity**			
General Fund	0	0	0
Revaluation reserve	27,978	30,934	2,956
PDC	122,468	112,983	(9,485)
Retained earnings	15,552	15,466	(86)
Other reserve	0		0
Total Taxpayers' Equity	165,998	159,383	(6,615)

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.

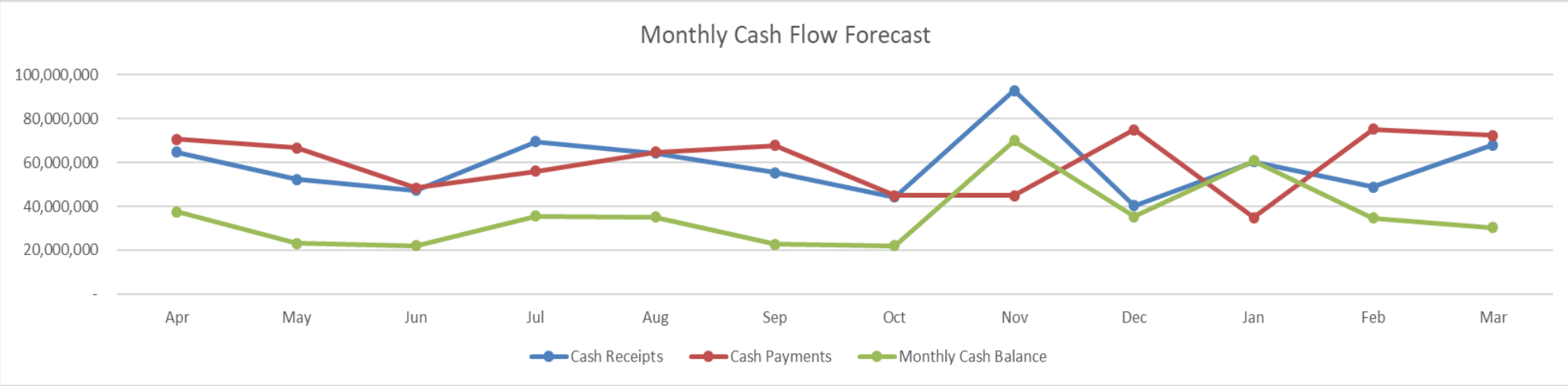
As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

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 will continue to hold most of this stock until next financial year. NWSSP are continuing to liaise with WG regarding the level of Brexit with the repayment of the additional cash which is now being carried forward into 2022/23

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been higher than usual, however there has been a significant reduction in the balance for the period with the cash balance of £30,388k being held on the 31st March.

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

		Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Totals £'000
	RECEIPTS													
1	LHB / WHSSC income	23,348	22,492	30,672	34,078	32,225	28,886	33,252	33,603	30,431	31,820	36,331	33,074	370,212
2	WG Income	33,807	26,132	11,582	30,431	27,512	21,398	6,388	56,520	693	26,150	2,964	5,204	248,781
3	Short Term Loans													0
4	PDC												27,872	27,872
5	Interest Receivable										3	6	6	15
6	Sale of Assets											31	41	72
7	Other	7,643	3,682	4,973	5,006	4,613	5,004	4,673	2,719	9,139	2,454	9,591	1,925	61,422
8	TOTAL RECEIPTS	**64,797**	**52,306**	**47,227**	**69,515**	**64,350**	**55,288**	**44,314**	**92,842**	**40,263**	**60,427**	**48,923**	**68,122**	**708,374**
	PAYMENTS													
9	Salaries and Wages	15,189	22,734	22,015	20,181	19,284	24,383	25,582	24,544	25,089	25,614	25,419	28,288	278,322
10	Non pay items	52,989	43,749	25,742	35,377	45,158	42,830	18,755	19,768	49,260	7,089	48,336	27,124	416,178
11	Short Term Loan Repayment												9,486	9,486
12	PDC Repayment													0
14	Capital Payment	2,375	277	540	453	225	623	631	499	612	2,181	1,386	7,462	17,264
15	Other items													0
16	TOTAL PAYMENTS	**70,552**	**66,760**	**48,297**	**56,011**	**64,667**	**67,836**	**44,968**	**44,811**	**74,961**	**34,884**	**75,141**	**72,360**	**721,249**
17	Net cash inflow/outflow	(5,755)	(14,454)	(1,070)	13,504	(317)	(12,548)	(655)	48,031	(34,698)	25,543	(26,218)	(4,238)	
18	Balance b/f	43,263	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	35,301	60,844	34,626	
19	Balance c/f	37,508	23,054	21,984	35,488	35,171	22,623	21,968	69,999	35,301	60,844	34,626	30,388	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	Full Year Budget £000	Full Year Actual £000	Closing Variance £000
VCC	37,247	37,247	0
RD&I	(118)	(118)	(0)
WBS	20,816	20,816	0
Sub-Total Divisions	**57,944**	**57,944**	**0**
Corporate Services Directorates	9,086	9,075	12
Delegated Budget Position	**67,031**	**67,019**	**12**
TCS	669	658	11
Health Technology Wales	(2)	(7)	5
Trust Position	**67,698**	**67,669**	**28**

VCC

	Full Year Budget £000	Full Year Actual £000	Closing Variance £000
Income	**63,953**	**64,047**	**94**
Expenditure			
Staff	42,127	41,602	525
Non Staff	59,072	59,692	(620)
Sub Total	**101,199**	**101,294**	**(94)**
Total	**37,247**	**37,247**	**0**

VCC Key Issues:

The reported final financial position for the Velindre Cancer Centre during 2021-22 was **breakeven.**

Income for 2021-22 represented an overachievement of **£94k**. This is largely from an increase in VAT savings from providing additional SACT Homecare, an over achievement on private patient income due to drug performance, which is above general private patient performance, additional funding for senior medical non-surgical workforce, increased income against the Radiation protection SLA, and reimbursement of WRP income for Quantum's. This is offsetting the divisional savings target, and the closure of gift shop and volunteer's office in response to Covid.

VCC reported an underspend on staff of **£525k** for 2021-22. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly in Nurse Management, Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting the premium cost of agency (£1,404k to end of March) although £729k is directly related to Covid and funded via WG. Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures. 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. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.

Non-Staff Expenditure reported a total overspend of **£(620)k** for 2021-22. There are underspends on general drugs from reduced activity and temporary closure of outreach clinics, Nuclear medicine warranty savings, along with cost avoidance generated from closure of gift shop and volunteer's office. Other underspends in VCC includes release of accountancy measures, and unallocated reserves to fund overall position. This is in part offsetting the increased spend on consumables within the Division, expenditure on facilities management such as the canteen refurbishment and other site improvements, the legal costs associated with clinical negligence and personal injury, along with reporting fees and oncotype in Senior Medical. The increase in price for utilities is starting to have an impact and is expected to be significant next year, which is being factored into the Trust IMTP, with reassurance from WG that income will be provided to support the increase in energy prices.

WBS

	Full Year Budget £000	Full Year Actual £000	Closing Variance £000
Income	**23,106**	**22,319**	**(787)**
Expenditure			
Staff	17,201	16,747	454
Non Staff	26,721	26,387	333
Sub Total	**43,922**	**43,134**	**787**
Total	**20,816**	**20,816**	**0**

WBS Key Issues:

The reported final financial position for the Welsh Blood Service during 2021-22 was **breakeven.**

Income underachievement to date is **£(787)k**, where activity is lower than planned on Bone Marrow and Plasma Sales, due to freezer breakdown and Covid suppressed activity. Plasma sales recovery to business-as-usual levels following hire of freezers, although this has not occurred as anticipated with only partial recovery taken place since December. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in income loss above Covid support, with assessments as to scale and sustainability strategy still ongoing.

Staff reported an underspend of **£454k** for 2021-22, which is above the division's vacancy factor target. Vacancies remain high at 37 as at end of march. Long standing vacancies in donor contact centre and transport have now been recruited, resulting in reduced vacancy factor. Plasma fractionation staffing costs were supported by division during 2021/22. Component development staffing costs incurred as a divisional cost pressure with no WHSSC funding secured.

Trust approval to appoint a 4th collection team in response to NHS Wales surge capacity and meeting blood demand commenced on 6th September 2021 and continues. These costs were met by WG during 2021-22.

Potential risks due to implications of cessation of CVP Funding where WG initial funding ended 31st March 2021, PYE funding was agreed for 21-22, tenure of RN posts significant as appointed on permanent contracts. SMT approval to partially mitigate the financial risk by transferring CVP permanent posts into team vacancies (where available). This practice is continuing with additional substantive Band 3 posts becoming vacant that has been agreed though Scrutiny to utilise to de-risk the staff group appointed permanently and award to CCA FTC staff to minimise the training required, FTC staff to be recruited to substantive vacancies.

Non-Staff underspend of **£333k** is largely due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services such as building maintenance and MAK business systems, which is offsetting overspends on utilities, licenses and the Divisions savings target.

Corporate

	Full Year Budget £000	Full Year Actual £000	Closing Variance £000
Income	**4,789**	**4,942**	**153**
Expenditure			
Staff	13,145	12,887	258
Non Staff	730	1,130	(400)
Sub Total	**13,876**	**14,017**	**(142)**
Total	**9,086**	**9,075**	**12**

Corporate Key Issues:

The reported final financial position for the Corporate division during 2021-22 was **breakeven.**

The Income overachievement for 2021-22 related to non-recurrent income received such as HEIW education funding and DHCW Welsh Nurse Care Record funding which was neutralised through expenditure.

Staff underspend was due to vacancies being held during the period, including the Chief Digital Officer and the Deputy Director of finance which will offset the CIP target and other pressures within non-staff.

The Non pay overspend of **£(400)k** was due to the divisional savings target £(158)k which is expected to be met in year via staff vacancies. Other main cost pressure during 2021-22 £(260)k

relates to the estates budget in VCC which is under immense strain due to the increased repair and maintenance costs of the hospital, recently added costs for statutory compliance and increased material costs, along with general inflation.

RD&I

	Full Year Budget £000	Full Year Actual £000	Closing Variance £000
Income	**3,874**	**3,750**	**(123)**
Expenditure			
Staff	2,865	2,759	107
Non Staff	890	873	17
Sub Total	**3,756**	**3,632**	**123**
Total	**(118)**	**(118)**	**(0)**

RD&I Key Issues

The reported final financial position for RD&I during 2021-22 was **breakeven.**

Expenditure was below target, mainly due to higher than expected vacancies.

Income was £123k below target through reduction of required planning support for R&D during 2021-22.

TCS – (Revenue)

	Full Year Budget £000	Full Year Actual £000	Closing Variance £000
Income	**0**	**0**	**0**
Expenditure			
Staff	525	514	10
Non Staff	144	143	1
Sub Total	**669**	**658**	**11**
Total	**669**	**658**	**11**

TCS Key Issues

The small underspend reported through TCS which was due to Vacancy with the programme management office.

HTW (Hosted Other)

	Full Year Budget £000	Full Year Actual £000	Closing Variance £000
Income	**1,568**	**1,543**	**(25)**
Expenditure			
Staff	1,082	1,082	0
Non Staff	484	454	30
Sub Total	**1,566**	**1,536**	**30**
Total	**(2)**	**(7)**	**5**

HTW Key Issues

HTW reported a small underspend of **£5k** for 2021-22 with the budget fully funded by WG.

TCS PROGRAMME DELIVERY BOARD

TCS PROGRAMME FINANCIAL REPORT FOR 2021-22 MARCH 2022

DATE OF MEETING	21st April 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mark Ash, Assistant Project Director
PRESENTED BY	Mark Ash, Assistant Project Director
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**
N/A		Choose an item.

ACRONYMS	
TCS	Transforming Cancer Services
Trust	Velindre University NHS Trust
PBC	Project Business Case
PMO	Programme Management Office
EW	nVCC Enabling Works
nVCC	New Velindre Cancer Centre
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
SDT	Service Delivery and Transformation

1. PURPOSE

1.1 The purpose of this report is to provide a financial update to the TCS Programme Delivery Board for the financial year 2021-22, outlining spend to date against budget as at Month 12.

2. BACKGROUND

2.1 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 the 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.

2.2 As at March 2021, the Cabinet Secretary for Health, Well-being and Sport, had approved capital and revenue funding for the TCS Programme and associated Projects of £20.710m and £1.678m respectively.

2.3 Included in this approval was funding for the IRS Procurement Project (Project 3a). The PBC for this project was endorsed by WG in 2019-20, providing capital funding of £1.110m from July 2019 to December 2022. The provision was £0.250m in 2019-20, £0.548m in 2021-22, and £0.312m in 2021-22.

2.4 In addition to WG funding, NHS Commissioners agreed in December 2018 to provide annual revenue funding towards the TCS Programme. £0.400m was provided in the initial year of 2018-19, with £0.420m annually thereafter.

2.5 Further revenue funding was provided by Trust in 2019-20 and 2020-21 from its own baseline revenue budget. Funding of £0.060m and £0.030m respectively was provided for nVCC Project Delivery (previously provided by WG until March 2019). Another £0.039m (2019-20) and £0.166m (2020-21) was provided to cover the costs of staff secondment from Velindre Cancer Centre.

2.6 The total funding and expenditure for the TCS Programme and associated Projects by the end of March 2021 was £23.923m: £20.710m Capital, £3.213m Revenue.

3. FUNDING

3.1 Funding provision for the financial year 2021-22 is outlined in the table below.

3.2 In August 2021, the Trust Board approved that the nVCC Project provide interim funding of **c£0.350m** to the EW Project to support the work packages associated with tree and vegetation clearance (c£0.250m) and site management and security (c£0.100m). The EW Project has now secured funding from the approval of its FBC, awarded in January 2022.

3.3 In **JANUARY 2022,** the EW FBC was approved and will cover the costs associated with vegetation and tree clearance works c£0.300m. However, it should be noted that the nVCC Project has provided the EW Project an additional c£0.600m of funding to cover the costs for the following:

- Site Management & Security c£0.326m
- Legal costs for the injunctions c£0.274m

3.4 In **MARCH 2022**, the nVCC Project has provided the EW Project an additional c£0.591mm of funding to cover the costs for the following:

- Site Management & Security c£0.345m
- Legal costs for the injunctions c£0.246m

Note: These costs are deemed by WG to be not in the scope of the EW Project.

3.5 In addition, the EW Project received a further c£0.452m from the nVCC Project to fund pay costs; technical advisors; tree clearance costs; and design costs. The funding needs to be re-provided to the nVCC Project in 2022-23.

3.6 The Trust has provided revenue funding of **£0.110m** to the nVCC Project.

Description	Funding	
	Capital	Revenue
Programme Management Office Allocation of £0.240m from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management was provided in April 2021 Allocation from WG 2021-22 revenue pay award funding was provided in September 2021 Forecast underspend in March 2022 allowed for a virement of Commissioners' Funding from the PMO to Project 6 – Service Delivery, Transformation and Transition to cover the latter's overspend	**£ nil**	**£0.227m** £0.240m £0.006m -£0.019m
Project 1 – Enabling Works for nVCC Capital funding from WG was provided on 24 March 2021 Capital funding of £27.393m awarded by WG on 18 January 2022 for the EW FBC, of which £1.786m has been allocated to the financial year 2021-22	**£2.036m** £0.250m £1.786m	**£ nil**
Project 2 – New Velindre Cancer Centre Capital funding from WG was provided on 24 March 2021 The Trust provided revenue funding in September 2021 for Project Delivery The Trust has provided revenue funding for the Judicial Review costs incurred between August 2021 and December 2021	**£3.461m** £3.461m	**£0.110m** £0.026m £0.084m

Description	Funding	
	Capital	Revenue
Project 3a – Radiotherapy Procurement Solution Final 9 months of a 28 month project, running from 1st August 2019 to 31st December 2021, with a funding allocation of £0.312m for 2021-22 from an overall funding allocation of £1.110m, provided in April 2021 Additional funding provided by the Trust for the Project's increased legal and staff costs in November 2021 Additional funding held by the Trust with the associated spend transferred to Corporate Finance Capital Reserves in March 2022	**£0.312m** £0.312m £0.264m -£0.264m	**£ nil**
Project 4 – Radiotherapy Satellite Centre The project is led and funded by the hosting organisation, Aneurin Bevan University Health Board; no funding requirement is expected from the Trust for 2021-22	**£ nil**	**£ nil**
Project 5 – SACT and Outreach A review of all the Trust Programme & Project resources is being undertaken to identify how these are deployed against Trust priorities. This project is on hold pending this review.	**£ nil**	**£ nil**
Project 6 – Service Delivery, Transformation and Transition Allocation of £0.180m from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management was provided in April 2021 Funding provided from the Trust's core revenue budget towards the costs of the Project Director post and the Project Manager post in April 2021 Allocation from WG 2021-22 revenue pay award funding was provided in September 2021 Additional funding provided from the Trust's core revenue budget towards the cost of the Project Manager post in November 2021 Forecast underspend in March 2022 allowed for a virement of Commissioners' Funding from the PMO to Project 6 – Service Delivery, Transformation and Transition to cover the latter's overspend	**£ nil**	**£0.332m** £0.180m £0.116m £0.009m £0.008m £0.019m
Project 7 – VCC Decommissioning A review of all the Trust Programme & Project resources is being undertaken to identify how these are deployed against Trust priorities. This project is on hold pending this review.	**£ nil**	**£ nil**
Total funding provided to date	**£5.809m**	**£0.669m**
	£6.478m	

4. FINANCIAL SUMMARY AS AT 31ST MARCH 2022

4.1 The summary financial position for the TCS Programme for the year 2021-22 as at 31st March 2022 is outlined below:

- **CAPITAL** spend of **£5.711m to M12** and a **variance of £0.038m underspend;** and
- **REVENUE** spend is **£0.658m to M12** and a **variance of £0.011m underspend.**

TCS Programme Budget & Spend 2021-22

CAPITAL	Financial Year Annual Budget	Annual Forecast	Annual Variance
	£	£	£
PAY			
Project Leadership	193,000	191,707	1,293
Project 1 - Enabling Works	100,000	213,521	-113,521
Project 2 - New Velindre Cancer Centre	1,008,500	773,833	234,667
Project 3a - Radiotherapy Procurement Solution	211,613	211,613	0
Capital Pay Total	**1,513,113**	**1,390,674**	**122,439**
NON-PAY			
nVCC Project Delivery	78,500	94,247	-15,747
Project 1 - Enabling Works	1,936,000	2,274,109	-338,109
Project 2 - New Velindre Cancer Centre	2,181,000	1,911,794	269,206
Project 3a - Radiotherapy Procurement Solution	100,388	100,267	120
Capital Non-Pay Total	**4,295,888**	**4,380,417**	**-84,530**
CAPITAL TOTAL	**5,809,000**	**5,771,091**	**37,909**

REVENUE	Financial Year Annual Budget	Annual Forecast	Annual Variance
	£	£	£
PAY			
Programme Management Office	218,833	198,329	20,503
Project 6 - Service Change Team	316,633	316,095	539
Revenue Pay total	**535,466**	**514,424**	**21,042**
NON-PAY			
nVCC Project Delivery	26,000	24,918	1,082
nVCC Judicial Review	84,000	83,709	291
Programme Management Office	8,534	19,763	-11,229
Project 6 - Service Change Team	15,000	14,766	234
Revenue Non-Pay Total	**133,534**	**143,156**	**-9,622**
REVENUE TOTAL	**669,000**	**657,580**	**11,420**

5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 31ST MARCH 2022

CAPITAL SPEND

Project 1 – Enabling Works

5.1 There is a final capital spend for the financial year 2021-22 of **£2.487m** against a budget of **£2.036m, with a variance of £0.452m overspend**. This overspend has been offset by an underspend by Project 2 – nVCC.

Work Package	**Total Spend for 2021-22 £m**
Pay	**£0.214**
Technical Advisers	£0.260
Construction Costs	£0.552
Utility Costs	£0.789
Supply Chain Fees	£0.192
Non Works Costs	£0.400
Asda Works	£0.081
Non-pay	**£2.274**
Total	**£2.488**

5.2 Many of the EW work packages associated with the EW OBC, for which funding was not provided by WG in 2021-22. Therefore, these work packages have been funded by the nVCC Project (see section 5.3), with the EW costs for 2021-22 relating to just the EW FBC.

Project 2 – nVCC

5.3 There is a final capital spend for the financial year 2021-22 of **£2.972m** against a budget of **£3.461m, with a variance of £0.489m underspend**. This underspend has been utilised to offset an overspend by Project 1 – Enabling Works.2.

Work package	**Total Spend for 2021-22 £m**
Pay	**£0.965**
Project Delivery Costs	£0.094
EW Works	£0.451
EW Legal Advice	£0.262
EW Reserves	-£0.195
nVCC Competitive Dialogue – PQQ & Dialogue	£1.291
nVCC Legal Advice	£0.020
nVCC Planning	£0.111
nVCC Reserves	-£0.028
Non-pay	**£2.006**
Total	**£2.972**

Project 3a – Integrated Radiotherapy Procurement Solution

5.4 There is a final capital spend for the financial year 2021-22 of **£0.0.312** for the IRS Project against a WG budget of **£0.312 with no variance**. There is an additional spend of £0.248m, which has been offset by Trust capital reserves and transferred accordingly.

Work package	Total Spend for 2021-22 £m
Pay	**£0.212**
Legal Advisors	£0.100
Financial Advisors	£nil
Business Case Advisors	£nil
Procurement Advisors	£nil
IRS Reserves	£nil
Non-pay	**£0.100**
Total	**£0.312**

REVENUE SPEND

Programme Management Office

5.5 The PMO spend for 2021-22 is **£0.218m** (£0.198m pay, £0.020m non-pay) against a revised budget of **£0.227mm**.

5.6 There is an underspend in pay costs of £21k due to a delay in recruitment of a Programme Administrator. However, this has been used to offset an overspend of £11k in non-pay costs, and £19k overspend by the Service Change Project, resulting in an overall underspend of £9k.

Projects 1 and 2 Delivery Costs

5.7 The full revenue costs in 2021-22 for project delivery are **£0.025m** against a budget of **£0.026m.** This spend relates to office costs and project support.

nVCC Judicial Review

5.8 There is a revenue spend of **£0.084m** against a budget of **£0.084m** in 2021-22 for the legal advice to deliver the requirements of the judicial review process as the Trust is an interested party.

Project 6 – Service Delivery, Transformation and Transition (Service Change)

5.9 The Service Change spend for 2021-22 is **£0.331m** (£0.316m pay, £0.015m non-pay), against a revised budget of **£0.331m, with no variance**.

6. Financial Risks & Issues

6.1 There are no outstanding financial risks or issues for the financial year 2021-22.

7. CONSIDERATIONS FOR BOARD

7.1 This report is included as an appendix to the Trust Board Finance Report.

8. 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	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 above.

9. RECOMMENDATION

9.1 The Trust Board are asked to **NOTE** the financial position as at 31st March 2022.

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	26.5.22

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	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 NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
Executive Management Board	27.04.2022	Noted
Audit Committee	03.05.2022	Noted
Quality, Safety and Performance Committee	12.05.2022	Noted

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
TCS	Transforming Cancer Services
SLT/SMT	Divisional Senior Leadership Teams / Senior Management Teams
EMB	Executive Management Board

1. SITUATION AND BACKGROUND

The purpose of this report is to:

- Share the March 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.
- Outline approach to risk appetite review for Summer 2022.

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Key Points for the Committee:

1. There has been extensive review of the Velindre Cancer Services risks which is reflected in the changes to risk profile at level 20 and 16 in this report.

2. During this next cycle, Executive Management Board will consider whether the overall risk profile reflects assessment for the Trust as a whole and changes made as a result of this assessment as appropriate. Although this is a question considered on each review of the risk profile by the Executive Management Team, it is clearer in this upcoming reporting cycle due to the progress in point 1 above. It also reflects a challenge made by the Trust Board in the March 31st meeting.

3. The remaining elements of the risk framework are on track to complete by end June 2022 and are described in section 3 of this report.

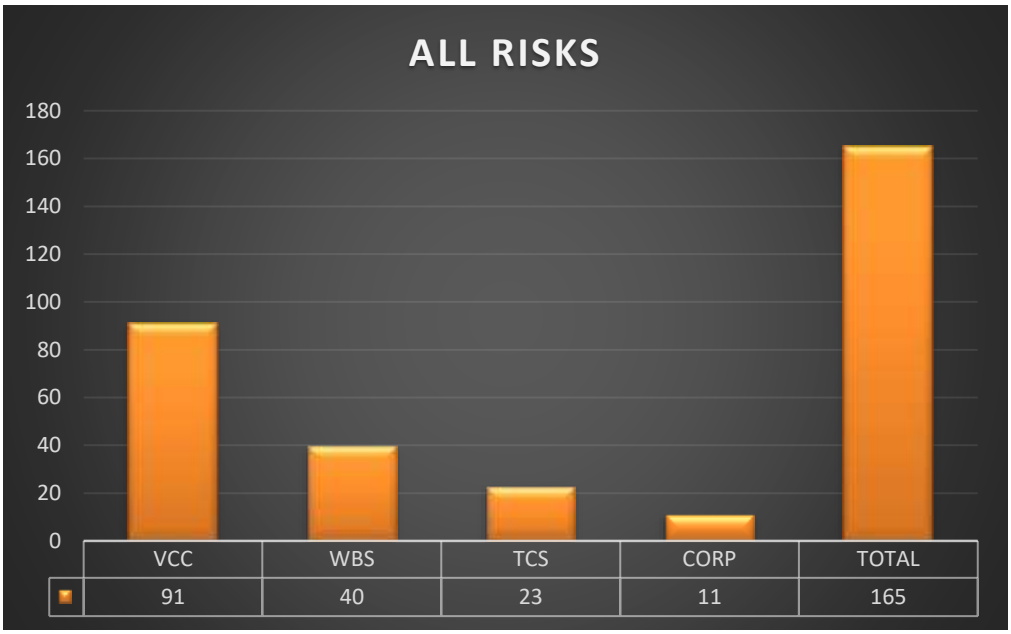
2.1 THE TRUST RISK REGISTER

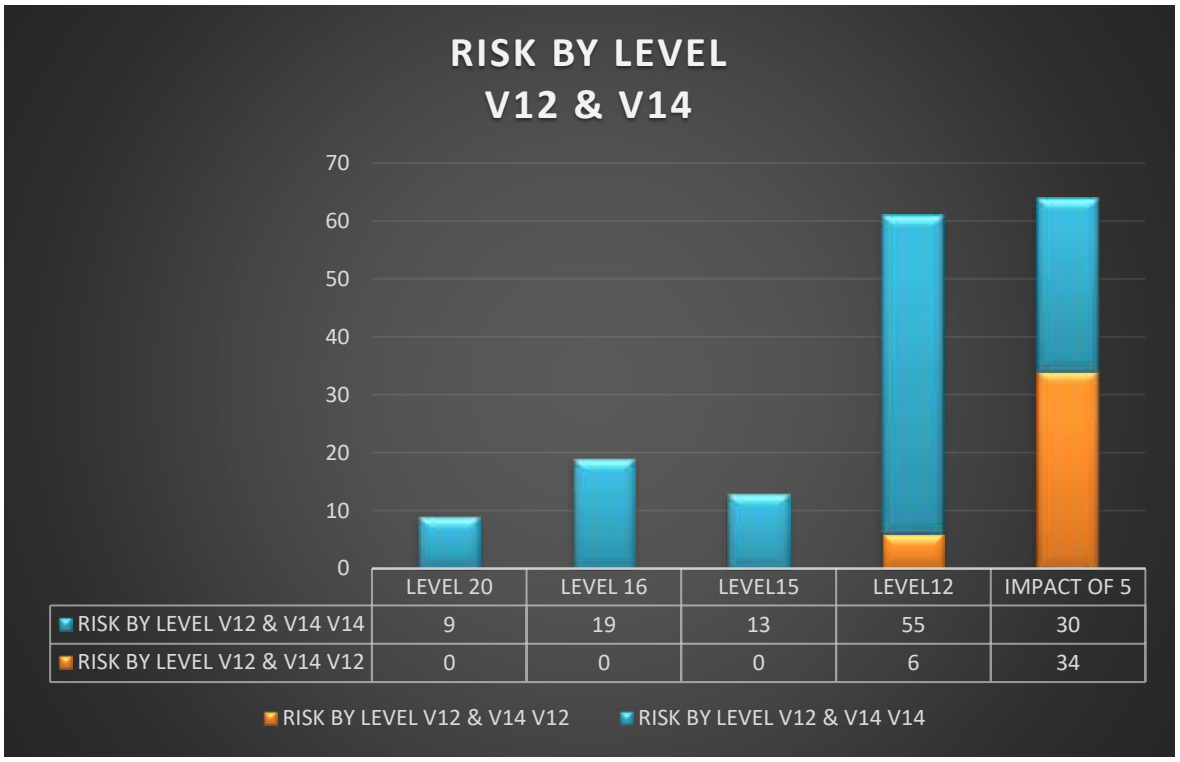
2.1.1 Total Risks

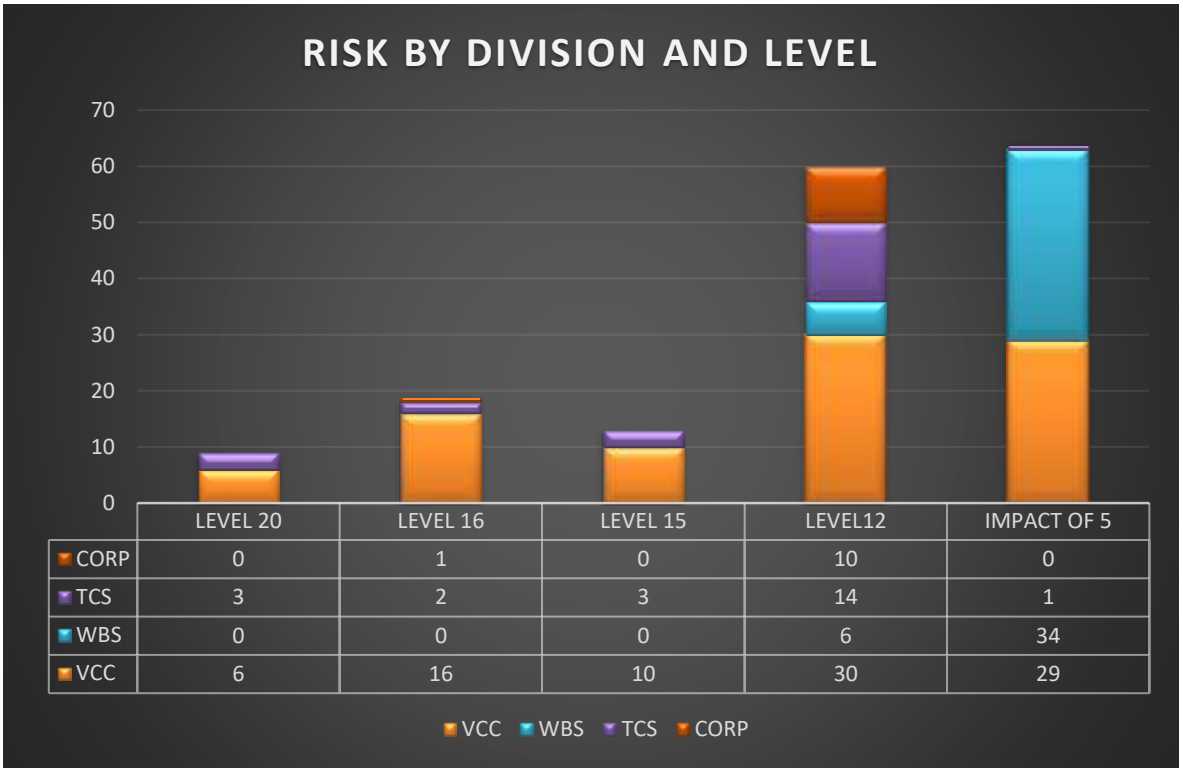
There are a total of 165 risks recorded in Datix Trust Risk Registers, 40 in version 12 and 125 in version 14. This compares to 170 risks is the same amount of total risks recorded in the March 2022 reporting cycle, i.e. five have closed – and the rationale are highlighted for the highest scoring risks in this report. The graph below provides a breakdown of the total number of risks by Division.

2.1.2 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.







2.1.3 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.

Risks level 25

There remain no level 25 risks up to 30th April 2022.

Risks level 20

The table below provides a breakdown of risks level 20. Following the Executive Management Board challenge, which was supported and further challenged by Independent Members in March and April's Quality, Safety and Performance, Audit Committee and Trust Board, Risk Owners across the Trust have further reviewed the highest rated risks. Due required Divisional Governance processes this work remains underway:

This review identified that although VCC SLT had reviewed their risks the Datix system had not been updated. Following review, the following changes have been made:

- Risk 2191 - *Inability to meet COSC / SCP targets* – Has been closed as only shadow reporting taking place until adopted by Welsh Government as a Tier 1 target.
- Risk 2200 - *There is a risk that patient treatment is delayed due to lack of staffing because of COVID 19 related absence* - has been reduced to a 16, given that sickness levels related to COVID 19 have reduced resulting in increase in capacity to support additional activity.
- Risk 2513 - *There is a risk that patient treatment is delayed as a result of a lack of medical work forward holding a prostate brachytherapy practitioners licence* - has been reduced to a 16 given the actions taken to reduce the risk.

The Digital Health & Care Record Project Team reports into the VCC SLT. The Project Team have asked for further support in reassessing the project risk profile, previously reported as three risks at level 20 and seven at level 16. The matter will be discussed at Project Board on in May and the appropriate changes will then be made to the profile. Given the agreement of Executive Management Board that although the overall Project should be reflected as one of the highest risks for the organisation, the current profile has not been included in this report as to not distort the overall picture until an agreed articulation is confirmed.

The VCC SLT will be reviewing their overall profile, following these updates in the next meeting

and will specifically discuss the challenge from the Trust Board meeting as to whether the profile reflects accurately the current Velindre Cancer Services risk profile.

The risk at level 20 is detailed in the table below and will be reviewed in the Transforming Cancer Services Sub-Committee. It has been subject to extensive challenge from Independent Members over many months. Further updates discussed in meeting on 4th May and progress on agreed actions for both Risk 2400 and Risk 360 are to be subject to scrutiny in the May and June Committees.

ID	Risk Type	Division	Review date	Title	Rating (current)	Rating (Target)	RR - Current Controls
2400	Workforce and OD	Transforming Cancer Services	30/04/2022	There is a risk that the lack of appropriate project support for Project 5, Outreach, from the programme will lead to delays in developing the solutions required for the project success.	20	6	Executive agreement on priority of agreeing final plan and implementation – Complete. Project Management recruitment underway. Cross-reference to Risk 360, rated 16 – *"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 and outcomes being delayed / not being met."*

Risks level 16

The work undertaken to further review risks have also resulted in a change in the number of level 16 risks. As of 30th April there are 9 risks scoring 16, with three reduced and one closed since the previous reporting cycle.

- Risk 2190 - *There is a risk that patient will continue to breach in radiotherapy as a result being unable to address challenging components of the pathway due to limited capacity available within Business Intelligence teams to source the appropriate data sets* – has reduced to 8. The current complexities of the radiotherapy pathways make it difficult for BI to identify the necessary data to reflect the different components. The Business Intelligence team have limited capacity available to undertake the work required to identify the appropriate data set. However, it was judged that there is not a risk of this having a significant impact on radiotherapy performance. The target score has also been reduced to a 4 to reflect SLT's continued management of this risk to green levels.

- Risk 2345 – Radiotherapy Department - *Change to service due to continued response to COVID 19* – has been closed as was describing the current issues in performance, as set out in the performance report, rather than a specific risk to be managed.

- Risk 2502 - *There is a risk that SACT and radiotherapy services may be negatively affected as a result of staff COVID 19 related absences resulting in delay to patient treatment and an increase in waiting times* – has reduced from a 16 to a 12 due to the contingency plans in place to support challenging service areas including redeployment of staff from other service areas, staff working 'down' to cover lower graded posts and the increased utilisation of virtual appointments and changes to patient pathways and exploring external capacity. Although there remains a risk on performance, there has been a reduction in *COVID 19* related sickness which is helping to address some capacity issues. However other factors such as an increase in referrals following release of *COVID 19* restrictions has also had an impact on the waiting times

    - To note that VCC SLT in next meeting will be assessing the risk to delivery risk of SACT and Radiotherapy in general, albeit not as a result of COVID-19 staff absences.

- Risk 2514 - *There is a risk that Standard Operating Procedures (SOPs) within Brachytherapy are not up to date* – reduced to a 8 due to the progress made by new Head of Brachytherapy Physics, now in post. Deputy is to be appointed. Good progress in working through updating of SOPs.

ID	Risk Type	Division	Review date	Title	Rating (current)	Rating (Target)	RR - Current Controls
2513	Performance and Service Sustainability	Velindre Cancer Centre	31/05/2022	There is a risk that patient treatment is delayed as a result of a lack of medical workforce holding a prostate brachytherapy practitioners licence	16	10	There is currently a national shortage of clinicians within holding this licence. 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. Expected date being confirmed and will be confirmed in next report.
2200	Performance and Service Sustainability	Velindre Cancer Centre	31/05/2022	There is a risk that patient treatment is delayed due to lack of staffing because of COVID 19 related absence	16	6	Demand and capacity is continuing to be monitored. Sickness levels related to COVID 19 have reduced resulting in increase in capacity to support additional activity. Cross-reference to VCC performance report.
2454	Workforce and OD	Corporate Services	01/05/2022	Digital Services Capacity / Skill Mix	16	8	Regular review of IT work plan, to ensure delivery is aligned to Trust / Divisional priorities. VCC and WBS IT work plans regularly reviewed, to be shared via relevant channels (BPG, SMT/SLT etc.). 'Agile' utilisation of Digital Services resource, to ensure focus on prioritised work. Specific actions to reach Target Risk Rating and articulation of the Risk will be considered by WOD Senior Team and confirmed in next report.
2193	Performance and Service Sustainability	Velindre Cancer Centre	31/05/2022	There is a risk that lack of Medical Physics Expert cover impacts on the Molecular Radiotherapy (Nuclear Medicine) services.	16	4	Currently scoping is taking place of the work required to develop a new service model to ensure appropriate level of Medical Physics Expert cover for nuclear medicine. An initial meeting has been set for May to discuss an outline model. Following this, specific actions to reach Target Risk Rating will be considered by VCC Senior Leadership Team and confirmed in next report.
2428	Compliance	Velindre Cancer Centre	31/05/2022	There is a risk of increased infection transmission within the cancer centre due to poor ventilation resulting in increased sickness and absence of staff and patients	16	8	Business case scheduled to VCC SLT in May for approval and consideration of funding from capital allocation.

2198	Financial Sustainability	Velindre Cancer Centre	13/12/2021	VCC may face financial loss, legal action, inadequate service provision as a result of no coordinated system for SLAs, contracts	16	6	Risk review overdue – therefore specific action to be taken with Finance and VCC teams in order to assess and appropriately rearticulate, score and assign actions as appropriate.
2528	Performance and Service Sustainability	Transforming Cancer Services	29/04/2022	There is a risk that Programme Master Plan objectives / outcomes are delayed and/or not met	16	6	Stocktake of all Projects and Programme to be undertaken - Work is underway to be completed by end of April '22. Refreshed Project Self-Evaluation toolkit - Work to be completed by end of May '22. Refresh of Master Programme Plan - Review Programme and Project resources / gaps and make appropriate investments where required. Introduce new ways of working - VF & Strategic Infrastructure Board - to be completed by end of June '22.
2501	Financial Sustainability	Transforming Cancer Services	04/04/2022	Risk of Inflation leading to increased costs	16	12	Paper on affordability submitted to Welsh Government. Ongoing
2517	Financial Sustainability	Transforming Cancer Services	04/04/2022	There is a risk that the competitive dialogue participants tenders exceed the CAPEX limit leading to increase project costs.	16	12	Paper on affordability submitted to Welsh Government. Ongoing

3 Development of Risk Framework

- Three key steps remain for the development of risk framework by end June:
    - Re-write of Risk Policy and Corporate Management Level Procedure to reflect the changes in the Framework which has been developed and delivered during this work over the past 18 months.
    - Three levels of training to be delivered:
        - All Staff – covering: why is risk management important, what is my role, first form of Datix 14, which is the simple input form which all staff in organisation have access to in order to raise a risk.
        - Management level – covering the Policy and Corporate Management Level Procedure and second form of 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.
        - Leadership level – covering the Policy and oversight roles - Divisional Leadership Teams, Executive Management Board and Trust Board. These are scheduled for June and early July, with the Board session scheduled for the Board Development session.
    - Transition of WBS Risks onto Datix 14.

- 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.

- Initial view on approach to risk appetite review to be discussed in Executive Management Board Shape meeting:
    - Consideration as to whether may want recommend to change the risk category thresholds for reporting so more calibrated at 16/15 rather than 12 for reporting residual level of risk to Board level.
    - Executive leads for risk categories will then discuss with Independent Member leads prior to taking to Board for sign off and approval.

- Following completion of the review of risks previously reported in the private part of the meeting, there are no risks at 16 or above which are now assessed as requiring further reporting due to the changing in commercial risk on these matters. For completeness, there are three risks below 16, all relating to the Integrated Radiotherapy Solution procurement, which have been confirmed as requiring continued reporting in private at present in the TCS Programme Scrutiny Sub-Committee due to the current stage of the competitive dialogue process.

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
	Completed for individual risks as appropriate
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.

5 RECOMMENDATION

The Trust Board is asked to:

- **NOTE** the risks level 20 and 16 reported in the Trust Risk Register and highlighted in this paper.
- **NOTE** the on-going developments of the Trust's risk framework.

TRUST BOARD

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	26/05/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

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	09.05.2022	Supported
Audit Committee	05.05.2022	Discussed and Reviewed
Strategic Development Committee	16.05.2022	Discussed and Reviewed

1. SITUATION

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), which may affect the achievement of the Trust's Strategic Objectives, and the 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 within the Trust.

1.2 The Trust Board is asked to:

a. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1.***

b. **NOTE** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 3.3.

2. BACKGROUND

2.1 The Trust Board must be able to assure itself that the Trust is operating effectively and meeting its Strategic Objectives. It does this through its internal governance structures, management controls and by providing assurance that its controls are operating effectively, and objectives are being met.

2.2 The Trust Board received the first iteration of the populated Trust Assurance Framework at its September 2021 meeting, which outlined the high-level Principal Risks that may threaten the achievement of the organisation's Strategic Objectives and intent, a further update was reported to the Trust Board in March 2022.

2.3 As previously indicated there is not expected to be significant movement in the articulation of these risks in the short-term, instead these will be reviewed and evolved in line with the Trust's strategic planning cycle or in response to significant external changes.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The following provides a high level summary of the work undertaken since March 2022, to update the Trust Assurance Framework, support its continued development, articulation and operationalisation within the Trust.

3.1 Revised reporting mechanism

3.1.1 Following discussion and engagement with risk colleagues in other Health Boards across Wales and the identification and assessment of increased automation of the Trust Assurance Framework colleagues in the Datix team are liaising with the Hywel Dda Datix team regarding the development of principal risks within Datix Version 14.

3.2 Trust Assurance Framework Dashboard

3.2.1 The updated Trust Assurance Framework Dashboard Report is included at ***Appendix 1.***

3.2.2 Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since March 2022 in respect of the following Principal Risks:

			NO REVIEW TAKEN PLACE			
			REVIEWED NO CHANGES			
			REVIEWED AND UPDATED			
			MAR	APR	MAY	JUN
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**				

3.2.3 The following is a high level summary of the key changes that have been made to the Trust Assurance Framework since March 2022, a full overview of these changes is provided in the Trust Assurance Framework Dashboard at ***Appendix 1:***

- To note, 'Residual' Risk Score is the current score, with the current control environment, and its effectiveness, taken into account. 'Inherent' is the risk score without the control environment operating.

- **TAF 01: Demand and Capacity**

    - **At present Residual Risk Score –** has increased from 12 to 16. This is as a result of further review of the risk by the risk owner and both Divisions. The risk was rearticulated to be:

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.

The previous articulation focused on the Business Intelligence capacity – as it was recommended that restating in terms of the risk on actual capacity more clearly focused on the risk and also resulted in the score increase in both residual and inherent risks.

- **Overall Level of Control Effectiveness -** has been assessed as 'Partially Effective'. Key controls and sources of assurance have undergone detailed review during the May cycle.
- **Sources of Assurance –** Key controls and sources of assurance have undergone detailed review during the May cycle.
- **Action Plan for Gaps Identified –**These will be reconsidered as part of next reporting cycle.

- **TAF 02: Partnership Working / Stakeholder Engagement**

  - ***Residual Risk Score*** - has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. However, an action plan is being developed to specifically address the control deficiencies and will be reviewed through Executive Management Board Shape to then update on in the May 2022 reporting cycle.
  - ***Sources of Assurance*** - ratings have now been added and assessed for the majority of the key controls in place operating as the first line of defence.
  - ***Action Plan for Gaps Identified*** – Ways of working changes, including with partner organisations, has been agreed with Internal Audit as an advisory piece for the 2022/23 work programme.

- **TAF 03: Workforce Planning**

    - ***Residual Risk Score*** – has remained at **9** in this report. However, following Executive Management Board discussion in the May meeting, it was requested that the scoring of this strategic risk to be reconsidered – as Executive Management's Board's view is that it was likely to have increased in score. This work will now be undertaken and reflected in the next reporting cycle.
    - ***Overall Level of Control Effectiveness –*** has been assess as 'Partially Effective'.
    - ***Sources of Assurance –*** have not been assessed but within the action, log third lines of assurance are planned to be reviewed, with a target date of July 2022.
    - ***Action Plan for Gaps Identified –*** Continued review and reporting through committee cycle is planned. Additionally a review of third lines of defence are planned for completion by July 2022.
    - Key Control **C1** - People Strategy is due to be finalised in May 2022. This will provide the strategic framework for effective workforce planning arrangements going forward and an update reflective of this will be included in the next reporting cycle.

- **TAF 04: Organisational Culture**

    - ***Residual Risk Score –*** has remained at **9** in this report. However, following Executive Management Board discussion in the May meeting, it was requested that the scope and scoring of this strategic risk to be reconsidered in light of the wider organisational change programme which is currently being shaped. This work will now be undertaken and reflected in the next reporting cycle.
    - ***Overall Level of Control Effectiveness –*** has been assessed as 'Partially Effective'. However, the action plan includes further development of key controls to an effective level.
    - ***Sources of Assurance –*** The action plan sets to identify third lines of assurance, as identified in the gaps in assurance.

- ***Action Plan for Gaps Identified –*** The action plan sets out the plan to continue to review and report through meeting cycles, develop third line of defence assurances and develop control effectiveness to an acceptable level.

- **TAF 05: Organisational Change / 'strategic execution risk'**

  - ***Residual Risk Score*** - has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. However, an action plan is in place to address the gaps in controls identified.
  - ***Sources of Assurance*** – There has been no change in this review
  - ***Action Plan for Gaps Identified*** – The action regarding development of enabling strategies is on target for completion in May 2022.

- **TAF 06: Quality & Safety**

  - ***Residual Risk Score*** - has remained the same at **15**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective', this is a change from the last reporting cycle, where an effectiveness rating of 'Not Yet Effective' was recorded.
  - ***Sources of Assurance*** – Sources of assurance remain unchanged from the last report.
  - ***Action Plan for Gaps Identified*** - has been reviewed and actions remain on target for completion by target dates.

- **TAF 07: Digital Transformation – Failure to embrace new technology**

  - ***Residual Risk Score*** - has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.
  - ***Sources of Assurance:*** all key controls remain in place.

- ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance, slippage as outlined above has been the result of the existing vacancy for the Chief Digital Officer.
- A full review is planned for this risk, which will be reported in the July meeting cycle.

- **TAF 08: Trust Financial Investment Risk**

  - ***Residual Risk Score*** – has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. This has not changed since the last review.
  - ***Sources of Assurance:*** the risk has been reviewed and no changes made to sources of assurance.
  - ***Action plan:*** Actions are on target for completion as expected.

- **TAF 09: Carl James – Future Direction of Travel**

  - ***Residual Risk Score*** – has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.
  - ***Sources of Assurance:*** the existing key controls remain unchanged since the last review.
  - ***Action plan:*** progress has been updated and target dates remain unchanged and on target.

- **TAF 10: Lauren Fear – Governance**

  - ***Residual Risk Score*** – has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Effective'. This remains unchanged since the last review.

- ***Sources of Assurance:*** the existing key controls in place remain unchanged since the last review.
- ***Action plan:*** the action plan remain unchanged since the last review.

3.2.4 In addition to the above, the following provides a high level summary of the two remaining Principal Risks that were reviewed with no changes made to the overall risk status, with key controls and sources of assurance in place.

3.3 **Key Points from March and April Governance Cycle**

3.3.1 There were three key themes which were discussed in the March Strategic Development Committee, the March Trust Board and the May Audit Committee to note. These matters were further noted in the May Strategic Development Committee.

3.3.2 **Link to Risk Register, Performance Framework and Quality Framework** - At the March Strategic Development Committee and March Trust Board, the link between the risk register and the Trust Assurance Framework was discussed. It was agreed that this is to be developed to link relevant risks on the register to the strategic risks in the Trust Assurance Framework within this year's work plan for the framework's development. Following the development of the performance and quality frameworks, key metrics relating to the strategic risks will also be linked. The connections between these four key frameworks is important to the ability of the Board to more effectively triangulate and assure going forwards. The first step is to link the risk register and Trust Assurance Framework – and this work will be completed over the summer for September 2022.

3.3.3 **Reverse Stress Testing** - There was an in-depth discussion at the March Strategic Development Committee was to understand the impact of the overall profile and the impact of a collection of these risks being brought together. The concept of reverse stress testing was commented on, that 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.

In the March Trust Board, this point was acknowledged in the paper and confirmed would be worked into the work plan for the framework's development. To note that in May Audit Committee, Independent Member expectation was that this should be progressed fairly quickly and so approach is currently being worked through. At a high level, it is proposed that this happens in parallel with the review of the overall risk profile, as approaching the macro level risk questions in this way will be a useful tool and input into the annual review.

3.3.4 **Link to Strategy Development** – At the March Trust Board, there were questions raised by Independent Members regarding the on-going development of the strategic risk profile, which forms the basis of the Assurance Framework.

In reviewing the profile over the next couple of months, 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 out thinking on macro strategic risks. For instance, articulations include matters such as:

- Sustainable, resilient operations
- Climate change
- Balance between human workers and intelligent robots
- Shifting talent pool and changing employee experience
- Flatter, more agile organisations
- New forms of funding
- Cyber crime
- Geo-political for Europe and China
- Consumer and service users expectations for authenticity
- Health care systems face the challenge of managing even more data
- Concerns over clinician burnout will continue
- Patient expectations for care at home

- Patient mental health and emotional continued focus
- Co-opetition and integration in system working

Also it will be important to frame the review in the Trust approved Strategy and Enabling Strategies.

The work will then need to culminate in a Board Development Session in September.

4. 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.

5. RECOMMENDATION

The Trust Board is asked to:

a. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1.***
b. **NOTE** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 3.3.

TAF DASHBOARD

DEMAND AND CAPACITY

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	May-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Jul-22	
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	4	4	16	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	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	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)		Senior Management Team, COO review and EMB Review, QSP committee and Board.		Welsh Government Quality, Planning and Delivery Review.	

TAF DASHBOARD

DEMAND AND CAPACITY

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		Performance Report Senior Management Team and EMB Review, QSP committee and Board		Welsh Government Quality, Planning and Delivery Review	
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		Performance Report - SLT, EMB, QSP and Board		Welsh Government Quality, Planning and Delivery Review	
C4	Demand and Capacity Plan for each service area	Heads of Service - Each Area	X	X		PE	Service area operational planning meeting		Performance Report - SLT, EMB, QSP and Board		Welsh Government Quality, Planning and Delivery Review	
C5	Active operation engagement with health boards on demand	Director VCC (VCS)	X	X	X	PE	SLT		Performance Report - SLT, EMB, QSP and Board		Welsh Government Quality, Planning and Delivery Review	

GAP IN CONTROLS	GAPS IN ASSURANCE
During May, the risk description has been updated as are the key controls and sources of assurance. Gaps and action plan now being confirmed	

TAF DASHBOARD

DEMAND AND CAPACITY

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE			
Action Plan	**Owner**	**Progress Update**	**Due Date**

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Jun-22	
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	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		

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	IA	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

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	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
2.2	Local Partnership Forum		X	X		PE	Feedback from LPF	IA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office	PA
2.3	and data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Wales Audit Office/Welsh Government	PA
3.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region		X			PE	Agreed to model for next phase	IA	Strategic Development Committee/Quality Safety and Performance Committeee	IA	Wales Audit Office/Welsh Government	PA
3.2	with effectively delivering ways of working/ work programmes			X		PE	Collectively agreed to and documented work programme	IA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
3.3	and data and measures to clearly track progress against objectives.				X	NE	With respective measures reported	IA				

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

4.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				
4.2	with effectively delivering ways of working/ work programmes			X		NE	Collectively agreed to and documented work programme	NA				
4.3	and data and measures to clearly track progress against objectives.				x	NE	With respective measures reported	NA				

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 of defence assurance are in place to a certain extent across most of the key controls. However, there is limited coverage from second and third line perspectives

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.	Jul-22
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		Jul-22

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	May-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Jul-22	
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	3	9	3	3	9	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	Not Assessed	Internal Audit Reports		To be completed as per compliance/ reg tracker update	
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback	Not Assessed	Trust Board reporting against Trust People Strategy		To be completed as per compliance/ reg tracker update	
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	reports via divisional and committee structures	Not Assessed				
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation Sheets	Not Assessed				

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	Not Assessed				
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	Not Assessed				
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	Not Assessed				
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports via divisional and committee structures	Not Assessed				
C9	Agile 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	Not Assessed				

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date

TAF DASHBOARD

WORKFORCE PLANNING

1.1	Ongoing updates to EMB and Committee forums	Sarah Morley		Jul-22
1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		Jul-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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Jul-22	

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	3	**9**	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		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	
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		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	

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					
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					
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					
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					
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board					
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group					

TAF DASHBOARD

ORGANISATIONAL CULTURE

C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings					
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					
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined					

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	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an "effective" level	Sarah Morley		Jul-22
1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		Jul-22
1.3	On going updates in EMB and Committee fora'	Claire Budgen		Jul-22

TAF DASHBOARD ORGANISATIONAL CHANGE/STRATEGIC EXECUTION RISK

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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Jul-22									
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**

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				Executive Management Board review		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				Executive Management Board review		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		Executive Management Board review/ patient and donor feedback		Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA

TAF DASHBOARD ORGANISATIONAL CHANGE/STRATEGIC EXECUTION RISK

1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x			Executive Management Board review		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				Executive Management Board review / staff feedback		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						Internal Audt Review		Audit Wales/HIW	IA

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)	May-22
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)	Sep-22

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including 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. This 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	May-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Jul-22	Goal 1		
EXECUTIVE LEAD	Nicola Willams			

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
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					
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 not finalized due to pandemic	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 & Candour guidance still under development	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 Trusts performance framework does not currently adequately monitor service level to board quality, safety, outcome and experiential measures
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 establishment - to operationally pull together all stands and feed into EMB & QSP

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	Trust wide consultation on the Quality & Safety Framework completed. Executive engagement session held. Final version being drafted.	May-22

TAF DASHBOARD

QUALITY AND SAFETY

1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Paul Wilkins Alan Prosser	Constitution of Corporate Quality & Safety Hub agreed & resourcing determined- awaiting confirmation of funding – aligned with restructuring of corporate Quality & Safety Team. OCP Process has 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	May-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Will be developed once Framework finalised	Jun-22
1.4	Instigate a Quality & Safety monthly operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Will be established once OCP completed	Jun-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Training arranged for March - delayed due to Omicron	Jun-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley		
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Planned for March 2022	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	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23
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	Jun-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.	Jun-22

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	May-22	5 - A sustainable organisation that plays it part in creating a better future for people across the globe
NEXT REVIEW	Jul-22	
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	3	4	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

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			PE
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE

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	PA	To be completed as per compliance/ reg tracker update	PA
Trust digital governance reporting	PA	Internal Audit Reports	PA		
Staff feedback	IA	Trust Board reporting against Trust Digital Strategy	PA		

TAF DASHBOARD

DIGITAL TRANSFORMATION

C4	Training & Education packages for donors, patients	Chief Digital officer	X			PE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA		
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA				
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA				
C7	Digital inclusion – in wider community	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	Trust digital governance reporting	PA		
C8	Opportunities for digital career paths	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	Trust digital governance reporting	PA		
C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA				
C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	PA				
C11	Trust digital governance	Carl James		X		PE	Trust digital governance reporting	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		

GAP IN CONTROLS	GAPS IN ASSURANCE

TAF DASHBOARD

DIGITAL TRANSFORMATION

Each of the controls (with exception of 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
	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

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	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (on track for July 2022) (new CDO commences on 1st July - will pick up on appointment)	Jul-22
1.2	December Strategic Development Committee	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to July meeting of SDC (new CDO commences on 1st July - will pick up on appointment)	Jul-22
1.3	New Performance measures for digital services (on track for July 2022)	Chief Digital officer		Jul-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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations									
NEXT REVIEW	Jul-22	**Goal 2**									
EXECUTIVE LEAD	Matthew Bunce	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		3	4	**12**	4	4	**16**	3	4	**12**	

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		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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
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

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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.	Jul-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.	Jul-22
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Initial proposals prepared, Executive discussions to shape and take forward	Jul-22

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

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	May-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Jul-22	**Goal 2**								
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	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**	**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			PE	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	IA	Audit Wales Reviews	PA

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

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	
Commercial expertise within the Trust	
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

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	May-22
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	May-22
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board decisions in May 2022)
1.5	development of clinical and scientific strategy	Jacinta Abraham		tbc
1.4	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions in May 2022)

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	May-22	1 - Outstanding for quality, safety and experience			
NEXT REVIEW	Jul-22	**Goal 1**			
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	PA	Internal Audit of Board Committee Effectiveness	PA

TAF DASHBOARD

GOVERNANCE

								Trust Board		Audit Wales Structured Assessment 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.		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		Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.	Complete

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

Equality Monitoring Report 31 March 2021

DATE OF MEETING	26 May 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	Claire Budgen: Head of Organisational Development, Paola Spiteri: Equalities, Diversity, Inclusion and Organisational Development Manager
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	**27.04.22**	**ENDORSED FOR COMMITTEE APPROVAL**
QUALITY, SAFETY & PERFORMANCE COMMITTEE	**12.05.22**	**ENDORSED FOR BOARD APPROVAL**

1. SITUATION/BACKGROUND

1.1 This report provides the equality monitoring staffing data in line with the Equality Act 2010 and the Public Sector Equality Duty (2011). The equality duty was created under the Equality Act 2010. The equality duty replaced the race, disability and gender equality duties.

1.2 The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales should produce an annual equality report by 31st March each year. The essential purpose of the specific duties under the Equality Act, in relation to monitoring, is to help authorities to have better due regard to the need to achieve the three aims of the general duty, which are to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it;
- foster good relations between people who share a protected characteristic and people who do not share it.

Therefore, as a specific duty itself, the role of annual reporting is to support the Trust in meeting the general duty. It also has a role in setting out achievements and progress towards meeting the other specific duties. In particular, the annual report supports the Trust to have a better due regard to the duties by providing an opportunity to;

- Monitor and review progress;
- Monitor and review the effectiveness and appropriateness of arrangements;
- Review objectives and processes in light of new legislation and other new developments;
- Engage with stakeholders around these issues, providing partners and the public with transparency.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The workforce statistics relating to protected characteristics as at 31 March 2021 can be seen in the attached report.

2.2 The data includes NHS Wales Information Systems and NHS Wales Shared Services Partnership. NHS Wales Information Systems ceased to be hosted by Velindre University NHS Trust on 1 April 2021 and are therefore all coded as Leavers within the year.

2.3 The analysis of the current workforce demographics will be presented in the Equality Monitoring Report of 31 March 2022 including a narrative review of progress in advancing equality of

opportunity between people with different protected characteristics.

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
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 **DISCUSS AND REVIEW** the attached report for **APPROVAL**.

Velindre University NHS Trust Equality Monitoring report 31 March 2021

The data includes NHS Wales Information Systems and NHS Wales Shared Services Partnership. NHS Wales Information Systems ceased to be hosted by Velindre University NHS Trust on 1 April 2021 and are therefore all coded as Leavers within the year.

Ethnic Origin

Ethnic Origin	Headcount	%
Asian	196	3.83
Black	89	1.74
Chinese	15	0.29
Mixed	72	1.41
Not Stated or Unspecified	717	14.03
Other	20	0.39
White	4002	78.30
Grand Total	**5111**	**100.00**

Age Profile

Age Band	Headcount	%
<=20 Years	22	0.43
21-25	393	7.69
26-30	742	14.52
31-35	744	14.56
36-40	607	11.88
41-45	545	10.66
46-50	607	11.88
51-55	630	12.33
56-60	508	9.94
61-65	245	4.79
66-70	45	0.88
>=71 Years	23	0.45
Grand Total	**5111**	**100.00**

Religious Beliefs

Religious Belief	Headcount	%
Atheism	853	16.69
Buddhism	12	0.23
Christianity	1883	36.84
Hinduism	35	0.68
I do not wish to disclose my religion,	671	13.13
Islam	98	1.92
Judaism	2	0.04
Other	389	7.61
Sikhism	6	0.12
Unspecified	1162	22.74
Grand Total	**5111**	100.00

Sexual Orientation

Sexuality	Headcount	%
Bisexual	32	0.63
Gay or Lesbian	71	1.39
Heterosexual or Straight	3552	69.50
Not stated (person asked but declined to provide a response)	307	6.01
Other sexual orientation not listed	2	0.04
Undecided	5	0.10
Unspecified	1142	22.34
Grand Total	**5111**	**100.00**

Gender Reassignment or Gender Identity

The ESR system currently does not have the data fields to allow for the collection of data on gender reassignment or gender identity.

Disability

Disability	Headcount	%
No	3425	67.01
Not Declared	156	3.05
Prefer Not To Answer	4	0.08
Unspecified	1321	25.85
Yes	205	4.01
Grand Total	**5111**	**100.00**

Marital Status

Marital Status	Headcount	%
Civil Partnership	62	1.21
Divorced	266	5.20
Legally Separated	22	0.43
Married	2356	46.10
Single	1613	31.56
Unknown	460	9.00
Widowed	32	0.63
(blank)	300	5.87
Grand Total	**5111**	**100.00**

Pregnancy and Maternity

On Maternity	Headcount	%
Yes	102	2.00
No	5009	98.00
Grand Total	**5111**	**100.00**

Employment Category by Sex

Employment Category By Gender	Headcount Female	Headcount Male	Grand Total
Full Time	2013	1846	3859
Part Time	1033	219	1252
Grand Total	**3046**	**2065**	**5111**

Pay Scales by Sex

Pay Grade By Gender	Female	Male	Total
Band 2	239	356	595
Band 3	501	217	718
Band 4	441	184	625
Band 5	447	262	709
Band 6	406	253	659
Band 7	313	201	514
Band 8 - Range A	122	130	252
Band 8 - Range B	70	66	136
Band 8 - Range C	36	58	94
Band 8 - Range D	15	16	31
Band 9	6	12	18
Consultant	52	37	89
Other	19	16	35
Specialty Doctor	5	3	8
Specialty Registrar	374	254	628
Grand Total	**3046**	**2065**	**5111**

Profession by Sex

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	50	21	71
Additional Clinical Services	300	121	421
Administrative and Clerical	1767	1169	2936
Allied Health Professionals	118	23	141
Estates and Ancillary	68	359	427
Healthcare Scientists	91	59	150
Medical and Dental	434	296	730
Nursing and Midwifery Registered	215	17	232
Students	3		3
Grand Total	**3046**	**2065**	**5111**

Contract Type by Sex

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	670	429	1099
Honorary	5	1	6
Non-Exec Director/Chair	1		1
Permanent	2370	1635	4005
Grand Total	**3046**	**2065**	**5111**

Leavers

Row Labels	Count of Employee Number
120 Corporate Division	20
120 Health Technology Wales Division	5
120 NHS Wales Informatics Service Division	858
120 NHS Wales Shared Services Partnership Division	250
120 Research, Development and Innovation Division	4
120 Transforming Cancer Services Division	4
120 Velindre Cancer Centre	94
120 Welsh Blood Service	53
Grand Total	**1288**

Leavers continued

Employment Category	Headcount	%
Full Time	1081	83.93
Part Time	207	16.07
Grand Total	**1288**	**100.00**

Age Band	Headcount	%
<=20 Years	4	0.31
21-25	96	7.45
26-30	206	15.99
31-35	198	15.37
36-40	169	13.12
41-45	153	11.88
46-50	143	11.10
51-55	130	10.09
56-60	101	7.84
61-65	66	5.12
66-70	19	1.48
>=71 Years	3	0.23
Grand Total	**1288**	**100.00**

Staff Group	Headcount	%
Add Prof Scientific and Technic	6	0.47
Additional Clinical Services	34	2.64
Administrative and Clerical	1021	79.27
Allied Health Professionals	8	0.62
Estates and Ancillary	29	2.25
Healthcare Scientists	9	0.70
Medical and Dental	150	11.65
Nursing and Midwifery Registered	29	2.25
Students	2	0.16
Grand Total	**1288**	**100.00**

	Headcount	Headcount	Grand Total
Employment Category By Gender	Female	Male	
Full Time	445	636	1081
Part Time	156	51	207
Grand Total	**601**	**687**	**1288**

	Headcount	Headcount	Grand Total
Pay Grade By Gender	Female	Male	Total
A & C Trust Payspine - Grade C	1		1
Adhoc	8	4	12
Band 2	30	25	55
Band 3	39	22	61
Band 4	72	49	121
Band 5	108	131	239
Band 6	119	146	265
Band 7	74	107	181
Band 8 - Range A	34	70	104
Band 8 - Range B	16	34	50
Band 8 - Range C	9	24	33
Band 8 - Range D	4	7	11
Band 9	1	4	5
Consultant	2	3	5
Local Salaried GP		1	1
Specialty Doctor	4	2	6
Specialty Registrar	80	58	138
Grand Total	**601**	**687**	**1288**

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	6		6
Additional Clinical Services	23	11	34
Administrative and Clerical	443	578	1021
Allied Health Professionals	6	2	8
Estates and Ancillary	5	24	29
Healthcare Scientists	3	6	9
Medical and Dental	86	64	150
Nursing and Midwifery Registered	27	2	29
Students	2		2
Grand Total	**601**	**687.00**	**1288**

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	138	115	253
Permanent	463	572	1035
Grand Total	**601**	**687**	**1288**

Gender	Headcount	%
Female	601	46.66
Male	687	53.34
Grand Total	**1288**	**100.00**

Sexuality	Headcount	%
Bisexual	9	0.70
Gay or Lesbian	19	1.48
Heterosexual or Straight	942	73.14
Not stated (person asked but declined to provide a response)	93	7.22
Undecided	2	0.16
Unspecified	223	17.31
Grand Total	**1288**	**100.00**

Religious Belief	Headcount	%
Atheism	283	21.97
Buddhism	6	0.47
Christianity	438	34.01
Hinduism	12	0.93
I do not wish to disclose my religion/belief	168	13.04
Islam	29	2.25
Judaism	1	0.08
Other	116	9.01
Sikhism	2	0.16
Unspecified	233	18.09
Grand Total	**1288**	**100.00**

Ethnic Origin	Headcount	%
Asian	48	3.73
Black	18	1.40
Chinese	1	0.08
Mixed	17	1.32
Not Stated or Unspecified	160	12.42
Other	4	0.31
White	1040	80.75
Grand Total	**1288**	**100.00**

Disability	Headcount	%
No	955	74.15
Not Declared	52	4.04
Prefer Not To Answer	1	0.08
Unspecified	235	18.25
Yes	45	3.49
Grand Total	**1288**	**100.00**

Marital Status	Headcount	%
Civil Partnership	16	1.24
Divorced	66	5.12
Legally Separated	4	0.31
Married	555	43.09
Single	451	35.02
Unknown	136	10.56
Widowed	8	0.62
(blank)	52	4.04
Grand Total	**1288**	**100.00**

On Maternity	Headcount	%
Yes	12	0.93
No	1276	99.07
Grand Total	**1288**	**100.00**

TRUST BOARD

Integrated Radiotherapy Solution (IRS) Procurement Outline / Full Business Case (OBC / FBC)

DATE OF MEETING	26th May 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Gavin Bryce, Associate Director of Programmes Phil Richards, IRS Senior Project Manager. Nic Cowley, IRS Procurement and Commercial Manager Matthew Bunce, Director of Finance Huw Llewellyn, Director of Commercial and Strategic Partnerships
PRESENTED BY	Huw Llewellyn, Director of Commercial & Strategic Partnerships
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
IRS Project Team	06/05/2022	ENDORSED
TCS Programme Delivery Board (PDB)	13/05/2022	ENDORSED
TCS Programme Scrutiny Sub-Committee (PSSC)	19/05/2022	ENDORSED

INITIALISMS	
ABUHB	Aneurin Bevan University Health Board
FBC	Full Business Case
IRS	Integrated Radiotherapy Solution
OBC	Outline Business Case
PBC	Programme Business Case
PDB	Programme Delivery Board
PSSC	Programme Scrutiny Sub Committee
RSC	Radiotherapy Satellite Centre
nVCC	new Velindre Cancer Centre
TCS	Transforming Cancer Services
VCC	Velindre Cancer Centre

1. INTRODUCTION

1.1 The IRS Project is a high value and complex procurement / project that will provide a step change in Radiotherapy Equipment, Software, Maintenance and Support for thirteen and a half years via a prime contractor arrangement.

1.2 The IRS Project is a critical equipment enabler of the RSC and nVCC and delivers a strategic intent approved by the Trust Board in 2016 to move away from a dual vendor arrangement to an integrated single vender Radiotherapy solution. It contributes to the development of the Trust's regional Clinical Model. Most notably, for Radiotherapy is the delivery of a Radiotherapy Satellite in partnership with Anuerin Bevan University Health Board.

1.3 The IRS OBC / FBC is an integrated document that combines the requirements of both stages of these business case processes. This integration was requested and agreed by Welsh Government to offer the most efficient and effective process in providing the necessary governance for this Project.

1.4 The IRS OBC / FBC has been developed by the IRS Project Team with specialist Healthcare Planning Advisor support. The IRS OBC / FBC presents the "Case" for the proposed investment of both capital and revenue resources to deliver a range of identified benefits to the Trust and the population of its Health Board Partners. The IRS OBC / FBC is structured to reflect the Treasury Green book guidance.

2. ANALYSIS

2.1 Following on from the IRS Programme Business Case (PBC), the Strategic Case has been updated and it confirms continued alignment with national and regional cancer policies (see Annex 1).

2.2 The investment objectives have been subject to a review and remain unchanged from those previously approved by the Trust Board and Welsh Government.

2.3 All demand figures in the Strategic Case have been updated. They reflect the impact of COVID-19 and the challenges it has posed to patients accessing radiotherapy services across the UK. Within Velindre Cancer Centre this resulted in a considerable drop in attendances during 2020/2021 of 33% and a subsequent increase of 10% in 2021/2022. The growth in activity is still constrained due to a reduction in presentation of patients with suspected cancer in primary care; the backlog of patients waiting for diagnostics and treatment; and the impact of measures to provide COVID safe care e.g. social distancing; additional infection prevention control measures which have reduced throughput and have the effect of capping available capacity.

2.4 The Strategic Case sets out a compelling case for investment given the forecast increase in demand, the advances in radiotherapy treatments, the inherent inefficiencies of the current technology and the age of the linear accelerator fleet at Velindre Cancer Centre.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	IRS Requirements relate directly to the quality of service that will be capable of being delivered by the solution
RELATED HEALTHCARE STANDARD	Safe Care
	IRS Requirements relate directly to the quality of service that will be capable of being delivered by the solution
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Completed at Programme Level
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Requirements will link to the Contract
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The requirements inform the proposed solution which in turn has financial costs

4. RECOMMENDATION

4.1 The Trust Board is asked to **APPROVE** the Strategic Case of the IRS OBC/FBC.

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Appendix B

Outline / Full Business Case: Update May 2022

Integrated Radiotherapy Solution

Strategic Case

STRATEGIC CASE

1 INTRODUCTION AND BACKGROUND

Introduction

1.1 The purpose of this business case is to present proposals for the procurement of an Integrated Radiotherapy Solution (IRS) that will ensure Velindre University NHS Trust (VUNHST) can continue to deliver safe, efficient and effective Radiotherapy Services to the population of Southeast Wales.

1.2 Having previously scrutinised and endorsed a Programme Business Case (PBC), VUNHST and Welsh Government have approved the commencement of an IRS procurement and the associated development of a combined Outline Business Case and Full Business Case (OBC/FBC). This approach recognises the non-traditional nature of this business case, in particular:

- There is an increasingly urgent need to start to replace aging Radiotherapy Equipment in the current Velindre Cancer Centre (Phase 1) as part of normal equipment replacement.
- Delivery of the IRS Project within required timescales is critical to delivery of the overall Transforming Cancer Services in Southeast Wales (TCS) programme timelines; and
- Dependencies and overlaps with the new Velindre Cancer Centre (nVCC) and Radiotherapy Satellite Centre (RSC) Projects.

1.3 This introductory section provides an overview of:

- The context of the proposed investment
- The governance arrangements for the Project; and
- The structure and content of the business case.

Context of proposed investment

1.4 The Trust, and its partners, are committed to providing safe, efficient and effective care to all our patients. To achieve this from a Radiotherapy perspective, it is essential that major medical equipment is renewed as part of a regular replacement cycle. This reduces the likelihood of equipment failure, obsolescence and ensures the most up to date treatments are available to our patients to support improved outcomes and quality of life.

1.5 This procurement project is critical to delivery of the Trust's long-term strategy, specifically the Transforming Cancer Services in South Wales (TCS) programme. This is an ambitious programme, which aims to deliver transformed Tertiary non-surgical Cancer Services for the population of Southeast Wales.

1.6 Central to this strategy is the need to provide new radiotherapy clinical equipment and digital solutions that will support the new Velindre Cancer Centre (nVCC), the Radiotherapy Satellite Centre (RSC) and, importantly, the existing Velindre Cancer Centre (VCC). This will facilitate the transformation opportunities that modern clinical equipment and digital solutions can deliver. It will also support service resilience, at a time of significant service demands, on an aged radiotherapy treatment machine fleet, which will be described in more detail later in this section.

1.7 Originally, it was planned that most of the major medical equipment, including radiotherapy equipment, would be replaced when the nVCC was opened. The rationale for this was that implementation costs would be reduced with the existing equipment 'stretched' beyond its recommended lifespan.

1.8 This original approach negated the need to relocate major medical equipment, which would affect service capacity, as downtime would be required during the lengthy recommissioning period.

1.9 Unfortunately, delays to the nVCC Project resulted in an increasing operational service delivery risk due to aging radiotherapy equipment at the VCC. This increasing risk, combined with the long lead times for equipment procurement, meant that alternative approaches needed to be considered. A review identified that the 'decoupling' of the IRS requirements from the nVCC Project and Radiotherapy Satellite Centre projects was required to effectively manage the new environment.

1.10 In order to effect this change, a Digital and Equipment Procurement De-coupling PBC was submitted to Welsh Government. After consideration and scrutiny, this PBC was endorsed by Welsh Government on 5th June 2019. Subsequently, VUNHST received a funding letter to facilitate the initial procurement phase of the IRS Project to a value of £1.11 million over three financial years starting in September 2019.

1.11 The Trust subsequently established the IRS Project Team that was independent of, but still related to, both the nVCC and RSC Project Teams.

1.12 It is also important to highlight that any decision to proceed with the contract will not commit the Trust or Welsh Government to any equipment and services beyond that which would be required to replace the existing treatment machine fleet at the VCC. The procurement is designed to achieve this aim whilst also facilitating the nVCC and RSC Projects through commercial and contractual design.

1.13 To support this independent, but facilitative approach, a Project agreement has been reached with the Welsh Government to develop a combined OBC/FBC which seeks approval to procure an IRS independent of approval of the nVCC and RSC OBCs. This procurement will include the following items:

- Radiotherapy Treatment Machines / Equipment
- Radiotherapy Informatics Solution (including Oncology Information System (OIS) and Treatment Planning System (TPS)
- Dosimetry, Quality Assurance Systems
- Clinical & Patient Safety Systems
- Ancillary equipment, IT and infrastructure.
- Project Management, Ongoing Support and Development Services
- Research & Development (including the option of a research machine in a bunker at the nVCC)

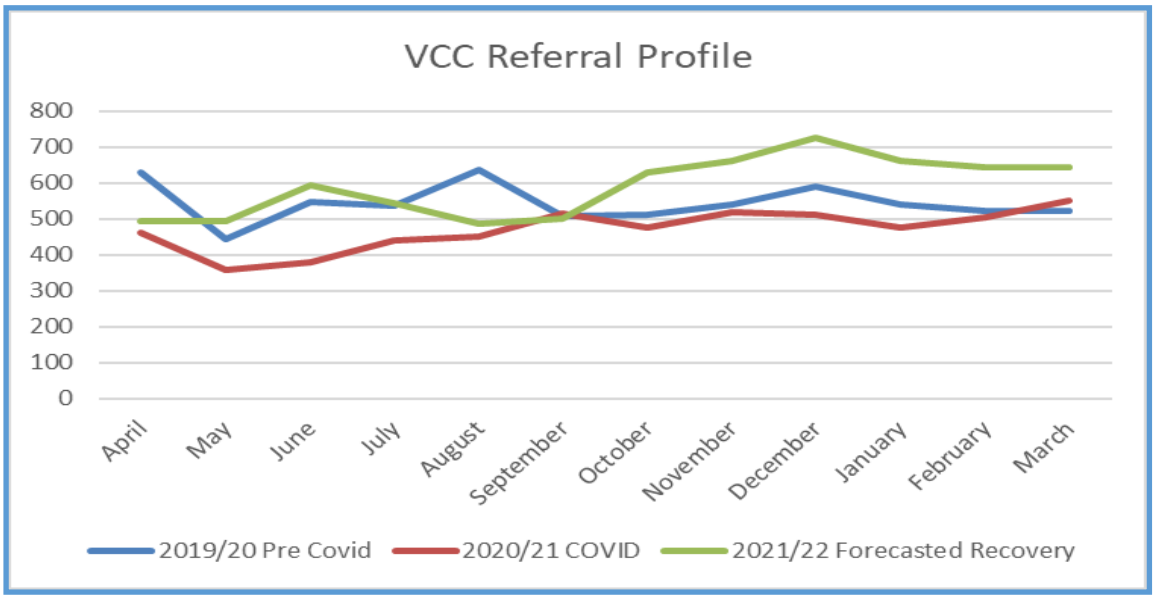
1.14 The business case confirms the need for VUNHST to deliver a modern radiotherapy solution that is resilient and has greater capability and capacity to enable the Trust to continue to treat increasing numbers of referrals from secondary care, which increasingly require more complex radiotherapy treatments.

1.15 The post COVID-19 surge of patients who have not accessed healthcare during the pandemic is still a distinct possibility. Some of these patients may present with later “staging” and require more complex treatments which will put additional pressure on VCC resource.

1.16 The table below shows the referral profile for 2019/20, 2020/21 (COVID) and 2021/22 Actual and Forecast recovery including the impact of the following:

- In 2020/21 referrals dropped by 13% due to the impact of Covid
- Recovery in 2021/22 includes full recovery from 2020/21 plus 8% growth in referrals based on growth experienced as at October 2021.

	April	May	June	July	August	September	October	November	December	January	February	March	Annual
2019/20 Pre Covid	628	442	547	536	635	506	511	539	591	539	522	523	6519
2020/21 COVID	461	357	379	441	452	515	477	520	510	476	503	552	5643
2021/22 Forecasted Recovery	493	494	594	545	486	500	629	663	727	663	642	643	7079



1.17 This includes the following assumptions:

- As covered above the COVID impact in 2020/21 was a reduction of 13% (876 Referrals), recovery started in October 2020 with Radiotherapy impacted due to lack of surgical bed capacity in UHB's. This continued through to September 2021 where an increase to Pre Covid levels occurred in September 2021
- The predicted 'Surge' or suppressed demand forecasted by the DU did not materialise at VCC due to extended diagnostic and treatment delays within UHB's, as well as suspension and reactivation of screening. We now have 12 – 14 weeks visibility of referrals from 'Point of Suspicion referrals and are now refining this to the 'Decision to Treat' stage.
- The patient pathway timing from 'Point of Suspicion 'referrals within the UHB's has increased from 127 days to 200 days, this varies by tumour site as well as by UHB 's now giving priority to Medium – High Risk patients in some instances presenting with later stage
- We have patient referrals on a frequent basis from our 3 predominant University Health Boards which act as an early warning of potential surge

- We are experiencing higher than forecast referrals for Breast (5%) and Colorectal (18%) we also suspect a significant number of Urology referrals are currently retained within UHB's

1.18 The IRS solution is also needed as a core element of the radiotherapy equipment replacement cycle at VCC, which had previously slowed due to the original planned delivery of the nVCC (now delayed). As predicted previously, the reliability of some of the Trust's Linear Accelerators has deteriorated with time. This has led to operational reliability issues and increased maintenance costs.

1.19 The procurement provides capacity to meet current demand and future growth forecasts. Forecasts that also underpin the need for the planned Radiotherapy Satellite Centre, and to facilitate the delivery and timeline of the nVCC and RSC Projects.

1.20 This OBC/FBC explores a range of options to identify a solution that both supports the urgent need to mitigate service delivery risks and enable current services, whilst supporting the key dependencies of the TCS Programme; specifically, the nVCC and the RSC projects.

1.21 At the time of finalising this business case the nVCC Project, is in the process of concluding competitive dialogue and moving towards final tender. Once the tendered costs are known from the Successful Participant the Full Business Case will be finalised and submitted to the Trust Board, Welsh Government and the Trust's Commissioners.

1.22 This document, as agreed by Welsh Government colleagues, comprises the second phase of a two-phase submission process which incorporates the following phases set out overleaf:

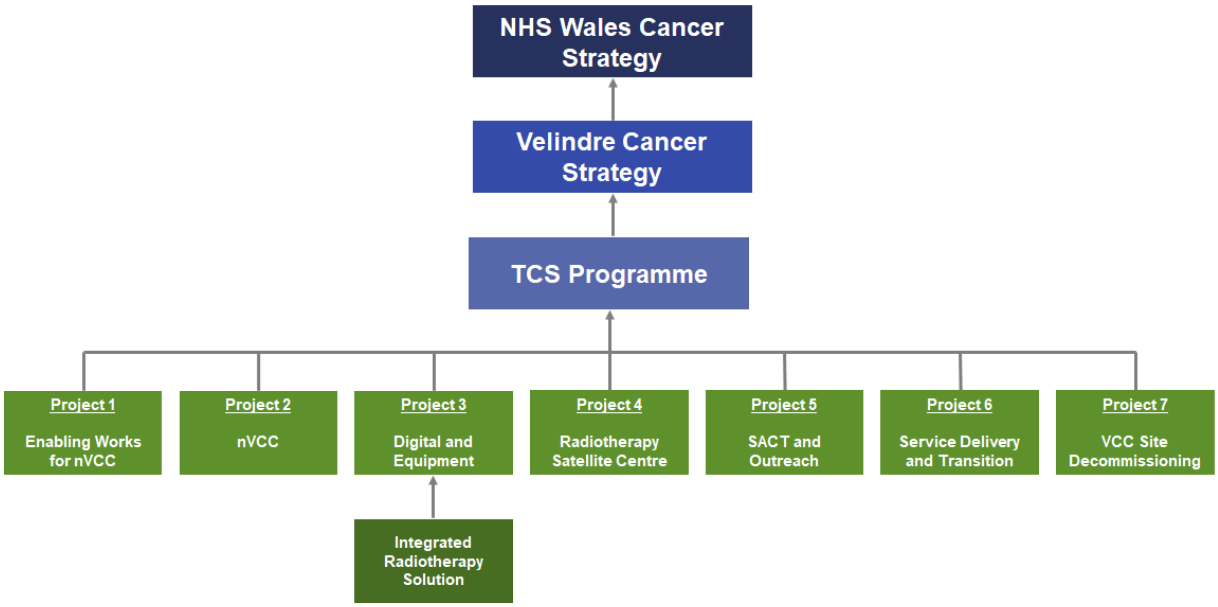
- **Phase 1:** An initial draft of the business case (submitted in November 2020) was developed in advance of the procurement process being completed. It set out the OBC requirements for the Strategic and Management Cases. It also set down the core components of the Commercial Case that are supplemented with the final contractual arrangements at FBC Stage. In addition, it outlined the options and set out the templates for the Economic and Financial Cases, although at that stage the templates within these chapters excluded costs and no conclusions were reached as the procurement was ongoing.

- **Phase 2:** This final version incorporates the results of the procurement process to complete the Economic, Commercial and Finance Cases, and refine, following feedback from WG scrutiny at Phase 1, the Strategic and Management Cases. This aligns with FBC requirements for all cases.

Project governance arrangements

1.23 As described earlier, the IRS project sits within the wider TCS programme which is designed to facilitate key aspects of the Velindre Cancer Strategy and NHS Wales Cancer Strategy.

Figure 1-1 Programme overview



1.24 The approval process for this business case is outlined in the table below.

Table 1-1 Business case approvals process

Approval Step	Purpose	Submission Target Date
Phase 1 Draft to Welsh Government	For review	November 2020
Phase 2 Final to Trust Board	For approval	May 2022
Phase 2 Final to Welsh Government	For approval	May 2022

1.25 The Project structure, and detailed governance arrangements, are further outlined in the Management Case.

Structure and content of OBC/FBC

1.26 This business case has been prepared in accordance with HMT Green Book and Welsh Government Better Business Case guidance, adapted to reflect the combined OBC/FBC format and two-phase submission approach that has been agreed with Welsh Government colleagues. The table below outlines how the phased approach has been applied to the Five Case model.

Table 1-2 - Phased approach and key components of the OBC/FBC

Chapter	Phase 1	Phase 2
Strategic Case	Sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme.	Refined and updated.
Economic Case	Explores the potential long list of options and identifies the preferred way forward and shortlist of options. Provides a template for completing the economic appraisal and outlines the main benefits of shortlisted options.	Appraises the economic costs, benefits and risks for the short-listed options based on the results of the procurement process. Demonstrates the preferred option best meets the needs of the service and optimises value for money.
Commercial Case	Describes the procurement strategy adopted and outlines the content and structure of proposed contract and associated contractual arrangements.	Provides the results of the procurement process and final proposed contractual arrangements.
Financial Case	Provides a template for completing the financial appraisal.	Sets out the financial implications of the preferred option based on the results of the procurement process. Confirms funding arrangements and affordability and explains any Balance Sheet impact.
Management Case	Demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality.	Refined and updated.

2 ORGANISATIONAL OVERVIEW

Introduction

2.1 The purpose of this section is to provide an overview of Velindre University NHS Trust (VUNHST) and Velindre Cancer Centre and its role in delivering non-surgical specialist cancer services to the population of Southeast Wales.

Velindre University NHS Trust

2.2 The Trust has evolved significantly since its establishment in 1994 and is operationally responsible for the management of the following two divisions:

- Velindre Cancer Centre; and
- Welsh Blood Service.

2.3 The Trust is also responsible for hosting the following organisations on behalf of the Welsh Government (WG) and NHS Wales:

- NHS Wales Shared Services Partnership (NWSSP); and
- Health Technology Wales (HTW)

Velindre Cancer Centre

2.4 Velindre Cancer Centre is located in Whitchurch on the North-West edge of Cardiff and is one of the ten largest regional clinical oncology centres in the United Kingdom (UK Radiotherapy Equipment Survey, 2008) and the largest of the three centres in Wales. The centre is in a building which is over 60 years old and does not have the facilities, space or modern infrastructure required to meet future service standards and predicted demand.

2.5 Velindre Cancer Centre is responsible for the delivery of non-surgical treatment, including Radiotherapy and SACT, recovery, follow-up and specialist palliative care. Following their specialist cancer treatment, Velindre Cancer Centre continues to support patients during their recovery and through follow up appointments. A significant proportion of Outpatient and SACT activity is already delivered in Health Board settings by Velindre Cancer Centre staff. However, all Radiotherapy activity is currently delivered at the Velindre Cancer Centre.

2.6 Specialist teams provide care using a well-established multi-disciplinary team (MDT) model of service for oncology and palliative care, working closely with local partners and ensuring services are offered in appropriate locations in line with best practice standards of care. The range of services delivered by Velindre Cancer Centre includes:

- Radiotherapy
- Systemic Anti-Cancer Therapies (SACTs);
- Inpatients
- Ambulatory car
- Outpatient services
- Pharmacy
- Specialist radiology/imaging
- Nuclear Medicine
- Specialist Palliative care
- Acute Oncology Service (AOS
- Living with the impact of cancer
- Education and Learning; and
- Research, Development and Innovation

2.7 The following patient services are delivered in outreach settings across Southeast Wales from the Velindre Cancer Centre in Health Board settings:

- SACT delivery
- Outpatient appointments
- Inpatient reviews; for patients receiving care and treatment in HB locations
- Health Board MDTs; and
- Research and Education

2.8 However, all Radiotherapy activity is currently delivered at the Velindre Cancer Centre.

Overview of Cancer Services in Southeast Wales

2.9 The planning and delivery of cancer services in Southeast Wales is the responsibility of the four Health Boards (HBs) as part of their statutory responsibility to meet the health needs of the populations they serve. The HBs are supported by the Welsh Health Specialist Services Committee (WHSSC) which commissions specialist cancer services on their behalf.

2.10 The four HBs in Southeast Wales are:

- Aneurin Bevan University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Morgannwg University Health Board; and
- Powys Teaching Health Board

Figure 2-1 Map of Local Health Boards across South East Wales

2.11 The HBs also work in partnership with the All-Wales Cancer Network, NHS Trusts, Community Health Councils, Voluntary and Charitable Organisations and Public Health Wales.

2.12 The four Health Boards, in conjunction with VUNHST and other stakeholders e.g., Wales Cancer Network (WCN), have formed the Southeast Wales Collaborative Cancer Leadership Group (CCLG). The purpose of the *Southeast Wales CCLG* is to provide effective system leadership for Cancer Services across Southeast Wales and to deliver improvements in outcome and service experience for the catchment population. It aims to achieve this through the building and nurturing of a sustainable, collaborative cancer community across the region to align change across the whole cancer system.

2.13 The CCLG oversees all Collaborative Cancer Programmes of work within the region, ensuring clear leadership and coordination with a focus on benefits delivery for patients, putting into practice the national policies, standards and procedures for the benefit of patients. The CCLG functions at a regional level in support of the work of the Cancer Implementation Group (CIG), a national group leading the implementation of the Single Cancer Pathway, and other Strategic Groups, on an All-Wales level.

2.14 The CCLG also looks beyond health to ensure its ways of working embed the Well-being and Future Generations (Wales) Act 2015 and contribute to the seven Well-being goals, the five ways of working and the embedding of the sustainability principle.

The Cancer Pathway

2.15 The delivery of cancer services across Wales generally conforms to a well-defined pathway of care which includes the following five key stages:

Table 2-1: The Cancer Pathway

Cancer Prevention: Enhancing public awareness and education to make informed decisions about lifestyle choices that promote a healthy, cancer free population.
Cancer Diagnosis: Cancer can be identified through a National Screening Programme or where cancer symptoms are identified by the patient/health care professional. If cancer is suspected the patient is assessed by a multi-disciplinary team in the Health Board (often supported by Velindre Cancer Centre staff) and cancer may be diagnosed.
Treatment: The treatment options for every patient are discussed and considered by multi-disciplinary teams (MDTs). The treatment options include surgery, non-surgical treatment e.g., Radiotherapy or Systemic Anti-Cancer Therapy (SACT), a combination of these treatments and supportive care. Care often straddles organisational boundaries.
Recovery/Follow Up: Regular follow up appointments are important to monitor recovery, manage and reduce the aftereffects of treatment and to ensure any signs of cancer relapse/recurrence are identified at their earliest stage.
End of Life Care: Sadly, not all patients survive cancer – openness about the need to plan end of life care is essential. A focus on living and dying well, early identification of needs and access to fast, effective palliation are important to reduce distress for both the patient and their family.

3 STRATEGIC CONTEXT

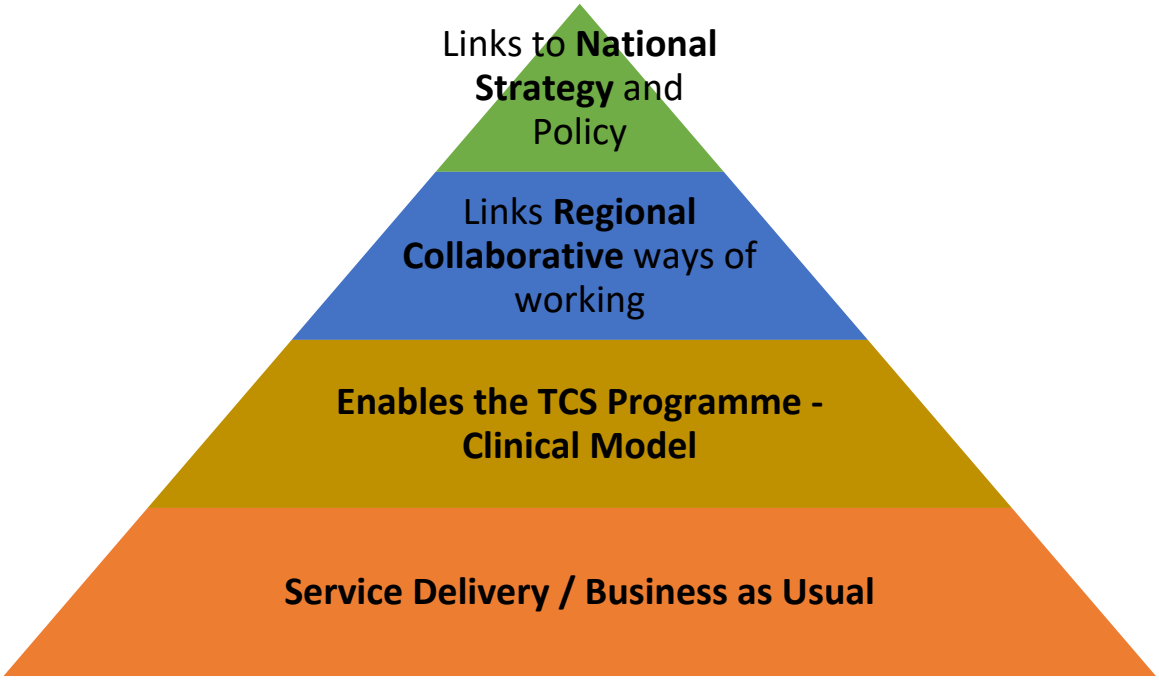
Introduction

3.1 This section of the business case outlines the strategic context for the proposals to procure an Integrated Radiotherapy Solution (IRS) by explaining how the project is strategically placed to support delivery of local and national goals.

3.2 Specifically, it considers the fundamental drivers behind these proposals including:

- Links to National Strategy and Policy
- Links to Regional Collaborative ways of working
- Enabling the Transforming Cancer Services in Southeast Wales (TCS) Programme by identifying the need for investment to support the future Clinical Model; and
- Service Delivery / Business as Usual needs: The need to maintain business as usual activities and to regularly and routinely replace major medical equipment

Figure 3-1 Fundamental Drivers



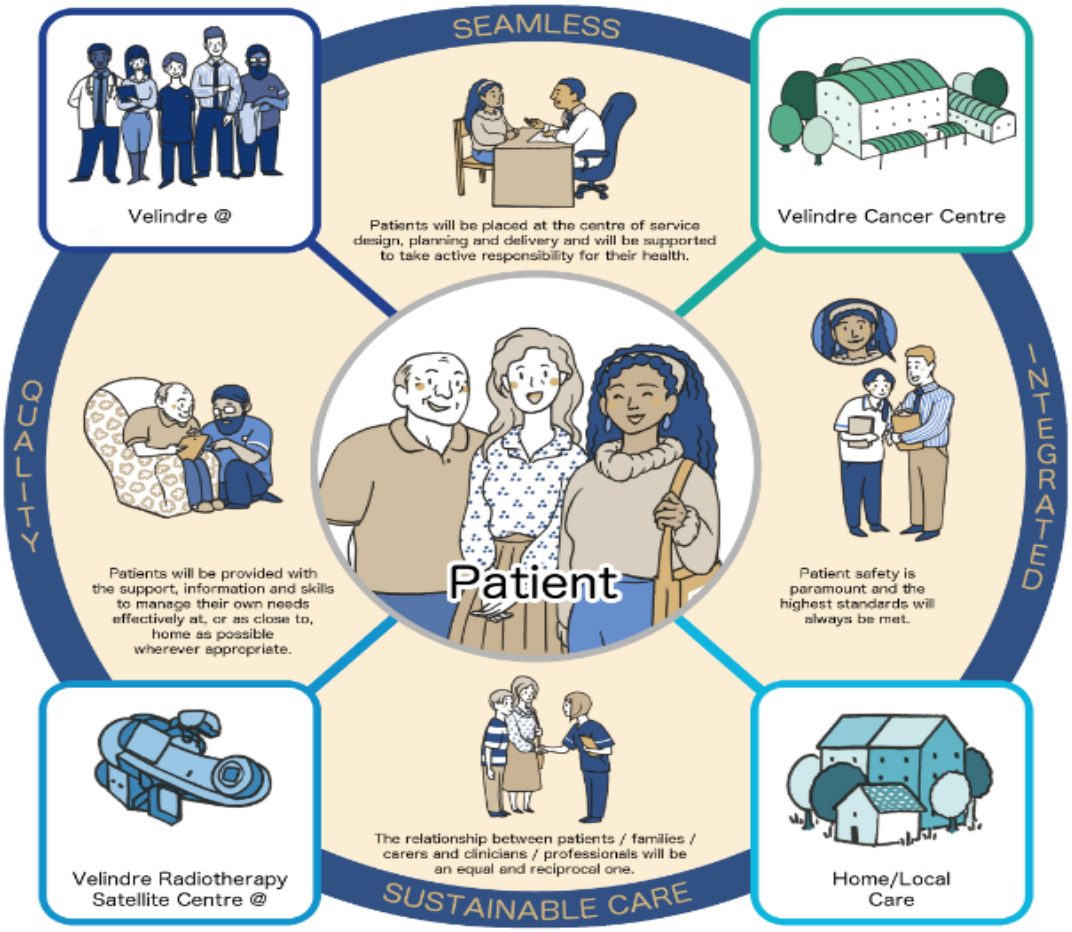
Alignment with TCS Programme

3.3 It is important to understand where this business case sits in the context of the overall Transforming Cancer Services (TCS) Programme and in the context of the requirement to continue to deliver safe, resilient and effective services from the VCC. In the case of the former, the TCS Programme is an ambitious Programme which aims to deliver transformed Tertiary non-surgical Cancer Services for the population of Southeast Wales.

3.4 The Strategic Case for the TCS Programme, its links to the Welsh Government Cancer Strategy and Velindre's own Cancer Strategy, are made in the TCS PBC. It is not the intention of this business case to restate these, rather to show alignment with this wider Programme's aims and objectives.

3.5 The TCS Programme developed a detailed clinical model through over 70 workshops/events/meetings involving more than 1,000 people – professionals, patients and public from a range of organisations including HBs, Third Sector and CHC. The clinical model is shown overleaf.

Figure 3-2 Clinical model



3.6 The Clinical Model within the TCS PBC, and as outlined in the diagram above, describes how services will be delivered in the future and is predicated on the following principles:

- The service model seeks to promote a new set of relationships which work in partnership to improve the way we collectively design and deliver services around patients' needs and to achieve these improvements in a truly sustainable way.
- The patient will be central to our plans with an integrated network of services organised around them. The organising principle seeks to 'pull' high quality care towards the patient that is accessible in their preferred location and will support them achieving their personal goals during treatment and subsequently living with the impact of cancer.
- Patient safety is paramount, and the highest standards will always be met.
- The relationship between patients / families / carers and clinicians / professionals will be an equal and reciprocal one.
- Patients will be provided with the support, information and skills to manage their own needs effectively at, or as close to, home as possible wherever appropriate.
- Optimising information technology, quality improvement systems, patient involvement, education and embracing innovative approaches to healthcare will all be essential to achieve high levels of service quality in a sustainable way.

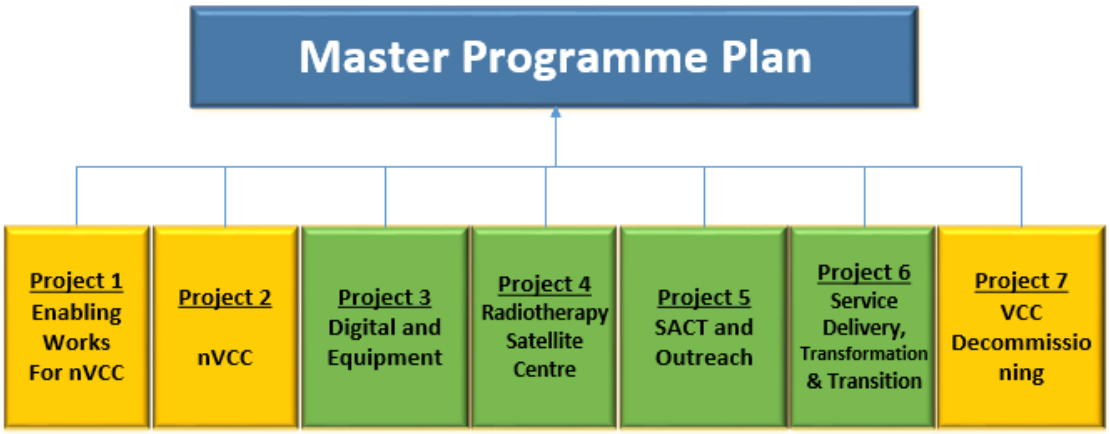
3.7 To deliver the principles of the new clinical model, care will be delivered differently and at different locations. This will require a number of infrastructure and technology projects as well as service change projects to be established.

3.8 These locations and their functions are described briefly below:

- **Health Boards**: A range of cancer care occurs within the Local Health Boards (LHBs), with a proportion of patients having all their care delivered by the Local Health Board (LHB) teams. For other patients who need non-surgical treatment, their care needs to be seamlessly planned with the non-surgical aspects of the pathway, as patient care can often transition from one team to another. The Velindre Outreach facilities and collaborative working will support this approach.
- **Velindre Outreach Centres:** These facilities will provide SACT, outpatient services, education and information provision and ambulatory care procedures within LHBs.
- **Velindre Radiotherapy Satellite Centre:** The Radiotherapy Satellite Centre (RSC) will provide radiotherapy treatment for approximately 20% of our patients (provided by 2 new treatment machines). This means better access for patients, reduced travel for patients and less use of transport services. This will mean that fewer patients need to travel to VCC for their radiotherapy.
- **New Velindre Cancer Centre:** The new Velindre Cancer Centre will provide specialist and complex cancer treatment including SACT, radiotherapy (including brachytherapy and unsealed sources) and specialist palliative care, inpatient facilities (being open for admission 24 hours/day, 7 days/week), a specialist acute oncology assessment unit and outpatient services, radiology and nuclear medicine.

3.9 To effectively control and successfully implement the TCS Programme it has been arranged into the following seven projects as set out below.

Figure 3-3 Seven TCS Projects



3.10 The seven Projects are structured and described in the table below.

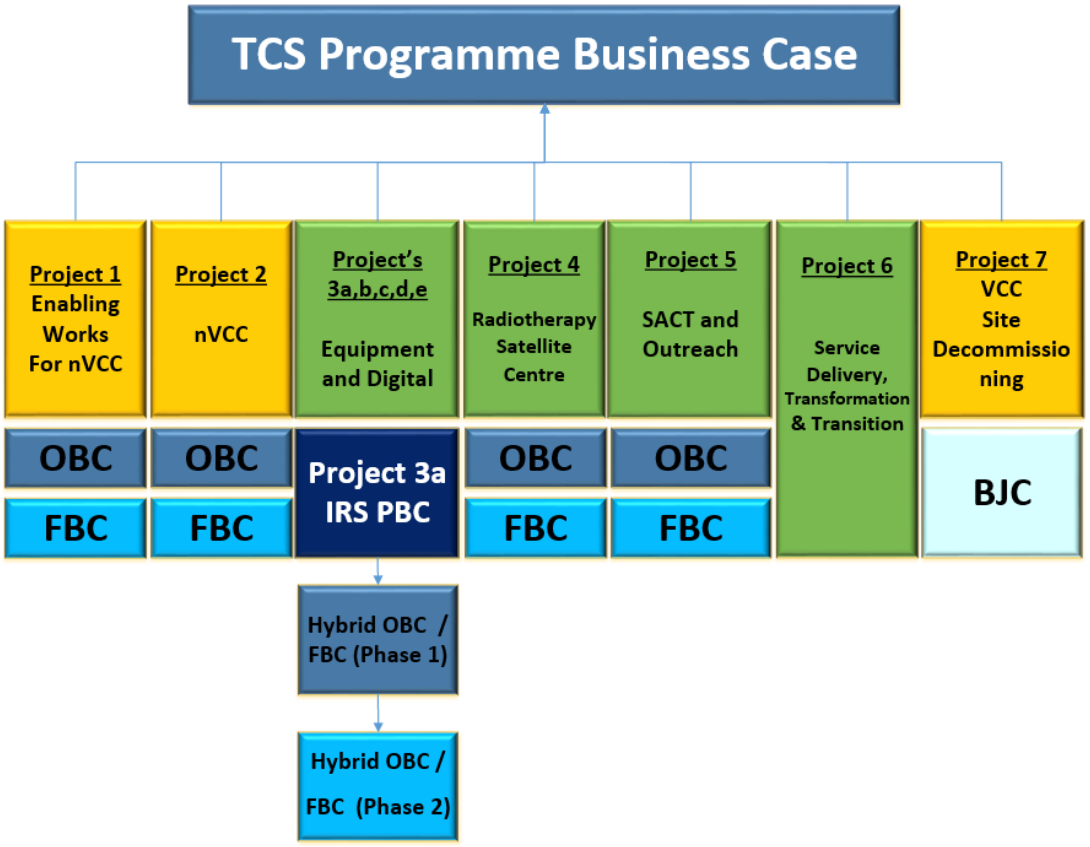
Table 3-1 Project Descriptions

Project Number / Name		Description
1	Enabling Works	All Enabling works needed to provide Primary and secondary access to the new Velindre Cancer Centre Site (includes the provision of utilities).
2	New Velindre Cancer Centre	The re-provisioning of a new Velindre Cancer Centre in the Whitchurch area of Cardiff.
3	Digital and Equipment	The provision of integrated Digital Information and Equipment Services across the TCS Programme. This Project oversees the IRS Project.
4	Radiotherapy Satellite Centre	Provision of a Radiotherapy Satellite Centre at Nevill Hall Hospital.
5	SACT and Outreach	The Provision of SACT and Outpatient services embedded in Local Health Boards. A minimum of two locations and a maximum of four
6	Service Delivery Transition and Transformation	This project is responsible for establishing and transforming all service delivery functions across the clinical model. It is also responsible for planning and implementing the transition between the old and new cancer centre.
7	Site Decommissioning	The decommissioning of the old Velindre Cancer Centre brownfield Site.

3.11 To deliver the TCS Programme, as described in the TCS PBC, a suite of Investment Cases is required, and it is important that this business case is seen in the context of the other investment cases that are being developed.

3.12 The diagram below sets out the TCS Programmes Business Case Framework and how it aligns to the seven projects.

Figure 3-4 TCS Programmes Business Case Framework



3.13 The diagram above sets out the TCS Programme Business Case Framework; the following principles apply following an assessment of cost and complexity relating to the individual projects:

- For all major infrastructure schemes (Projects 1, 2, 4, 5) an Outline and Full Business Case will be developed unless the costs and complexity for Project(s) 5 are deemed to be low cost and non-complex where a Business Justification Case may be more appropriate. If a BJC is to be considered it must have the support of the investment decision maker.
- A BJC is expected to be required for the decommissioning project (Project 7). This assumption will be tested and will need to be agreed by Welsh Government later in the programme.
- Project 6 Service Delivery Transition and Transformation is predominately service change with no infrastructure. These costs will be met by the Trusts commissioners and as such no Capital Business Case will be produced (although justification in other forms will be provided).

- Project 3 Digital and Equipment has five projects in total, of which this IRS Procurement and Implementation Project is project 3a, will have different arrangements. The procurement of the IRS outlined in this business case will be structured in such a way that it can facilitate the delivery of this Project in the event of the business cases for nVCC (Project 2) and RSC (Project 4) gaining approval.

3.14 The capital equipment costs for IRS will also be referenced in the OBCs for the nVCC and RSC Projects. This business case will allow VUNHST to procure the IRS (Phase 1 Implementation), as this is now urgent to maintain safe, resilient and effective services within the VCC, and the rationale for this will be described in later sections.

Trust Radiotherapy Equipment: Strategic Direction

3.15 Given the importance of clinical equipment to the Trust in delivering effective, high quality and safe patient care there have been a number of previous approvals made by the Trust Board that set the strategic direction of travel for equipment, these are:

- The Prime Contractor approach for treatment machines (procurement approach).
- The TCS Equipment Strategy.
- Cognitive by Design (Digital Vision).

The Prime Contractor Approach

3.16 In 2015 members of the Radiotherapy Development Group (RDG) reviewed the impact of running Velindre Cancer Centre (VCC) as a dual-vendor site for treatment machines. The review concluded that operating within the confines of a dual-vendor site detrimentally impacted on a number of areas of the radiotherapy service, including:

- Efficiency and patient flow
- Capacity and the ability to work flexibly
- Workforce and the burden of training (planning and treating patients; and maintaining, running and operating the machines)
- Support services including the Record and Verify (R&V) and IT software
- Resources to undertake a competitive tender process for every new machine
- Resources to manage two commercial contracts and service providers: and
- Limitations on Research and Development capacity.

3.17 This is explored further in the Business Needs section in Chapter 4.

3.18 The Velindre University NHS Trust Board, in September 2016, approved the recommendation that VCC should undertake a compliant and transparent procurement exercise to identify a 'Prime Contractor' to meet VCC's capital radiotherapy equipment needs. The anticipated benefits linked to this decision included:

- Patient Outcome
- Patient experience and satisfaction
- Staff satisfaction
- Service resilience and efficiency
- Business and financial planning
- Research and development
- Reputation

TCS Equipment Strategy

3.19 On the 8th of March 2017 Velindre's Board approved a TCS Equipment Strategy that set out how Velindre planned its equipment requirements needed to enable the TCS Programme.

3.20 The approved position was as follows:

Table 3-2 Approved Position

Category	Approved Decision
Replacement Options	Extend the operational life of some existing equipment assets, accept some accelerated depreciation (on others) and replace all new in nVCC
Transition Options	Replace all Radiotherapy Treatment Machines using a 'big bang' approach
Maintenance Options	Co-produced In-house and Vendor (as now)

3.21 The delivery model adopted in the nVCC OBC was agreed with Welsh Government in 2017 and aligned to this approach.

3.22 It should be noted that as a result of significant slippage in the nVCC Project the approach outlined above needed to be adapted to manage service-related risks. These risks and the potential solution will be described later in this section.

Cognitive by Design

3.23 VUNHST has been progressing significant developments in Information Management and Technology (IM&T) systems. These have been a combination of national programmes, internationally used systems and bespoke local developments all of which have enabled an improvement in services for professionals, patients, and donors. The Trust has prioritised the development of its IM&T Strategy to support the identified organisational and clinical priorities and to ensure that next generation IM&T is used to transform service delivery. At the heart of the informatics delivery are the four principles from the "Informed Health and Care: A Digital Health and Social Care Strategy for Wales" (2015).] These are:

- Information for you (the patient).
- Supporting Professionals (digital tools).
- Improvement and Innovation (better use of information / whole systems approach).
- A Planned Future (joint planning regional and national).

3.24 VUNHST has produced an ambitious strategic informatics programme, "Digital Excellence", which over the next five years, will implement a range of national technology solutions, while growing our capacity and capability to embrace innovative technologies. This is based on the fundamental premise that high quality healthcare in the 21st century cannot be delivered with out of date or obsolete legacy systems, and/or paper-based information recording and delivery. TCS has developed a strategic vision for Cancer Services entitled "Cognitive by Design" that underpins the digital programme for future investment.

3.25 By utilising IM&T as a critical enabler to support service transformation, Velindre University NHS Trust aims to fundamentally redesign administrative, operational and clinical processes to maintain high levels of data quality, and not only ensure information is accurate and up to date, but also embedding state of the art technologies to deliver exceptional services.

3.26 The enablement of, and connectivity of staff and patients is critical to the success of the Digital Programme. To this end the Trust is working with colleagues from across NHS Wales to ensure mobile computing requirements, patient engagement systems, as well as digital staff communication tools are at the forefront of the Digital Programme.

3.27 To ensure the Trust continues to provide the most effective informatics services, we will continue to explore further opportunities for standardisation of processes, rationalising systems and solutions, alignment of resources, where possible, and share best practice both from across the divisions, and also externally, by incorporating the lessons from other Health Board/Sector experiences.

3.28 The future design of a fully integrated radiotherapy solution is a key aspect of new ways of working, modernising and rationalising the number of digital systems so that clinicians will be trained in one system rather than specialising or only being able to use one or other of the existing applications.

3.29 This activity will involve significant process flow mapping and data migration of existing services to ensure that future services are fit for purpose. This will be a complex and resource intensive activity but will be fundamental to the future successes of the service.

3.30 Over the last two years and following a separate business case proposal the Trust has implemented an interim radiotherapy treatment planning system to ensure a resilient as possible service due to legacy arrangements no longer being available. The treatment planning system will be an important feature of the transition to the IRS service.

3.31 To ensure that the Trust's digital vision has been robustly tested the Trust has commissioned an assurance review of its Digital Vision, development plan and delivery capacity. This assurance has been delivered by an industry leader in this field (Channel 3).

3.32 The report provides assurance across the range of areas reviewed. Channel 3 have confirmed that:

- The digital vision aligns with the clinical vision providing clarity in objectives which are generally well understood.
- The programme plan is being built on solid foundations.
- The skills and capabilities of the existing team are high.

3.33 Specifically, in relation to our Radiotherapy Solution PBC the Channel 3 Report confirms that:

'The procurement of the new Radiotherapy Treatment Machines is being well managed according to best practice. The use a competitive dialogue process enables value to be driven out of the procurement. The Programme is engaging expert advice to compliment the "in house" expertise available. Engagement with national Advisory Services is efficient and consistent'.

Links to National Strategy

3.34 By enabling delivery of the TCS programme, the project aligns with key national strategies including the ***Welsh Government Programme for Government 2021-26*** which sets out Welsh Government commitments over the next five years to improve the lives of people across Wales. The project specifically aligns with the following well-being objectives:

- **Provide effective, high quality and sustainable healthcare** by creating a 21st century NHS that tackles health inequalities and focuses on prevention. Specifically, by improving access to Radiotherapy services.

- **Build an economy based on the principles of fair work, sustainability and the industries and services of the future** by building an economy based on sustainable jobs. Specifically, by creating skilled jobs and apprenticeships.
- **Build a stronger, greener economy as we make maximum progress towards Decarbonisation** by developing a modern and productive infrastructure which acts as an engine for inclusive and sustainable growth.
- **Embed our response to the climate and nature emergency in everything we do by delivering a green transformation**. Specifically, through greater green energy.

3.35 ***Ministerial Priorities for NHS Wales*** published on 9 July 2021, set out the Minister for Health and Social Care's eight priorities for NHS Wales to complement and contribute to the Welsh Government Programme for Government. The projects will directly contribute to these as follows:

- **Covid-19 Response:** Ensuring there is adequate capacity to meet future demand.
- **NHS Recovery:** Long term capacity to meet demand.
- **A Healthier Wales:** Improved access and better patient outcomes.
- **NHS finance and managing within resources:** Providing best value for money.
- **Supporting the health and care workforce:** Improvements to workflow releasing staff time.

4 CASE FOR CHANGE

Introduction

4.1 This section of the business case establishes the case for change for the procurement of an Integrated Radiotherapy Solution (IRS) by providing a clear understanding of:

- The spending objectives (what the proposals seek to achieve);
- Existing arrangements (what is currently happening); and
- Business needs (what is required to close the gap between existing arrangements and what is required in the future).

Spending objectives

4.2 As this business case is facilitative of, whilst also being independent of, the overall TCS Programme Business Case, it is important for this investment case to align and support the delivery of the overall TCS Programme's spending objectives.

4.3 The Investment Objectives for the IRS therefore been aligned with the TCS Programme spending objectives, refined to fit with the procurement of this type of solution, and also to meet the spending objectives of the existing VCC.

4.4 The Investment Objectives for this proposal are set out in the table below and are matched to the TCS Spending Objectives:

Table 4-1 Spending objectives

Ref	TCS Spending Objective	Ref	IRS Investment Objective
PSO1	To build a new hospital that supports quality and safe services	RIO1	To procure and implement a new Integrated Radiotherapy Solution that supports quality and safe services
PSO2	To provide sufficient capacity to meet future demand for services	RIO2	To provide an Integrated Radiotherapy Solution that has sufficient capacity to meet future demand for services
PSO3	To improve patient, carer and staff experience	RIO3	To deliver an Integrated Radiotherapy Solution that improves patient, carer and staff experience
PSO4	To provide capacity and facilities to support the delivery of high-quality education, research, technology and innovation	RIO4	To provide an Integrated Radiotherapy Solution that promotes capacity and the delivery of high-quality education, research, technology and innovation in Radiotherapy

Existing arrangements

4.5 Currently all Radiotherapy Treatment and Treatment Planning services are carried out at the existing Velindre Cancer Centre in Whitchurch, Cardiff.

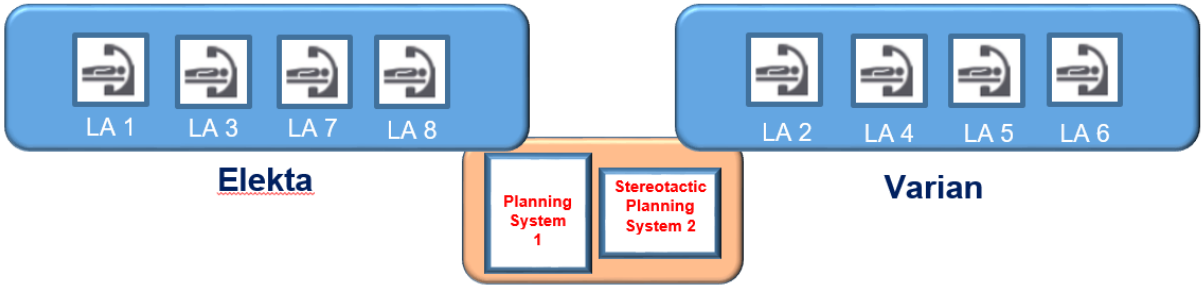
4.6 In 2019/20, the Radiotherapy Department facilitated attendances of patients and delivered 54,899 fractions of Radiotherapy. Activity reduced during 2020/21 and 2021/22 due to the impact of Covid-19 but is expected to increase to 58,464 by 2022/23.

4.7 The current radiotherapy service has eight Linear Accelerator machines of varying ages, two of them with advanced (stereotactic) capabilities, two CT Simulators (for RT planning NB: not part of the IRS procurement as recently replaced), a superficial unit and a brachytherapy service. The Linear Accelerators are split equally between two vendors (Elekta and Varian).

4.8 The service currently has three treatment planning systems, two for general external beam radiotherapy and one for cranial stereotactic applications. Velindre Cancer Centre does all of its treatment planning in house. Each of the existing vendor's treatment machines operate within their own Oncology Information System environment.

4.9 The diagram below sets out the configuration of the Radiotherapy Linear Accelerators and Treatment Planning System at the Velindre Cancer Centre. It illustrates the split of core Linear Accelerators by Vendor and the associated planning systems. The plan is to further harmonise in the new solution to remove variation between vendors.

Figure 4-1 Configuration of the current Radiotherapy Solution



4.10 The Radiotherapy Physics service, outside of its treatment planning function, has the specialist expertise to be able to carry out significant elements of system maintenance and support but utilises vendor support in specific instances. There are support contracts in place with the main vendors, however these do vary considerably in terms of parts and labour inclusivity, and do not guarantee performance. There are no contractual obligations placed on either vendor currently with regard to guaranteed uptime and performance of their equipment.

4.11 The existing age profile of Velindre's treatment machines as of 2021 is set out in the table below.

Table 4-2 Age Profile

Linac Identifier	Type	Age in 2021
LA1	Elekta Synergy	13
LA2	Varian TrueBeam Stx (Stereotactic)	5
LA3	Elekta Synergy	14
LA4	Varian TrueBeam STx (Stereotactic)	7
LA5	Varian Trilogy	9
LA6	Varian Clinac	16
LA7	Elekta Synergy	11
LA8	Elekta Synergy	10

Business needs

4.12 There is an increasingly urgent need to procure the proposed IRS in order to reduce the likelihood of equipment failure, obsolescence and ensure the most up to date treatments are available to our patients. This is critical to providing a safe, efficient and effective Radiotherapy service under existing arrangements and enabling delivery of the TCS programme.

4.13 Predictions with regards to decreasing reliability of aging treatment devices have proven correct. The Trust's oldest treatment machine LA6 has been prone to significant down time and is also subject to a recently issued end of life notice from the manufacturer.

4.14 The main drivers for change are:

1. **The age profile of treatment machines at the existing Velindre Cancer Centre and the increasing risk to service delivery.**
2. **The complications that arise as result of current dual vendor arrangements.**
3. **Increasing incidences of cancer and associated increases in demand both now and in the future including the potential for COVID-19 surge due to delays in access to diagnosis.**
4. **The essential project interrelationships between this procurement and the TCS programme.**

Business need 1: Age of Treatment Machines at Existing Velindre Cancer Centre

4.15 There is an independent need for VUNHST to re-procure treatment machines and associated Radiotherapy Equipment to ensure that it can continue to deliver safe and effective Radiotherapy Treatments to the population of Southeast Wales. Investment is needed irrespective of whether the RSC and nVCC projects are delayed or not approved to go ahead. This is why Phase 1 implementation of the IRS will concentrate on the replacement of two standard treatment machines in the existing VCC.

4.16 Radiotherapy treatment machines have a manufacturer recommended life of 10 years. Beyond this date, they can become more unreliable and maintenance costs can increase, as we have experienced. In line with the recommended 10-year life these assets are depreciated over the same period for financial accounting purposes (straight line depreciation).

4.17 The table below sets out the age profile and illustrates whether individual treatment machines are under or over their 10-year life in 2021.

Table 4-3 Age Profile with Years over Recommended Asset Life

Linac Identifier	Type	Age in 2021	Years over Recommended asset Life
LA1	Elekta Synergy	13	+3
LA2	Varian TrueBeam STx (Stereotactic)	5	
LA3	Elekta Synergy	14	+4
LA4	Varian TrueBeam STx (Stereotactic)	7	
LA5	Varian Trilogy	9	
LA6	Varian Clinac	16	+6
LA7	Elekta Synergy	11	+1
LA8	Elekta Synergy	10	

4.18 VUNHST has committed as part of its TCS Equipment Strategy to minimise wherever possible the replacement of major medical equipment ahead of the nVCC being delivered, but this has created corresponding risks.

4.19 The rationale for this decision was as follows:

- It was believed that some major medical equipment assets could safely be “stretched” thus delivering increased value for money (although due to the delays in the nVCC and RSC projects this is untenable).
- Replacing new major medical equipment in the nVCC had certain benefits as it removed the need to relocate treatment machines from the VCC which would create treatment capacity issues.

4.20 The increasing age profile of the existing treatment machines and associated equipment (such as Radiotherapy Informatics Solution, and workflow systems) at the existing VCC has become an urgent business driver.

Transition Plan

4.21 The table below sets out a replacement programme of the Trust's treatment machines as originally planned and integrated with the TCS Programme, it has been updated to reflect the new Project timelines for the RSC and nVCC Projects.

4.22 At the time of issuing final tender:

- The RSC was planned to open (first patient treated) in April 2024 with two standard treatment machines.
- nVCC was planned to open (first patient treated) in April 2025.
- Any increase in the number of Treatment Machines beyond the existing 8 machines will increase staffing and operating costs. These costs will be part of the RSC FBC and managed through normal commissioning discussions with the Trust's commissioners as part of its Long-Term Agreement (LTA).
- The approach outlined above is consistent with the Radiotherapy Satellite Business case.

Table 4-4 Treatment Machine Ages – Based on RSC 2024 Opening

		Planning Scanario - No Early Replacement of Linacs - wait for RSC 2023 and nVCC 2024 as previosly planned																											
		Location	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020		2021		2022	2023		2024		2025	2026
																		Transition YR		Transition YR			Transition YR		Transition YR			
LA10	Std	RSC																						0	1	1	2	3
LA9	Std	RSC																						0	1	1	2	3
LA8	Std	VCC							0	1	2	3	4	5	6	7	8	9	9	10	10	11	12	12	13	0	1	2
LA7	Std	VCC						0	1	2	3	4	5	6	7	8	9	10	10	11	11	12	13	13	14	0	1	2
LA6	Std	VCC	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	15	16	16	17	18			0	1	2
LA5	Std	VCC								0	1	2	3	4	5	6	7	8	8	9	9	10	11	11	12	0	1	2
LA4	Stereo	VCC										0	1	2	3	4	5	6	6	7	7	8	9	9	10	0	1	2
LA3	Std	VCC			0	1	2	3	4	5	6	7	8	9	10	11	12	13	13	14	14	15	16			0	1	2
LA2	Stereo	VCC												0	1	2	3	4	4	5	5	6	7	7	8	0	1	2
LA1	Std	VCC				0	1	2	3	4	5	6	7	8	9	10	11	12	12	13	13	14	15	15	16	0	1	2
Total											6	7	7	8	8	8	8	8	8	8	8	8	8	8	8	10	10	10
Avg Age											4.17	4.43	5.43	5.63	6.63	7.625	8.625	9.625	9.625	10.625	10.625	11.625	12.625	8.375	9.375	0.2	1.2	2.2
Peak Age											8	9	10	11	12	13	14	15	15	16	16	17	18	15	16	1	2	3

4.23 The table above was based on the Radiotherapy Satellite Centre opening in 2024 and the nVCC in 2025. It shows one treatment machine reaching a peak age of 18 years in 2023 and four of the Trust's treatment machines being considerably over they recommended life in 2023. Should the RSC not go ahead as planned, and no early procurement of treatment machines approved the situation at Velindre Cancer would worsen.

4.24 The increasing age of the services treatment machines are major drivers described in this business case. A range of options will be developed that will mitigate these scenarios.

4.25 In readiness for IRS contract award the service needs to agree the sequencing and prioritisation of machine replacement at VCC considering a number of factors such as machine life expectancy, patient treatment demand and service resilience needs. The service has discussed and considered a number of factors in order to make a recommendation on this.

4.26 This sequencing ensures that there are minimal implementation delays following contract award to the successful bidder. This also enables the service to commence service continuity planning readiness in advance and for the estates team to also commence any construction planning readiness for this phase. The prime factors that were considered being machine age, service resilience, obsolescence and any potential IRS bidder outcome which may be seen as influencing any decision in order that this may not be considered as any procurement bias in the future.

4.27 Linear accelerators have a recommended service life of 10 years from manufacturers, although many of the machines at VCC are beyond this age.

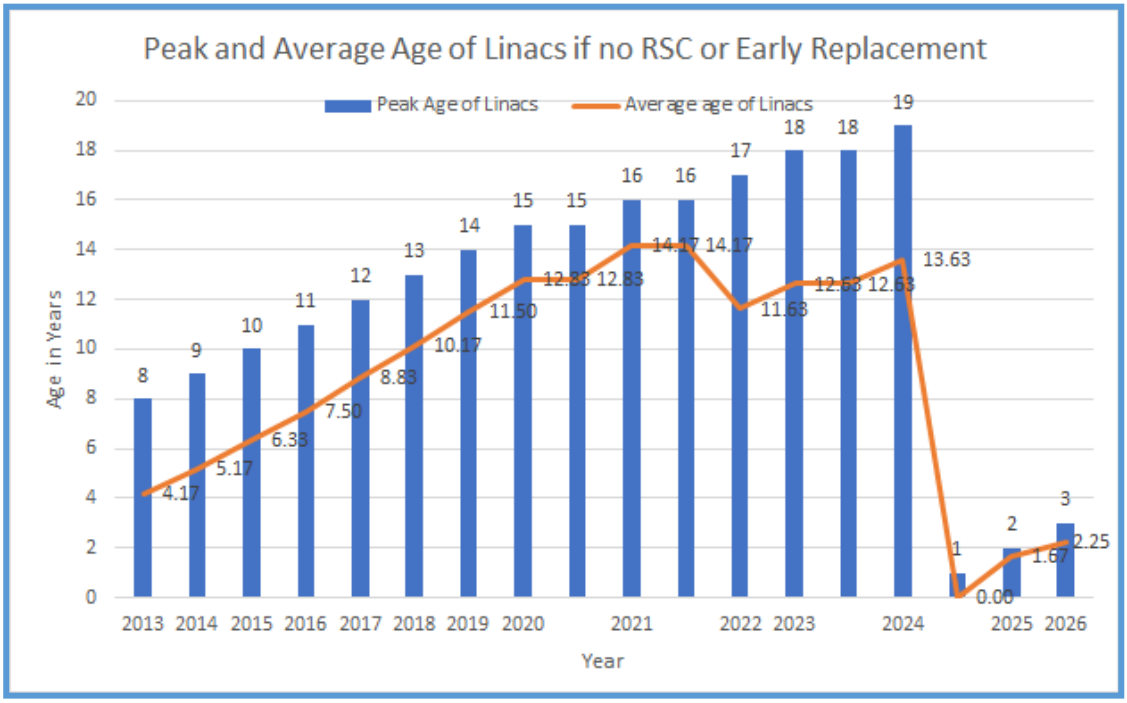
4.28 An end-of-life notice for 2023 has been received on **LA6** which makes this the **first** machine for consideration and also that some limitations of the design on this machine make it obsolete for some more modern treatment techniques.

4.29 Due to the current mixed manufacturer design of radiotherapy service at VCC, machines are matched for service with secondary machines in order to ensure treatments can be maintained should there be issues with any particular machine. **LA5** is recommended as the **second** machine to be replaced because this machine is the resilient machine for LA6 and which makes service continuity planning for treatments the next most urgent need to ensure service can be maintained.

4.30 Neither of the above recommendations would be altered by the outcome of the IRS award.

4.31 The graph below sets out the peak and average ages of treatment machines

Figure 4-2 Peak and Average Ages of Treatment Machines



Treatment Machine reliability – likely consequences

4.32 It is highly likely that treatment machine reliability will decrease with age and as a result this reduces treatment machine availability (as the burden of repairs increases). Allied to this, there are increasing costs associated with unreliability.

4.33 An illustration of this is that Velindre has previously operated one treatment machine to 14 years of age before a major component failure meant the treatment machine was classed beyond economical repair and required full replacement. With three of the eight treatment machines at Velindre reaching or exceeding this age by 2021 the service wide risks are high. If nothing is done to address this, significant service disruption could easily manifest with long lead times required to procure and commission any replacement treatment machines.

4.34 The increasing age profile of the existing treatment machines and associated equipment (such as Radiotherapy Informatics Solution, and workflow systems) at the existing VCC is becoming more of a critical driver through the passage of time.

Business need 2: Complications of Dual Vendor Arrangements

4.35 As set out in the Strategic Context (Section 3), a review was conducted by the Radiotherapy Development Group in 2015 which was subsequently approved by the Trust Board in 2016. This report highlighted the inefficiencies associated with running a dual vendor site. The impact of dual vendor remains a current issue at the VCC as it creates the following issues:

- Sub optimal efficiency and patient flow.
- Lack of capacity and the ability to work flexibly.
- Increased workforce requirements and the burden of training (planning and treating patients; and maintaining, running and operating the machines).
- Requires complex support services including the R&V and IT software.
- Additional resources are required to undertake a competitive tender process for every new machine.
- Additional resources are needed to manage two commercial contracts and service providers.
- Places limitations on Research and Development capacity.

4.36 These issues are explored in further detail in the paragraphs below.

4.37 **Service resilience:** As a result of compartmentalisation into a dual-vendor environment, service resilience in the event of machine breakdown has been significantly impaired as it is not possible to transfer patients from one machine type to another without an extended re-planning process. This has a prohibitive time and resource overhead for the service and significant disruption or interruption of ongoing treatment courses for patients. Services with a larger number of matched machines are significantly more resilient than those without. Recent assessments undertaken at VCC indicate that a fully matched machine environment with appropriate service resilience capacity would provide uptime improvements in the region of 5%.

4.38 **Service development limitations:** It would be beneficial for the service to develop and implement a single paperless process for the radiotherapy patient pathway, with all information held electronically in a single Oncology Information System. This is not currently feasible while we are running dual systems which have quite distinct operational modes.

4.39 **Workforce impacts:** Additional workload results from the commissioning and implementation requirements associated with a dual vendor arrangement. For example, volumetric modulated arc therapy solutions are distinctly different on the Elekta and Varian platforms and these require separate commissioning and clinical implementation plans and resource allocation. The same situation applies for introduction and development of Image Guided Radiotherapy, Respiratory Motion Management and any other new technology requirements. Also, our Treatment Planning Systems require full commissioning datasets for each type of vendor's machines. Several years of work have already been committed in this regard.

4.40 These overheads inevitably lead to delays in clinical implementation of new techniques 'across the board' in our centre, not least because the alternative systems require comparative evaluation even before one or other (or the pair) of the options is pursued. This was verified in the Demand and Capacity Review that the Trust commissioned Attain in 2020.

4.41 **Radiotherapy Information System support requirements:** Computing staff within the Radiotherapy Physics Department at VCC are required to support both systems. There is effectively a doubling of work in supporting and implementing system upgrades and when these are required. There is also a potential knock-on effect if, and when, Digital Healthcare Wales (DHCW) needed to develop new interfaces to CANISC which is also going end of life and requires replacement.

4.42 The complexities of our dual vendor environment have been highlighted with current work to develop links with the national RT Dataset, with interfaces needing to be developed, tested, implemented and supported from both vendors' RT information systems (Aria and Mosaic).

4.43 **Training requirements:** All staff involved in delivering the radiotherapy service require full training on each vendor's equipment and associated operating and information systems. There is currently elevated risk of operational confusion and misunderstanding due to the differing ways in which the two systems work. Staff involved include Therapy Radiographers, Clinical Oncologists and Clinical Scientists, Technologists and Mechanical and Computing Engineers in Medical Physics.

4.44 **Procurement and commercial:** There are extra costs associated with having two providers and needing to carry out separate tenders to replace treatment machines. In addition, there are costs associated with managing two separate maintenance contracts.

4.45 **Estimated cost of the procurement process:** A conventional procurement scenario would be as follows:

- Assume a six-month period for development of business case and equipment selection.
- This would typically involve 8 senior staff (average mid band 8b = £70K) from the service (4 from Medical Physics, 2 from Radiotherapy, 1 project manager, 1 procurement officer).

- Depending on age of machine and central capital funding availability, machines may be purchased individually or in pairs to maximise resilience.
- For a 10-machine configuration, this may involve procurement of 3 pairs of machines and 4 individual machines, therefore 7 procurement exercises over a 10-year period.

4.46 Due to the rapid evolution of radiotherapy technology older machines are unable to deliver the full range of treatments offered by VCC and other leading centres. Therefore, continuing to operate outdated equipment will have a detrimental effect on patient care.

4.47 As an example, LA6, which has now received an End-of-Life notice, cannot be used for online CT imaging or arc therapies. This reduces availability, capacity and further narrows business continuity options for the service and its patients.

Business need 3: Increasing Cancer Incidences and Radiotherapy Demand

VUNHST has been developing its Business Intelligence (BI) functions to ensure that it can better plan its future services. This includes the ability for the Trust to have advanced notice of Health Board activity by tumour site.

4.48 VUNHST has used a number of recognised methods to inform its RT Planning assumptions:

- Reported Cancer incidences in Wales and UK (retrospective).
- VUNHST own activity data and trends.
- Benchmarking of our findings / Planning Assumptions.

Reported Cancer Incidences

4.49 It should be noted that Cancer Incidence data is reported retrospectively and is often up to three years old at the time of publication. It still however provides a useful tool in identifying trends and is particularly powerful when correlated against actual activity data.

4.50 In 2015, VUNHST contacted the Welsh Cancer Incidence Surveillance Unit (WCISU, Part of Public Health Wales) asking for a comprehensive report to be commissioned that would assist in forecasting the likely demands that would be placed on VUNHST.

4.51 Following on from the detailed analysis of the incidences of cancer carried out by WCISU, combined with the UK population comparisons and expert knowledge both internally and externally to Velindre, a Radiotherapy Growth Planning assumption of 4% was derived. This was made up of 2% growth, 1% Increase in access and 1% attributed to increasing treatment complexity.

4.52 VUNHST has, since this point, been monitoring its actual activity verses it's planning assumptions and in 2017 took the decision to revise its planning assumptions from 4% to 2% where it remains today.

4.53 Benchmarking VUHNST's planning assumptions with other non-surgical cancer centres validated our approach, this was further strengthened by Cancer Research UK's research findings on predicted future increases in the incidences of cancer as described in their publication "Cancer in the UK 2018". In addition to this, Attain's 2020 Radiotherapy Demand and Capacity Review incorporates more up to date benchmarking data.

4.54 The impact of Covid resulted in a reduction of external referrals of 13%. The planning assumptions made for referral activity in 2021/22 was 13% COVID recovery, 10% Growth. In the first two quarters of 2021/22 this recovery and Growth has been achieved. There is suppressed demand in UHB's that may stimulate a further surge in Q3 & Q4 which is monitored monthly particularly in Breast & Colorectal tumour sites

Revised WCISU Incidence Data to 2015 (from data up to 2013)

4.55 VUNHST, as part of its research, reviewed new incidence data from WCISU and other registries in UK and Ireland to establish the most up to date incidence information. When reporting incidence data in European Age Standardised Rates (EASR) per 100,000 there is a downturn / or flattening in the incidences of cancer diagnosis across the UK and Ireland. Of note is that the EASR standardises data to facilitate comparison of unlike populations. The Welsh population is increasing, and so is the proportion of the population in advanced age groups. In standardising Welsh cancer incidence data, the impact of an increasing elderly population is partially negated. When crude cancer incidence rates are considered, a sustained growth in disease incidence over time is apparent as shown in the chart overleaf. This ranges from 589.9 (per 100,000) in 2007 – 2011to 626.5 in 2013 – 2017.

Figure 4-3 Cancer Incidence per 100,000 (Wales)

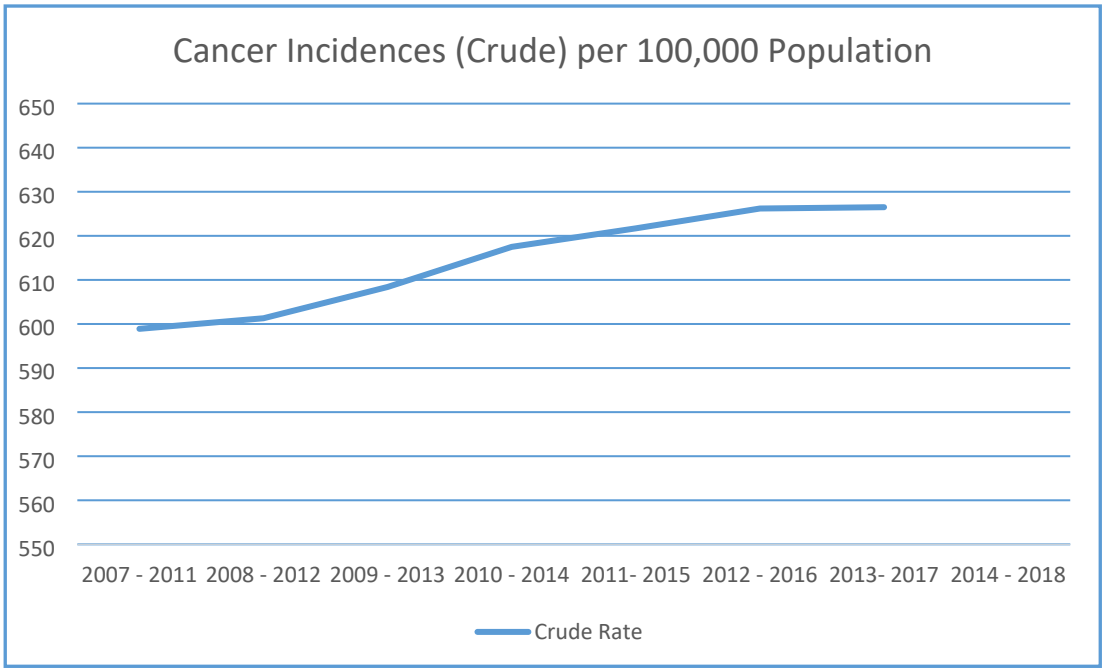


Table 5 - Cancer Incidence per 100,000 2007 = 2017

	2007 - 2011	2008 - 2012	2009 - 2013	2010 - 2014	2011- 2015	2012 - 2016	2013- 2017	2014 - 2018
Crude Rate	598.9	601.3	608.4	617.5	621.7	626.2	626.5	
EASR	643.1	639	640	642.4	639.5	637.1	630.6	

4.56 WCISU also concluded the following from its updated research:

- The number of new cases of cancer in residents of Wales continues to rise in men and women – there were 19,026 new cases in 2013, up by over 12 per cent compared to 2004.
- The largest increases in numbers in men and women were in the 65-69- and 70-74-year-old age groups.
- Cancer becomes more common with increasing age, except for the 90+ age group in women – the age specific cancer rate rises more steeply in men than women with increasing age, and for ages 70 years and over, rates in men are over 50 per cent higher than women.
- Age-specific all cancer incidence rates in older age groups reduced dramatically in men from 2004 to 2013 whereas in women there was little change.
- The predicted supressed demand of 35K referrals (DU) across Wales impacted on UHB's in March and April 2021with increases in most primary sites. VCC experienced a reduction of 13% referrals in 2020/21 compared against 2019/20. This recovery was factored into 2021/22.

Velindre Radiotherapy Activity (Fractions)

4.57 Radiotherapy Velindre Cancer Centre has seen the fractions it delivers increase from 53,948 in 2016/7 to 54,899 in 2019/20 as set out in the table 4-7 below. In addition to this activity increase, the service also experienced an increase in the complexity associated with Radiotherapy planning and treatment delivery.

4.58 Using actual activity data from 2016/17 – 2021/22 it has been possible to further uplift the fractions delivered by 2% per annum to illustrate the likely demands the service will need to meet in the future. This allows the Trust to more accurately articulate its Radiotherapy service requirements.

4.59 The activity data 2016 – 2021/22 (actuals) and what was forecast demand 2021 – 2032 at the time of developing the FBC is set out in table 4-7 below.

Table 4-6 Activity Data 2016-2032

	2016/17 Actual	**2017/18 Actual**	**2018/19 Actual**	**2019/20 Actual**	**2020/21 Actual**	**2021/22 Actual**	**2022/23 Forecast**	**2023/24 Forecast**
VCC	53948	51229	54997	54899	36861	40507	58464	47915
Outreach								11719
Total	**53948**	**51229**	**54997**	**54899**	**36861**	**40507**	**58464**	**59634**
	2024/25 Forecast	**2025/26 Forecast**	**2026/27 Forecast**	**2027/28 Forecast**	**2028/29 Forecast**	**2029/30 Forecast**	**2030/31 Forecast**	**2031/32 Forecast**
VCC	48873	49851	50848	51865	52902	53960	55039	56140
Outreach	11953	12192	12436	12685	12938	13197	13461	13730
Total	**60826**	**62043**	**63284**	**64550**	**65840**	**67157**	**68500**	**69870**

4.60 The decline in activity in 2020/21 and 2021/22 (highlighted in red) relate to the impact of Covid-19. Activity has increased between 2021 and 2022 as the pandemic recedes, but it should be noted that risk based working practices are still artificially suppressing demand.

Velindre Radiotherapy Attendances

4.61 The table 4-8 overleaf sets out the number of annual Radiotherapy attendances at Velindre since 2012/13. The service experienced a dip in attendances in 2016 – 2018 which was common across other UK Radiotherapy services but has since reversed.

Table 4-7 Number of Annual Radiotherapy Attendances

	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Actual	2016/17 Actual	2017/18 Actual	2018/19 Actual	2019/20 Actual	2020/21 Actual	2021/22 Actual
2012/13 attendance with 2% growth	48072	49033	50014	51014	52035	53075	54137	55220	56324	57450
Attendance actual	48072	51951	54981	54591	51467	50564	55522	54899	36861	40618
Attendance actual growth		**8**	**6**	**-1**	**-6**	**-2**	**10**	**-1**	**-33**	**10**

**attendance actual growth figure is a percentage rise or fall*

4.62 Since 2012/13 there has been an overall increase in attendances from 48,072 to 54,899 in 2019/20, this is an average increase of 975 attendances per year. In 2021 Radiotherapy attendances dropped off dramatically as the impacts of COVID-19 were felt across the health system. In 2021/22 there was a 10% return in attendances even with operational restrictions still suppressing demand.

4.63 There are significant fluctuations between the years. It is therefore important as recognised by the National Radiotherapy Advisory Group (NRAG) guidance that when planning radiotherapy services there is a degree of capacity retained to manage fluctuations in demand without impacting on patient experience and waiting list performance.

4.64 As described earlier in this section there has been a steady increase in fractions delivered and patient attendances at the Velindre Cancer Centre. It has also been stated that the complexity and time to deliver new techniques are increasing notably.

Benchmarking our Planning Assumptions for Radiotherapy Activity

4.65 As alluded to previously and in order to validate Velindre's 2015 planning assumptions for Radiotherapy, a benchmarking exercise was undertaken with similar Cancer Centres across the UK. These centres were identified as good comparators in terms of size, service model and population served. This was confirmed by Attain's 2020 Radiotherapy Demand and Capacity Review.

4.66 The comparable tertiary cancer centres involved were:

- The Beatson West of Scotland Cancer Centre.
- The Clatterbridge Cancer Centre NHS Foundation Trust.
- The Christie Cancer NHS Foundation Trust.
- Leeds Teaching Hospital NHS Trust.
- The Royal Marsden NHS Foundation Trust.

4.67 The anonymised information obtained during the benchmarking exercise is set out in the table below referenced as Peer Sites:

Table 4-8 Benchmarking Exercise

Service	Annual growth assumption/years		Other cancer centres annual growth predictions
	2016/17 - 2022/23	2023/24- 2031/32	
Radiotherapy (Initial Assumption)	**4%**	**2%**	Peer Site A – 3.8% Peer Site B 1.5% Peer Site C – 3% Peer Site D – N/A Peer Site E – 4.0%
Radiotherapy (Revised)	**2%**	**2%**	

4.68 The benchmarking exercise demonstrated that the Trust's clinical growth assumptions in 2015 were in line with those from other cancer centres across the UK, where this data was available.

4.69 As previously described in 2017 a review of the 2015 growth assumptions was carried out. This review examined whether predicted growth forecasts had manifested into service activity. The Trust modelled a range of scenarios utilising the integrated activity workforce and finance model and as a result the growth assumption was adjusted from 4% (as shown above) to 2% in line with actual activity from 2014/15 to 2015/16.

Future Planning Requirements

4.70 VUNHST has taken a flexible approach to how it plans its infrastructure projects within the TCS Programme as it is aware that predicting Radiotherapy demand is influenced by many factors, some of which our beyond the control of Velindre as a tertiary provider. Factors such as referral preferences from Multi-Disciplinary Teams, changing clinical indications for radiotherapy, the staging of cancer referrals and the adoption of clinical trials could all have a bearing on Velindre's Radiotherapy activity. Both the nVCC and RSC Projects have been developed to allow flexibility and adaptability in response to changing activity demands.

4.71 The Velindre Cancer Centre has developed tried and tested methods to calculate its future Radiotherapy requirements. The nVCC and RSC business cases outline how this is achieved by turning research, benchmarking and activity data into future planning requirements using industry standard approaches.

4.72 As a result of this methodology, the following planning assumptions were used within the nVCC and RSC business cases:

1. 2% Growth in Radiotherapy Activity year on year
2. Years 2018 – 2023 current service performance given constraints (no service efficiency machine) was applied
3. Year 2024 onwards calculated on greater efficiency due to availability of service efficiency machine at the nVCC.

4.73 Further to this, the impact of Covid on demand was considered, including the following factors:

- COVID in 2020/21 reduced referral by 13%. Cancer Recovery Programme for VCC was implemented using various parameters.
- Radiotherapy in 2019/20 received 4343 referrals, during COVID 2020/21 this reduced to 3772. As of 30 September 2021, 1997, referrals were received with a forecast outturn of 4387.
- Breast, Colorectal, Lung and Urology have shown 32% growth when compared to 2019/20.

4.74 This was used to identify the number of Treatment Machines required and the resulting planned configuration is set out in the table below.

Table 4-9 Planned Configuration

Location	Number	Type	Notes
VCC / nVCC	6	Standard Machines	Core requirement
VCC / nVCC	2	Advanced Machines	Core requirement
RSC	2	Standard Machines	Contractual option

4.75 This is the same configuration as the existing VCC which has two stereotactic machines and six standard treatment machines but **may vary on the individual bidder's actual solution.**

Business need 4: Project Interrelationships

4.76 The procurement of an IRS is independently needed as part of the VCC Radiotherapy service business as usual activities. It has been 'decoupled' from the RSC and nVCC infrastructure project approvals as the VCC service is required to deliver the Trust's Radiotherapy Equipment Strategy and refresh its radiotherapy digital equipment as it reaches the end of its recommended life or becomes obsolete.

4.77 In the event of the nVCC and/or the RSC Projects being approved, the procurement of an IRS becomes a major enabler to the smooth implementation, transition and continuity of service for patients.

4.78 The IRS procurement as set out in the table below, enables the nVCC and RSC Projects in the following ways:

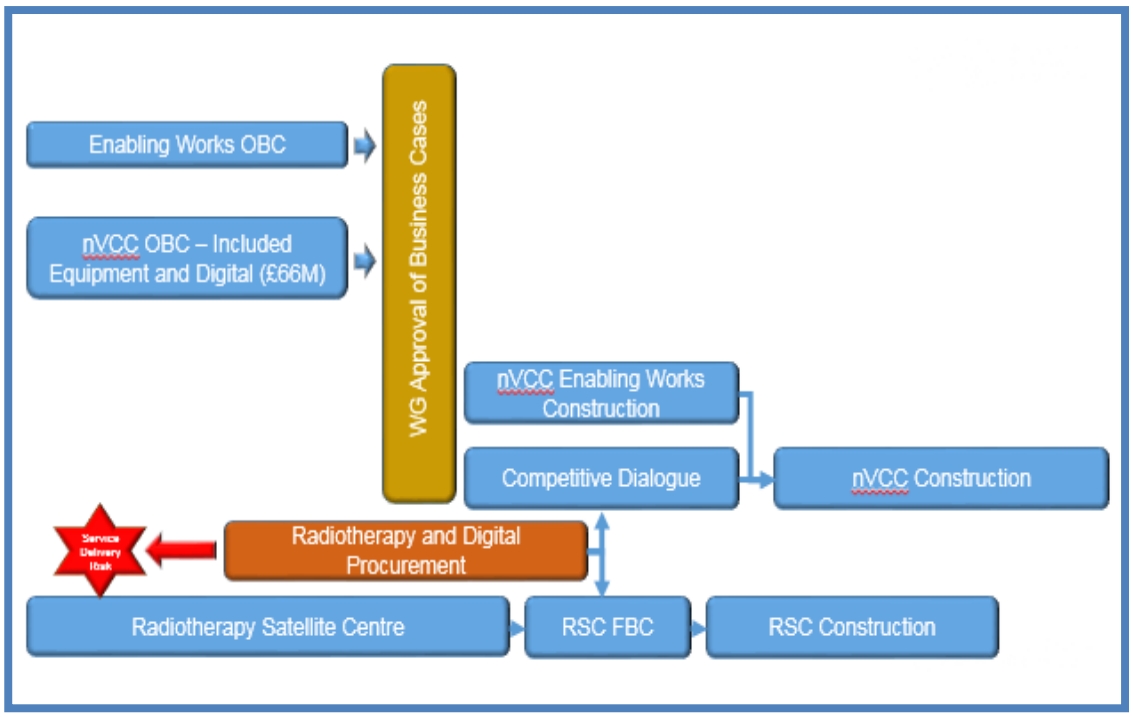
Table 4-10 IRS Procurement

Project	Enabler / Requirement
Project 2. nVCC	There is a contractual requirement for VUNHST to inform the bidders during competitive dialogue the specifications of equipment that will be installed in the nVCC. Different bidders have different bunker and interface requirements. Failure to start the IRS procurement in a timely manner may mean that this contractual requirement cannot be met as the bidders will not be known until the IRS Procurement has been concluded.
Project	**Enabler / Requirement**
Project 3. RSC	Similarly, to the nVCC there is a requirement for the specification of the IRS to inform the design of the Radiotherapy Satellite Centre.

Key Programme Dependencies

4.79 The diagram overleaf illustrates the complex interdependencies that currently exist and have been set out in the preceding narrative. It shows that the IRS procurement is important to assure delivery of the Radiotherapy Service at the nVCC and at the RSC. The timing and proposed procurement approach has been set down in detail in the Radiotherapy Commissioning paper that supports the nVCC OBC.

Figure 4-4 Complex Interdependencies



Summary of Business Needs

4.80 The case for change clearly demonstrates there is an urgent need to procure the IRS to ensure that VUNHST can continue to provide a safe, efficient and effective Radiotherapy service both currently and as part of the TCS programme.

4.81 This is summarised in the table overleaf which shows how the existing arrangements and business needs align with the project investment objectives (and by associated the programme spending objectives) and demonstrate that doing nothing is not a feasible option.

Table 4-11 Summary of the case for change

RIO1 To procure and implement a new Radiotherapy Solution that supports quality and safe services	
Existing arrangements	**Business needs**
Ageing equipment: • 8 treatment machines - 5 of which have exceeded the 10-year life expectancy and 1 issued with End of Life Notice. • 3 treatment planning systems - 1 of which is reaching end of life • Each treatment machine vendor operates in its own Oncology Information System	• Reliability reduces with age of machinery increasing the likelihood of equipment failure and obsolescence. • Increasing burden of repairs result in growing costs. • Increased risk to service delivery and ability to provide most up to date treatments. • Need for interim arrangements to support a functional Radiotherapy Informatics Solutions during any transition period.
RIO2 To provide a Radiotherapy Solution that has sufficient capacity to meet future demand for services	
Existing arrangements	**Business needs**

• Increasing incidences of cancer, more access to services and increasing complexity of treatments results in planning assumptions of 2% growth in demand p.a.
• All services currently delivered from the existing Velindre Cancer Centre with
  ○ Ageing equipment
  ○ Dual vendor arrangements (8 linacs split equally between 2 vendors)
• From July 2021 a surge impact of 23% was planned, with the Trust running at 31% in September 2021 as more surgery patients are received from Health Boards.
	• The unreliability of ageing equipment and inefficiencies resulting from a dual vendor approach combine to reduce availability and capacity, creating risks around business continuity and VUNHST's ability to meet demand.
	• Given the forecast growth in demand of 2%, these risks will continue to increase over time.
	• The TCS programme seeks to address these risks with the development of the nVCC and RSC projects. The procurement of an IRS is critical to successful delivery of these.

RIO3 To deliver a Radiotherapy Solution that improves patient, carer and staff experience	
Existing arrangements	**Business needs**
• Ageing equipment • Dual vendor arrangements (8 treatment machines split equally between 2 vendors)	• The dual vendor arrangements result in the need to operate differing systems resulting in suboptimal patient flow, increased workforce and training requirements. • This reduces capacity and flexibility. • Outdated equipment and inefficiencies are detrimental to patient care and experience.
RIO4 To provide a Radiotherapy Solution that promotes capacity and the delivery of high-quality education, research, technology and innovation in Radiotherapy	
Existing arrangements	**Business needs**

• All services currently delivered from the existing Velindre Cancer Centre with
  ○ Ageing equipment
  ○ Dual vendor arrangements (8 treatment machines split equally between 2 vendors)
	• The dual vendor arrangements limit R&D capacity.

	• In addition to Business-as-Usual needs, in the event of the nVCC and RSC projects being approved, the existing ageing equipment and dual vendor arrangements will not enable successful implementation and realisation of TCS programme benefits.

5 POTENTIAL SCOPE

Introduction

5.1 This section of the business case identifies the potential scope of the Project in terms of the key service requirements that should be considered in designing the future solution and developing options.

Key requirements

5.2 Given the business needs, such as the major interfaces, service requirement and inherent risks identified, there is a need for the IRS procurement to deliver the following:

- The identification of a Prime Contractor which, depending on approvals of the associated OBCs, will support the development of the RSC Project and nVCC Competitive Dialogue process.
- The ability of the Trust to have in place a compliant contract to deliver treatment machines to support service delivery activities.
- Requirement to replace critical radiotherapy related clinical informatics systems to support service delivery and improvement.
- Requirement to replace hospital wide, critical clinical informatics systems which are dependent on the new radiotherapy design to support service delivery and improvement i.e., integration with the CANISC replacement.
- The ability to mitigate any procurement challenge or risks to delivery earlier as not to present a critical path delay to the overall programme, hence de-risking, nVCC and RSC.
- The ability to incrementally develop a solution that will be fully functional at the VCC and the RSC ahead of the nVCC commissioning, will reduce integration and service-related risks.
- The ability to mitigate any procurement challenge or risks to delivery earlier as not to present a critical path delay to the overall programme, nVCC and RSC.
- Remedial works for machines that are not replaced in Phase 1 but which need to remain functional until Phase 3.

Procurement scope

5.3 The potential scope of the IRS procurement is proposed to include:

- Radiotherapy Treatment Machines / Equipment.
- Radiotherapy Informatics Solution (including Oncology Information System (OIS) & Treatment Planning System (TPS).
- Dosimetry & Quality Assurance Systems.
- Clinical & Patient Safety Systems.
- Ancillary equipment, IT and infrastructure.
- Project Management, Ongoing Support and Development Services.

- Research & Development (including the option of a research machine in a bunker at the nVCC).

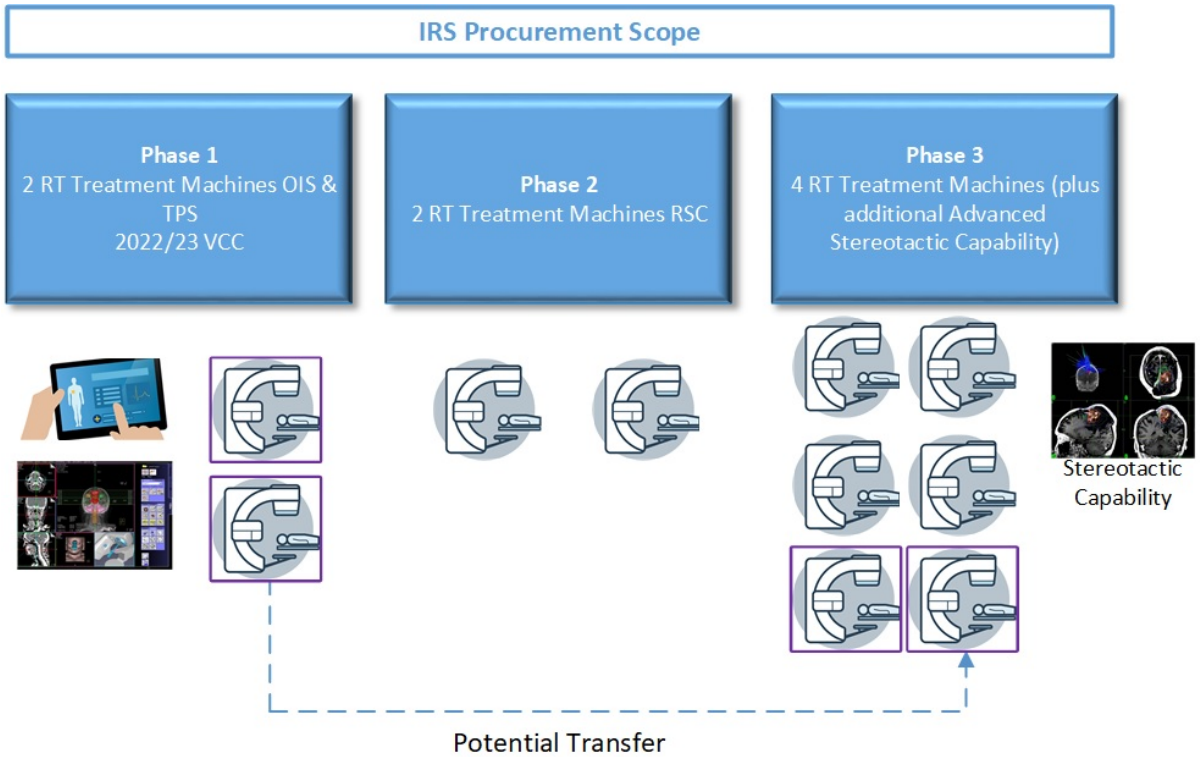
5.4 In addition, there are service requirements (non-hardware) to include:

- Integration with other systems to be advised.
- Professional services for delivery and data migration of existing services.
- Assistance with transition planning will be required.
- Ongoing support and development services.

5.5 The proposed procurement will be implemented in three phases which are described below:

- **Phase 1 –** Replacement of the Interim TPS solution and delivery of a new Radiotherapy Informatics Solution and two treatment machines for the VCC to mitigate age related risks. Remedial works for machines which are not replaced but which need to remain functional until Phase 3.
- **Phase 2 –** 2 x Standard treatment machines required at the RSC. In the event the RSC business case is not approved this phase will not go ahead.
- **Phase 3 –** 6 x treatment machines required. If the nVCC business case is approved, this will involve two (potential) transfers from VCC from Phase 3. In the event the nVCC business case is not approved the treatment machines will be installed at VCC.

Figure 5-1 Proposed procurement phasing



5.6 There is a need for the procured IRS to deliver a fully integrated solution, incorporating hardware and an IT system which is a future proofed.

5.7 To achieve this, a dedicated Digital and Equipment Project Board accountable to the TCS Programme Delivery Board has been established and this group has established a dedicated IRS Project Team. This IRS Project Team will manage the procurement to progress this integrated solution.

5.8 When the nVCC is commissioned, there will be two relatively new treatment machines in the old VCC if this business case is approved. Currently the costed assumption is that these treatment machines will be relocated.

5.9 The ages of these treatment machines will range from 3-4 years depending on the date the nVCC is commissioned. A cut off point in terms of cost and risk (component hardening / frailty) of relocating a treatment machine is normally 5 years.

6 BENEFITS AND RISKS

Introduction

6.1 This section of the business case identifies the benefits, risks, constraints and dependencies in are considered when developing and assessing the options for an Integrated Radiotherapy Solution (IRS).

Benefits

6.2 By addressing the business needs and achieving the spending objectives the project will deliver a range of benefits that align with the NHS Infrastructure Investment Criteria listed below.

> **Health gain:** improving patient outcomes and meeting forecast changes in demand
>
> **Affordability:** reduction in costs over the long term
>
> **Clinical and skills sustainability:** reducing service and workforce vulnerabilities and demonstrating solutions that are flexible and robust to a range of future scenarios
>
> **Equity:** where people of highest health needs are targeted first; and
>
> **Value for money:** optimising public value by making the most economic, efficient and effective use of resources.

6.3 The table presents the benefits that the project is expected to deliver, categorised by type: cash releasing, non-cash releasing, quantifiable and qualitative. Work is underway to develop these further and a final version of this table will be provided in the final submission of the combined OBC/FBC.

Table 6-1 Main benefits

ID	Benefit	Description	Beneficiary	Benefit Type	Metric
B01	Reduced risk of service failure	Reduced risk of catastrophic failure due to more up to date machines	VUNHST	Unmonetisable - Qualitative	Not measurable
B02	Reduced risk of obsolescence	Improved functionality due to more up to date machines	VUNHST	Unmonetisable - Qualitative	Not measurable
B03	Increased flexibility	Better continuity due to the flexibility provided by matched machines	VUNHST	Unmonetisable - Quantifiable	See Bidder's Framework
B04	Better patient outcomes and safety	Better patient outcomes due to the improved functionality and better compliance with good practice	VUNHST	Unmonetisable - Qualitative	**See Societal Benefits B16**
B05	Benefits of increased automation and use of	(a) Reduced clinical time required for patient scheduling (b) Reduced	VUNHST	Quantifiable	See Bidder's Framework

	integrated systems	appointment times + Other benefits associated with automation and integration			
B06	Environmental benefits	Reduction in energy usage resulting in reduction in carbon emissions	VUNHST	Unmonetisable - Quantifiable	See Bidder's Framework
B07	Community benefits	Job creation	VUNHST	Unmonetisable - Qualitative	**See Societal Benefits B17**
B08	Improved patient and carer experience	Improved resilience will reduce risk of cancelled appointment resulting in a better experience for patients and carers	VUNHST	Quantifiable	See Bidder's Framework
B09	Improved staff experience	Improved wellbeing of workforce due to more up to date machines	VUNHST	Quantifiable	See Bidder's Framework
B10	Increased R&D opportunities	Increased R&D opportunities as a result of newer equipment and collaboration with a single vendor	VUNHST	Unmonetisable - Qualitative	**See Societal Benefits B13 and B14**
B11	Better business intelligence	Access to improved analytics and reduction in manual data collection	VUNHST	Quantifiable	See Bidder's Framework
B12	Benefits of service support	Improved service report reduces burden of major system upgrades	VUNHST	Quantifiable	See Bidder's Framework
B13	Additional investment in RD&I	Increased investment in Research, Development & Innovation	VUNHST	Non-Cash Releasing	Additional RD&I income from successful bidder
B14	Future research bunker opportunity	Opportunity to receive a discount on the procurement of a treatment machine for a future research bunker	VUNHST	Non-Cash Releasing	Cost avoidance
B15	Creation of capacity contingency	Advanced technology provides ability to deliver additional fractions creating capacity to deal with additional demand if required in the future	VUNHST	Non-Cash Releasing	Number of additional fractions available
B16	Advanced technology leads to better patient outcomes	Advanced technology contributes to better patient outcomes supporting the TCS Programme aim of improved survival rates	Patient	Societal	Number of additional survivors
B17	Job creation	Implementation of IRS creates new Engineering and Apprentice Engineer roles	Economy	Societal	Number of additional jobs created in UK market

Risks

6.4 Risk is the possibility of a negative event occurring that adversely impacts on the delivery of the project and its benefits. The main risks that the project must address are listed in the table below.

Table 6-2 Main risks

ID	Risk	Mitigation	Risk Type
A1	Risk that capital and revenue funding is not available / not agreed	Regular engagement with WG and Trust's commissioners relating to funding levels required. Trust requirements are designed in such a way as to reward bidders to come within an affordability threshold	Implementation Risks
A2	Risk that approvals are delayed	Regular updates, project plan and forward look against Trust and WG business cycles	Implementation Risks
A3	Risk that implementation is delayed because of preferred supplier (including supply chain issues and component delays)	Trust has a contract in place and agreed implementation plan which the bidder would be expected to perform against therefore there is the opportunity to seek liquidated damages	Implementation Risks
A4	Risk that bidder does not specify correct construction design resulting in the building not accommodating the solution	Detailed contract drafting with regards to the interface for the nVCC and RSC projects identifies relevant pass-ups and pass-downs between the contracts. There are also dispute resolution and third-party rights retained. Liquidated damages are available as a remedy. Engagement between the construction partners and bidder	Implementation Risks
A5	Risk of construction delays within VCC, RSC and nVCC phases leading to IRS implementation delays	Detailed contract drafting with regards to the interface for the nVCC and RSC projects identifies relevant pass-ups and pass-downs between the contracts. There are also dispute resolution and third-party rights retained. Liquidated damages are available as a remedy.	Implementation Risks
A6	Risk of implementation delays due to limited capacity and/or capability	Effective workforce planning, clear identification of roles and early recruitment, dedicated WOD/recruitment resource to support the process. Clear governance process in place. Change control measures in place (e.g. change freeze, etc.), where change freeze not possible or acceptable, clear priorities should be in place.	Implementation Risks
A7	Risk that there is a lack of integration with WPAS/WCP (CANISC replacement) interface	Featured within the requirements to mitigate the interface risk issues	Implementation Risks
A8	Risk that bidder is unable to support implementation with the appropriate skilled resource	Evaluation seeks to reward the bidder who can describe their team's capability and skills	Implementation Risks
A9	Ongoing risk of Covid impacting on ways of working (social distancing, travel restrictions, etc.)	Following government guidance, use of relevant PPE, re-planning as necessary (e.g. increased training sessions,	Implementation Risks

		moving face-to-face to online where required)	
A10	Risk that there are IT issues as a result of obsolescence of existing VCC infrastructure	Regular engagement with IT colleagues to identify any gaps with regards to VCC infrastructure versus solution designs and readiness requirements	Implementation Risks
A11	Risk of multiple deliveries/phases converging within narrow timescale impacting on ability to properly resource - overlapping with other Projects' implementation plans	Fully resourced and agreed project implementation plan including milestones and communications	Implementation Risks
A12	Risk that legacy data not available in timeline required / risk to it being lost during implementation	Ensure workarounds are in place to allow access to legacy data to inform new treatments. Back-up/Failover provision for accessing data during Data Migration.	Implementation Risks
A13	Risk that there is an inability to / unwillingness to adopt required changes to ways of working across all services	Change management processes communications, stakeholder plans, etc. Clinical mandate	Implementation Risks
A14	Risks associated with access / storage because of solution moving to cloud	Change control. Contractual mitigations ensuring that Trust has the ability to retrieve its own data from the cloud at the end of the contract. Increased training and adherence to GDPR + NIS within the solution design approvals and contract.	Implementation Risks
B1	Risk that the bidder's technical solution does not fully meet the service requirements (not able to fully procure)	Trust requirements have been developed by Trust specialists and subject to independent internal and external review	Solution Design Risks
B2	Risk that the bidder's technical solution leads to an inefficient solution / poor functionality that does not fully meet the service requirements (cannot be fully delivered)	Trust requirements have been developed by Trust specialists and subject to independent internal and external review. Bidder ownership during implementation to ensure solution design can be fully met.	Solution Design Risks
B3	Risk that the bidder's technical solution leads to a clinically unsafe / unusable solution that needs to be resolved	Trust requirements have been developed by Trust specialists and subject to independent internal and external review. Bidder ownership during implementation to ensure solution design can be fully met.	Solution Design Risks
B4	Risk that a provider announces technical advances after procurement process.	Adequate change control process, contract	Solution Design Risks
B5	Risk that Velindre requires changes due to change in clinical indications or treatments meaning the solution would need to change to accommodate - more specialist treatments	Adequate change control process, contract, remaining aligned to current research trials ongoing	Solution Design Risks
B6	Risk that there are data quality issues as a result of the new design not meeting previous functionality	Trust requirements have been developed by Trust specialists and subject to independent internal and external review. Bidder ownership during implementation to ensure solution	Solution Design Risks

		design can be fully met. Adequate change control process	
B7	Risk that solution does not have the appropriate level of resilience and redundancy	Clearly defined requirement that the solution must be resilient in all main features	Solution Design Risks
C1	Risk of legal challenge from unsuccessful bidder	Robust and legally assured procurement process	Contract Risks
C2	Risk that the preferred supplier becomes insolvent	PQQ process included financial due diligence including Dunn & Bradstreet reports; ability to ask for parent company guarantee; step-in rights	Contract Risks
C3	Poor contract performance - Risk of fitness for purpose of end contract to solve problems (e.g. SLAs for repairs/maintenance etc.) - poor bidder performance	Contractual remedies exist, regular contractual meetings with supplier. Ability to issue early warning and termination notices should performance deteriorate	Contract Risks
C4	Contract not as robust / fit for purpose	Carried out commercial and contractual dialogue over many sessions. The Trust has been in receipt of legal advice in regards to the development of the contract.	Contract Risks
C5	Risk that there is inadequate ongoing contract and performance management - appropriate resource is not in place for future ongoing management of contract and solution (capacity, awareness) - relationship management (note organisation ability to manage process)	Contract management resource has been included within the business case resource plan. Mechanisms in place within the contract and regular service meetings in place.	Contract Risks
C6	Risk that Trust is unable to meet ongoing contractual obligations (e.g., engineering, etc.)	Agreed recruitment plan within the business case for the key resource to manage and maintain the contract	Contract Risks
C7	Risk that any changes to financial treatment for external issues such as CPI, VAT, etc., make the contract unaffordable	Regular engagement with WG and Trust's commissioners relating to funding levels required. Trust requirements are designed in such a way as to reward bidders to come within an affordability threshold. Working with advisors to understand accounting treatment and associated VAT implications.	Contract Risks
C8	Risk of contractual dispute arising	Mechanisms such as escalation arrangements and termination clauses within the contract	Contract Risks
C9	Risk that FBCs for nVCC and RSC are not approved	Minimum number of machines in the contract. Programme master planning and control plans to manage dependencies across the programme and projects.	Contract Risks
D1	Risk that demand and capacity is underestimated	Carried out future planning based on estimated increases in incidences of cancer as per Cancer Research UK. Continually monitor demand and capacity and option of catalogue and change control to buy additional goods and services. Bidders scope for	Operational Risks

		technology improvements over the life of the contract to increase efficiencies.	
D2	Risk that demand and capacity is overestimated	Carried out future planning based on estimated increases in incidences of cancer as per Cancer Research UK. Continually monitor demand and capacity.	**Operational Risks**
D3	Risk that unable to recruit suitably skilled resource required to deliver the service - availability of applicants	Effective workforce planning and early recruitment, dedicated recruitment campaign	**Operational Risks**
D4	Risk of increased downtime due to machine failures	Delivery of the preferred option	**Operational Risks**

Constraints

6.5 Constraints relate to the parameters that the project is working within and any restrictions or factors that might impact on the delivery of a project. For the procurement of an IRS this includes:

- Affordability constraints which are explored within the Financial Case.
- Timelines for the new Velindre Cancer Centre (nVCC) and Radiotherapy Satellite Centre (RSC) projects which have implications for the way in which the IRS contract will be constructed.
- Availability of internal resources to deliver the project.
- Legacy systems to manage through transition.
- Need to engage adequately with partners to ensure there is the appropriate level of buy in order to optimise Research and Development opportunities.
- Public contract regulations drive the timeline of the IRS procurement.

Dependencies

6.6 Dependencies include things that must be in place to enable the project or project phases to be delivered. They typically include links to other projects and funding requirements that are likely to be managed elsewhere.

- Access to adequate capital funding via Welsh Government and revenue funding from the Trust's Commissioner's

7 CONCLUSION

7.1 The Strategic Case demonstrates a compelling case for investment to support the procurement of an Integrated Radiotherapy Solution (IRS). The key factors supporting the case for investment are:

- There is a need to replace treatment machines to reduce service delivery risks regardless of the nVCC and RSC projects.
- Cancer incidences and activity are increasing as is the complexity of treatment and a surge of COVID-19 cases remains a distinct possibility
- The current VCC has a dual vendor approach which is inefficient.

TRUST BOARD

Radiotherapy Satellite Centre (RSC)
Full Business Case (FBC)

DATE OF MEETING	26th May 2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Andrea Hague, Director of Service Transformation
PRESENTED BY	Andrea Hague, Director of Service Transformation Huw Llewellyn, Director of Commercial & Strategic Partnerships
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
RSC Project Team	April 2022	ENDORSED
VCC SLT	May 2022	ENDORSED
TCS Programme Delivery Board	13th May 2022	ENDORSED
TCS Scrutiny committee	19th May 2022	ENDORSED

INITIALISMS	
ABUHB	Aneurin Bevan University Health Board
FBC	Full Business Case
IRS	Integrated Radiotherapy Solution
OBC	Outline Business Case

PDB	Programme Delivery Board
RSC	Radiotherapy Satellite Centre
RT	Radiotherapy
nVCC	new Velindre Cancer Centre
TCS	Transforming Cancer Services
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
WG	Welsh Government

1. INTRODUCTION

1.1 The Outline business case for the Radiotherapy Satellite Centres (RSC) was approved by Velindre University NHS Trust (VUNHST) and Aneurin Bevan University Health Board (ABUHB) in 2020 and subsequently approved by Welsh Government (WG).

1.2 Since that time the two organisations have continued to work in partnership on plans to develop and operate the RSC. VUNHST will provide the clinical services and ABUHB will provide landlord services and facilities for the RSC. This partnership work has led the production of a Full Business Case (FBC) and a copy of the strategic case from the FBC is attached for consideration for approval.

1.3 Radiotherapy is a key modality in the treatment of cancer and its role is increasing. The Transforming Cancer Services (TCS) programme clearly identified that the service at Velindre Cancer Centre (VCC) will be unable to deliver high, quality, reliable and sustainable service without an expansion in capacity. In addition to capacity a key factor supporting a RSC is the benefit of care closer to home. The RSC is a key project (project 4) within Transforming Cancer Services (TCS) programme.

1.4 This RSC FBC is closely aligned to the Full Business Case for the new VCC (nVCC) and is also closely integrated to the Full Business Case for the Integrated Radiotherapy Solution (IRS), with alignment in terms of the interface matters namely equipment, software and implementation resources for the radiotherapy equipment.

1.5 Since the Outline Business Case (OBC) the following are the key changes:

- The project team has worked closely with Shared Services and WG to support changes to the proposed development to make the build more sustainable (green) and to ensure it is digitally enabled to meet future requirements.

- Previously the equipment costs and workforce requirements to commission the linear accelerator machines (linacs) and the other associated equipment for installation were included in the IRS business case, however after discussion and agreement with WG these costs are now included within the RSC FBC as capital expenditure.

1.6 The FBC is structured to reflect the Treasury Green book guidance and as such it consists of 5 distinct Cases containing the following elements:

- Strategic Case
- Economic Case
- Commercial Case
- Financial Case
- Management Case

The Strategic case is the focus of this paper and due to commercial in confidence issues the other four cases, at this stage, will be considered in the private Trust Board meeting.

2. ANALYSIS

This section of the report summarises the main issues, including changes and updates, to the Strategic case of the RSC FBC since the approved OBC document. Full information is in the full strategic case attached. In TCS Scrutiny Sub-Committee on 19th May, there was challenge from Independent Members on ensuring the role of the Trust, risks and impact on patients was made as clearly as possible. The following summary looks to address these key points:

- The clinical arguments supporting the need for a RSC remain unchanged. Radiotherapy plays a vital role in the treatment of cancers with 50% of all cancer patients benefiting from receiving radiotherapy as part of their cancer management and 40% of all patients cured of cancer being cured by Radiotherapy. In addition there remains evidence that the local access to a radiotherapy centre increases the uptake of treatment, which in turn leads to improved clinical outcomes. Local access also impacts on patient experience through travel times and it has been estimated that over 6,600 patient journeys will be less than currently due to the provision of a RSC at Nevill Hall hospital (NHH).

- The Strategic Case confirms continued alignment with updated national and regional cancer policies.

- The investment objectives have been reviewed and remain unchanged.

- Activity and projected activity levels have been reviewed in light of recent activity including the COVID-19 pandemic and this review confirmed that the original TCS assumptions of 2% average per annum increase in referrals is still relevant in projecting radiotherapy capacity requirements.

- The age profile of the current linacs at VCC, the fact there is no expansion space on current VCC and the timescales for the new VCC means the Trust has limited ability to expand its capacity to meet this forecast demand . The development of the RSC provides additional radiotherapy capacity to patients in SE Wales to meet this forecast demand.

- This Radiotherapy capacity needs to be in place ahead of nVCC as demand exceeds capacity but also to enable medical physics staff to be available to commission equipment at RSC and in nVCC.

- The review of projections on demand for radiotherapy continue to indicate, as previously outlined in OBC, that without the development of additional capacity VUNHST will be unable to continue to deliver safe and effective radiotherapy services, or meet its forecast demand or deliver its performance targets.

- More detailed work has been undertaken on the workforce model and its alignment with activity growth and with the workforce requirements for the commissioning of IRS equipment in the RSC.

In summary the Strategic Case sets out a compelling case for development of a RSC given the capacity requirements and the benefit to patients of care closer to home.

2.1 **Key project milestones** are as follows:

Milestone	**Date**
Submission of FBC to WG	May 2022
WG Approval	July 2022
Start on Site	August 2022
Construction Completion	February 2024
Linac Commissioning Period & Anticipated Beam on Date	February to July 2024

3. NEXT STEPS

3.1 Following approval of the FBC by the Trust Boards of Aneurin Bevan University Health Board and Velindre NHS Trust, the FBC will be formally issued to Welsh Government with a supporting letter from both organisations. Upon receipt Welsh Government will

commence their formal scrutiny processes which is expected to take no longer than three months.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Provision of additional Radiotherapy capacity via the RSC relates directly to the quantity and quality of service that the Trust is able to deliver for patients.
RELATED HEALTHCARE STANDARD	Safe Care
	RSC relate directly to the quality of radiotherapy services that the Trust is able to deliver.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Completed at Programme Level
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 business case outlines the financial requirements for the commissioning and operational running of the unit.

5. RECOMMENDATION

5.1 The Trust Board is requested to **APPROVE** the strategic case of the RSC FBC.

FULL BUSINESS CASE - EXECUTIVE SUMMARY

To be inserted

1.0 INTRODUCTION

Purpose of Business Case

1.1 The purpose of this Full Business Case (FBC) is to confirm:

- The case for change and the preferred option as set out in the approved Outline Business Case (OBC) are still relevant and that no significant changes have occurred since OBC approval.
- That the preferred option is still the construction of a new Satellite Radiotherapy Unit at Nevill Hall Hospital.
- That a "cost not to be exceeded" has been agreed with the Supply Chain Partner in the sum of £29.588 million.
- That the total cost of the preferred option is £45.452 million and that this includes the provision of the Integrated Radiotherapy Solution (previously excluded from the OBC) that is being procured by VUNHST as part of their larger proposed Integrated Radiotherapy Solution.

Structure of Document

1.2 This FBC has been prepared using the agreed standards and format for Business Cases, as set out in:

- HM Treasury Guide to Developing the Project Business Case 2018
- NHS Wales Infrastructure Planning Guidance (2015)
- HM Treasury, the Green Book: Appraisal and Evaluation in Central Government: Treasury Guidance (2003).
- Public Sector Business Cases using the Five Case Model: A Toolkit Guidance and Templates (2007)

1.3 The approved format is the 5 Case Model, which comprises of the following key components:

- The **Strategic Case** which sets out the Strategic Context and the Case for Change, together with the supporting investment objectives for the Scheme.
- The **Economic Case** which demonstrates that ABUHB / VUNHST have selected a *preferred way forward,* which best meets the existing and future needs of the Service and is likely to optimise Value for Money (VFM).
- The **Commercial Case** which outlines the potential procurement strategy.
- The **Financial Case** which addresses the capital and revenue implications and the issue of affordability.
- The **Management Case** which demonstrates that the scheme is achievable and can be successfully delivered in accordance with accepted best practice.

2.0 STRATEGIC CASE

2.1 Introduction

2.1.1 The Strategic context and associated case for change has not changed since submission and approval of the OBC and is summarised below for completeness.

2.2 Background

2.2.1 Radiotherapy is the use of ionising radiation, usually high energy x-rays to treat disease and is usually used to treat malignant disease (cancer) and some benign indications. It has an important role in treatment of cancers as 50% of all cancer patients will benefit from receiving radiotherapy as part of their cancer management. Developments in radiotherapy techniques and the increasing incidence of cancer indicate that the demand for radiotherapy will continue to rise and require sufficient and resilient capacity to be made available. Work to date by VUNHST indicates the service will be unable to deliver a high quality, reliable and sustainable service without an expansion in capacity.

2.2.2 This needs to meet the demand of non-surgical cancer services, together with the poor condition of the estate at Velindre Cancer Centre (VCC) led to the Transforming Cancer Services in South East Wales programme (TCS), which developed with partners a clinical model for non-surgical cancer services. This model included a Radiotherapy satellite centre (RSC) and this business case focuses on the RSC and its role to secure radiotherapy capacity for the population of South East Wales. The capacity needs to be in place ahead of the new VCC as demand is already exceeding capacity but also to enable medical physics staff to be available to commission the equipment in RSC but also in the new VCC.

2.2.3 In addition to the lack of capacity, a key factor supporting the case is the benefit of care being delivered closer to home, especially as there is evidence that uptake of radiotherapy in Wales is below best practice and there is evidence that availability of services closer to patients leads to increased uptake of treatments – which in turn will lead to improved outcomes and better experiences for patients.

2.2.4 Following agreement on the TCS clinical model, the process for determining the best site for the RSC was established with partner organisations through an evaluation exercise. This led to the selection of Nevill Hall Hospital as a site for the RSC and as such this is a joint project between the 2 organisations.

2.2.5 The remainder of this Strategic Case will provide more detail on the above issues to support the case for change for this service development.

2.3 Organisational Overview

2.3.1 This section will provide an overview of Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) and their relevant Service

Hospitals as well as an overview of Cancer Services in South East Wales and the whole system leadership arrangements.

Aneurin Bevan University Health Board (ABUHB)

2.3.2 Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013.

2.3.3 It serves an estimated population of over 639,000, approximately 21% of the total Welsh population.

2.3.4 With a budget of £1.4 billion the HB delivers healthcare services to people in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen and also provide some services to the people of South Powys.

2.3.5 The Health Board covers diverse geographical areas and has to take account of a mix of rural, urban and valley communities. The valleys experience high levels of social deprivation, including low incomes, poor housing stock and high unemployment.

2.3.6 The Health Board employs over 16, 700 (11,972 WTE) staff, two thirds of whom are involved in direct patient care. ABUHB is the largest employer in Gwent.

2.3.7 The Health Board provides a comprehensive range of acute hospital based, Community based, Mental Health and Primary Care services via a large and complex estate consisting of the following:

- The Grange University Hospital (Specialist and Critical Care Centre),
- 3 Local General Hospitals - Royal Gwent, Neville Hall, Ysbyty Ystrad Fawr
- 5 Community Hospitals - County, Ysbyty Aneurin Bevan, St Woolos, Chepstow and Monnow Vale
- 4 Mental Health Hospitals - St Cadoc's, Llanfrechfa, Maindiff Court, Ysbyty'r Tri Chwm
- 8 Locality based Mental Health Units and 1 Residential Unit on LGH site, 4 unoccupied units across Gwent.
- 30 Locality based Community clinics
- Nearly 300WTE General Practitioners and salaried GPs
- 375 General dental practitioners in 79 practices
- 131 Community pharmacies
- 69 Optometry premises

Velindre University NHS Trust (VUNHST)

2.3.8 The Trust is operationally responsible for the management of the following two divisions:

- Velindre Cancer Centre;
- Welsh Blood Service;

- Host for the NHS Wales Shared Services Partnership (NWSSP)on behalf of the Welsh Government (WG) and NHS Wales:

2.3.9 Velindre Cancer Centre located in Whitchurch, Cardiff and is one of the ten largest regional clinical oncology centres in the United Kingdom and the largest of the three centres in Wales. The Trust is the sole provider of non-surgical specialist cancer services to the catchment population of 1.5 million across South East Wales, from Chepstow to Bridgend and from Cardiff to Brecon. Additionally it provides more specialist radiotherapy services across the whole of South Wales. Velindre Cancer Centre employs around 863 (751WTE) members of staff and has approximately 70 volunteers who provide a range of 'added value' roles across the centre. The Trust also works in partnership with a wide range of third sector, charities, Higher Education Institutions (HEIs) and Industry/Commercial Partners to deliver high quality cancer care and undertake clinical research.

2.3.10 Velindre Cancer Centre is responsible for the delivery of non-surgical treatment including Radiotherapy and Systemic Anti-cancer Therapy (SACT), recovery, follow-up and specialist palliative care. These services are provided by specialist teams using a well-established multi-disciplinary team (MDT) model of service for oncology and palliative care, working closely with local HB partners, and ensuring services are offered in appropriate locations in line with best practice standards of care. Following their specialist cancer treatment, Velindre Cancer Centre supports patients during their recovery and through follow up appointments.

2.3.11 The following patient services are delivered in outreach settings in Health Board (HB) locations across South East Wales from Velindre Cancer Centre:

- SACT delivery,
- Outpatient appointments,
- Inpatient reviews; for patients receiving care and treatment in HBs
- Health Board MDTs; and
- Research and Education
- Acute Oncology services.

2.3.12 However, all Radiotherapy activity is currently delivered at the Velindre Cancer Centre.

2.4 Overview of Cancer Services in South East Wales

2.4.1 The planning and delivery of cancer services in South East Wales is the responsibility of the four Health Boards (HBs) (Aneurin Bevan University Health Board, Cardiff ad Vale University Health Board; Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board) as part of their statutory responsibility to meet the health needs of the populations they serve. The HBs are supported by the Welsh Health Specialist Services Committee (WHSSC) which commissions specialist cancer services on their behalf.

2.4.2 VUNHST and the HBs work in partnership with the All Wales Cancer Network, NHS Trusts, Community Health Councils, Voluntary and Charitable Organisations and Public Health Wales.

2.4.3 The four Health Boards, in conjunction with VUNHST and other stakeholders have formed the South East Wales Collaborative Cancer Leadership Group (CCLG). To provide effective system leadership for Cancer Services across South East Wales and deliver improvements in outcome and service experience for the catchment population through Collaborative Cancer Programmes of work within the region The CCLG fully supported the RSC OBC and the development of this FBC is in line with this support from CCLG.

The Cancer Pathway

2.4.4 The delivery of cancer services across Wales generally conforms to a well-defined pathway of care which includes the following five key stages:

Table 2-1: The Cancer Pathway

Cancer Prevention: Enhancing public awareness and education to make informed decisions about lifestyle choices that promote a healthy, cancer free population.
Cancer Diagnosis: Cancer can be identified through a National Screening Programme or where cancer symptoms are identified by the patient/health care professional. If cancer is suspected the patient is assessed by a multidisciplinary team in the Health Board (often supported by Velindre Cancer Centre staff) and cancer may be diagnosed.
Treatment: The treatment options for every patient are discussed and considered by multi-disciplinary teams (MDTs). The treatment options include surgery, non-surgical treatment e.g., Radiotherapy or Systemic Anti-Cancer Therapy (SACT), a combination of these treatments and supportive care. Care often straddles organisational boundaries.
Recovery/Follow Up: Regular follow up appointments are important to monitor recovery, manage and reduce the after-effects of treatment and to ensure any signs of cancer relapse/recurrence are identified at their earliest stage.
End of Life Care: Sadly, not all patients survive cancer – openness about the need to plan end of life care is essential. A focus on living and dying well, early identification of needs and access to fast, effective palliation are important to reduce distress for both the patient and their family.

The Single Cancer Pathway (SCP)

2.4.5 The Suspected Cancer Pathway (SCP) aims to ensure that patients begin a first definitive treatment no later than 62-days after the point of suspicion of cancer. Such an ambition necessarily presents capacity challenges at all points of the patient pathway, not least in relation to treatment delivery.

2.4.6 A direction of travel in the field of radiotherapy is the adoption of a revised suite of time to treatment measures in the near future in Wales. These measures, developed by the Clinical Oncology Sub-Committee (COSC), will replace the extant JCCO measures. The COSC quality measures are supported by definitions which better reflect the ever increasing complexity of radiotherapy planning and will require the great majority of patients referred for radiotherapy treatment to begin their treatment within 21-days of referral. This is in step with the overarching ambition of the SCP, but again will pose significant capacity challenges.

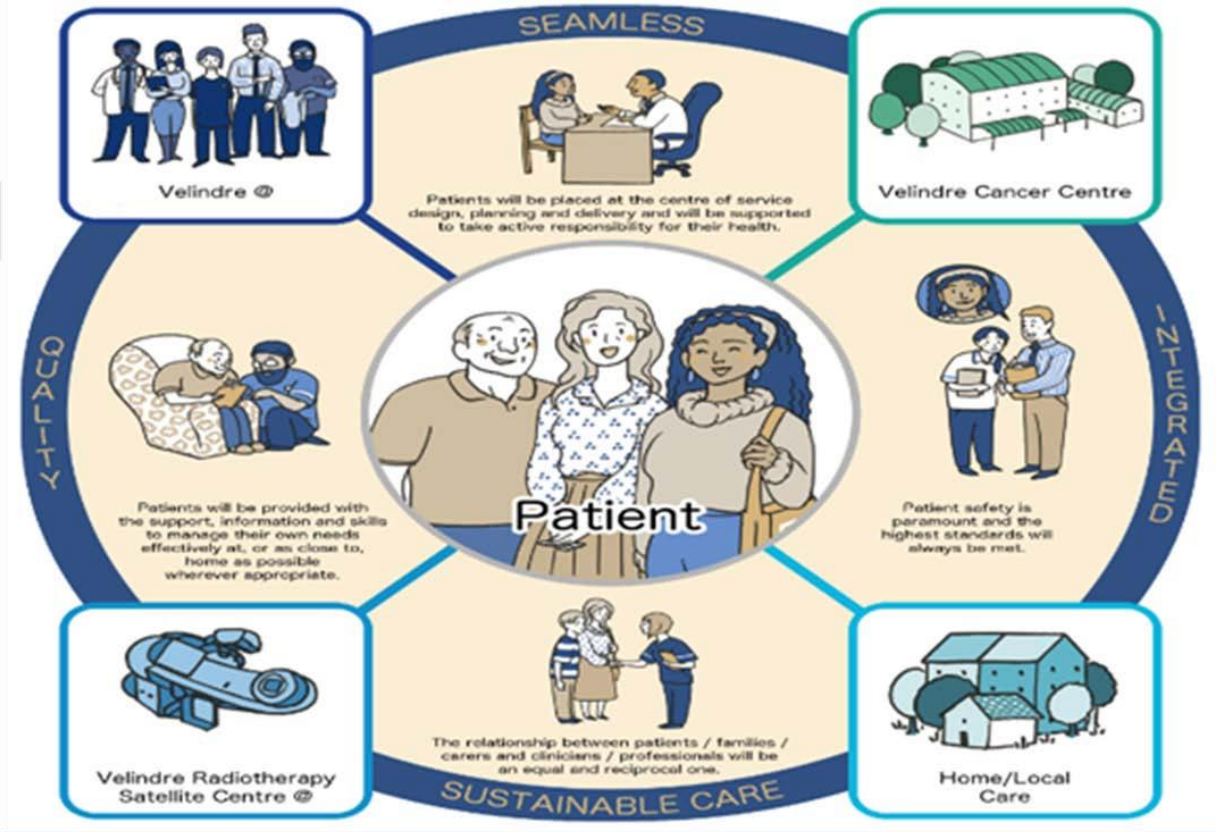
2.4.7 It is obvious that efforts to achieve the SCP timescales and the adoption of the new COSC quality will exacerbate issues associated with the availability of treatment capacity at VCC due to rising demand.

Transforming Cancer Services (TCS) Programme

2.4.8 It is important to understand where this FBC sits in the context of the overall TCS Programme. The TCS Programme is an ambitious Programme which aims to deliver transformed Tertiary non-surgical Cancer Services for the population of South East Wales.

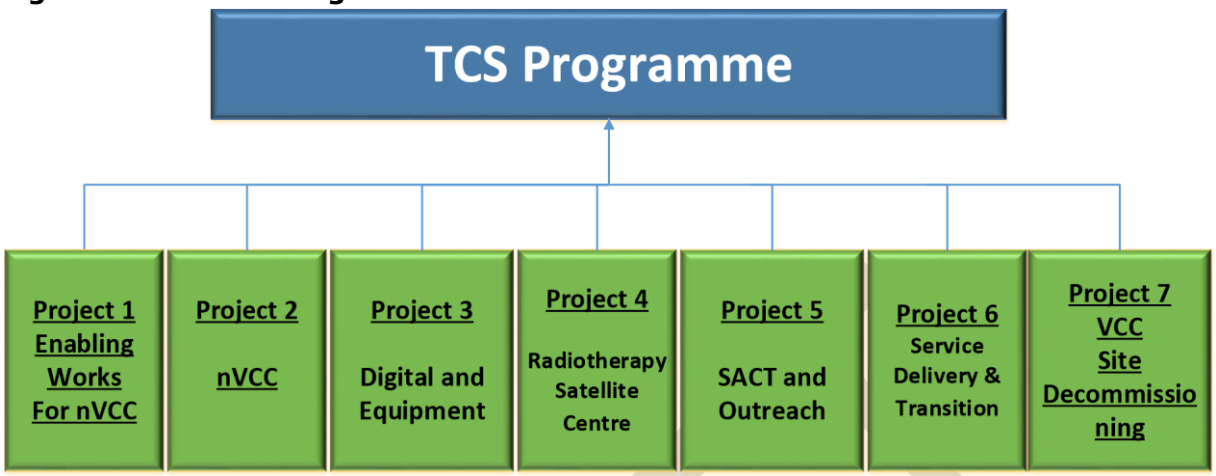
2.4.9 Through detailed stakeholder engagement the clinical model is shown below was developed and approved by HBs.

Figure 2-1: Clinical Model



2.4.10 Following agreement on the proposed clinical model 7 programmes of work/projects were developed to deliver the TCS programme:

Figure 2-2: Seven Programmes of Work



2.4.11 The Strategic Case for the TCS Programme, its links to Welsh Government Strategy and Velindre's own Cancer Strategy, are made in the TCS Programme Business Case (PBC). It is not the intention of this FBC to restate these, more to show alignment with this wider Programme's aims and objectives.

2.4.12 This FBC is also related to the Full Business Case FBC) for the new Velindre Cancer Centre (nVCC) and the FBC for the Integrated Radiotherapy Solution (IRS). The latter project aims to deliver the Trust decision to seek one prime vendor to deliver a fully integrated Radiotherapy solution and move away from the current situation of dual vendors of Radiotherapy equipment. The Integrated Radiotherapy Solution Procurement FBC is being developed from a Digital and Equipment Procurement De-coupling PBC which will be submitted to Welsh Government in May 2022.

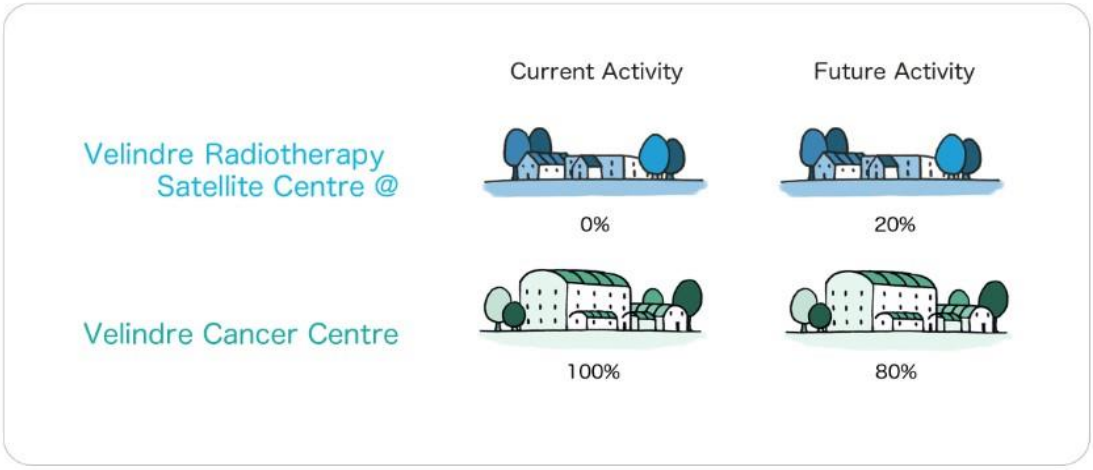
2.4.13 The Clinical Model within the TCS PBC, and as outlined in diagram above describes how services will be delivered in the future and is predicated on the following principles:

- The service model seeks to promote a new set of relationships which work in partnership to improve the way we collectively design and deliver services around patients' needs and to achieve these improvements in a truly sustainable way.
- The patient will be central to plans with an integrated network of services organised around them. The organising principle seeks to 'pull' high quality care towards the patient that is accessible in their preferred location and will support them achieving their personal goals during treatment and subsequently living with the impact of cancer.
- Patient safety is paramount, and the highest standards will always be met.
- The relationship between patients / families / carers and clinicians / professionals will be an equal and reciprocal one.

- Patients will be provided with the support, information, and skills to manage their own needs effectively at, or as close to, home as possible wherever appropriate.
- Patients will be treated at their closest centre where appropriate and safe to do so (removal of HB boundaries).
- Optimising information technology, quality improvement systems, patient involvement, education and embracing innovative approaches to healthcare will all be essential to achieve high levels of service quality in a sustainable way.

2.4.14 To deliver the principles of the new clinical model, care will be delivered differently and at different locations. This will require a number of infrastructure and technology projects as well as service change projects to be established including this business case for a **Radiotherapy Satellite Centre** to provide radiotherapy treatment for approximately 20% of patients (provided by 2 new linear accelerators).

Figure 2-3: Current & Future Activity



2.4.15 This means better access for patients, reduced travel for patients, associated improved outcomes, and less use of transport services. This will mean that fewer patients need to travel to VCC for their radiotherapy. These Benefits are the focus of this business case.

Preferred Operational Model

2.4.16 The TCS Programme undertook an appraisal of a wide range of operational delivery models for all its services and as outlined in the OBC after evaluation (financial and non-financial).

The preferred operating scenario was:

Table 2-2: Preferred Operating Scenario

Radiotherapy Service	5 days a week, 9.5 hours a day at both nVCC and RSC 7-day Radiotherapy service for emergency patients and for urgent palliative patients who are treated at VCC

2.4.17 Following the determination of the clinical model and the preferred operating model it was necessary to determine an appropriate location for the satellite centre.

Process for Identifying a Preferred Site

2.4.18 In 2017 a process was undertaken with HBs and CHCs to determine a preferred location for Velindre's Radiotherapy Satellite Centre. Full details of the process were included in the OBC.

2.4.19 The Evaluation Panel, comprising HB, Trust and CHC representatives:

- Approved the evaluation report;
- Approved the key findings and results outlined within the report;
- Approved the 'preferred' site location option to host the Radiotherapy Satellite Centre as being Nevill Hall Hospital (site 8) based upon the analysis presented.

2.4.20 This FBC is based on this Site Selection Evaluation as set down by the Joint Leadership Team at the IIB Meeting 24 July 2019 and the Projects response to the Welsh Government approval letter to proceed dated 28th November 2019.

Project Partnering Arrangements

2.4.21 Following the selection of ABUHB as the site for the RSC the 2 organizations developed project partnering arrangements where both organsiations will develop and operate the RSC as a partnership with clearly defined roles and responsibilities for each organization within the partnership agreement.

2.4.22 ABUHB will build and provide the landlord services and facilities for the RSC building.

2.4.23 VUNHST will provide the clinical services and own the associated clinical equipment within the RSC.

2.5 Strategic Policy Context

2.5.1 This section of the Full Business Case (FBC) summarises the strategic context for the Radiotherapy Satellite Centre (RSC) Project.

Strategic Context in Wales

2.5.2 The Welsh Government has published a wide range of national strategies which provide the framework for the planning and delivery of public services in Wales. These are supported by a range of policies, frameworks and guidance which relate more specifically to health and social care.

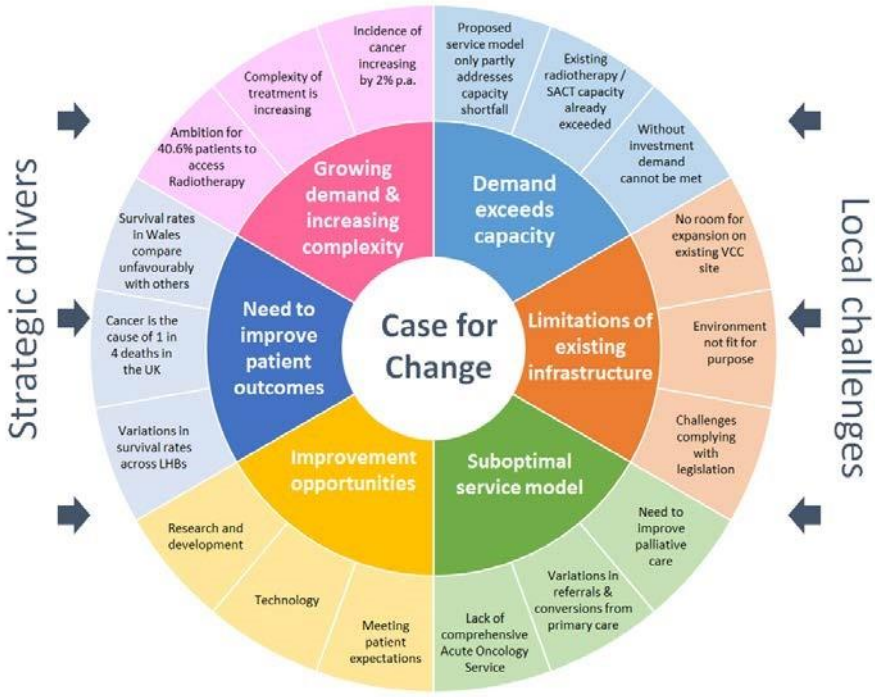
2.5.3 In addition, the TCS Programme and its partner organisation continually scans the environment at a population, national, regional and local level to develop our knowledge and intelligence on key issues which we need to take account of in the strategic planning and delivery of services.

2.5.4 The TCS Programme Business Case (PBC) outlines the strategic context for the Transforming Cancer Services Programme and describes how the Programme is central to VUNHST's ability to deliver key national and local strategic objectives, especially in relation to those outlined in the following strategic documents:

- Well-being of Future Generations (Wales) Act (2015)
- A Healthier Wales: Our Plan for Health and Social Care
- Prudent Healthcare: Securing Health and Well-being for Future Generations
- Together for Health – Cancer Delivery Plan
- The Velindre University NHS Trust Cancer Strategy; and
- Velindre Cancer Centre Strategy for Radiotherapy

Note: It has been agreed with commissioners, through the collaborative scrutiny process, that the PBC is extant and for contextual understanding only. However, the PBC will remain a 'live' document which will be updated at key milestones in the Programme and is currently being updated.

Figure 2-4: Strategic Drivers and Local Challenges



2.5.5 Clinical outcomes for cancer patients in Wales compare unfavourably with other countries.

National context. The Quality Statement for Cancer in Wales

2.5.6 Clinical outcomes for cancer patients in Wales compare unfavourably with other countries.

2.5.7 The Welsh Government's Quality Statement for cancer builds on the work of the 2012 and 2016 Cancer Delivery Plans. Published in March 2021 it describes a five year phase of cancer service development, which must take advantage of the widespread consensus that has emerged on priority areas, bring programmes to fruition, and maintaining the national leadership and local engagement that has been achieved. This will ensure that there is a long-term and consistent approach to improving outcomes as envisaged in the Wellbeing of Future Generations Act and demonstrated by international experience.

2.5.8 This statement discusses how over the past decade, cancers have been one of the most common causes of death in Wales and this is likely to remain so in the decades ahead due to the ageing nature of the population. It is vital that cancer is effectively prevented where possible, that cases of cancer are detected at earlier more treatable stages, and that complex treatment pathways are optimised; while throughout people are properly supported and co-produce their care. Ultimately, the aim is to improve population survival and reduce cancer mortality rates.

2.5.9 Quality attributes of cancer services in Wales are based around the following themes:

Equitable
Equity of access and consistency in standards of care. A workforce planned to meet forecasted demand.

Safe
System level focus on recovery to pre-pandemic waiting list volume. More resilient regional services.

Effective
More cases of cancer are detected at earlier, more treatable stages through more timely access to diagnostic investigations.

Evidence-based surgical techniques, radiotherapies, systemic anti-cancer therapies and genomic therapies are routinely available. All eligible patients are offered access to research trials and Wales provides excellent supporting infrastructure for cancer research.

Efficient
Clinicians working in cancer pathways work at the top of their license or are supported to improve their skill mix and are also enabled to take part in the quality assurance cycle and research activity

Person centred
Person-centred cancer care is culturally embedded and supported by a common approach to assessing and managing people's Needs.

Timely
Cancer services are measured and held accountable using metrics that reflect the quality of patient care and its outcomes. Timeliness of cancer pathways is measured across their entire length, beyond first definitive treatment and including recurrent disease

2.5.10 All the HBs within SE Wales, and within the remit of this business case, along with VUHNST have used these pillars as the basis for their plans for cancer services to meet the needs of their local population .

Local Strategic Context in VUNHST and ABUHB

2.5.11 As mentioned above both VUNHST and ABHB have Cancer Strategies and delivery plans for cancer services which have shared ambitions.

2.5.12 ABUHB Cancer Strategy *Cancer Services: Delivering a Vision 2020-2025* has the following ambition:

Figure 2-6: ABUHB Vision

ABUHB Vision:
Improve prevention, optimise treatments, patient outcomes and reduce health inequalities for our population and those we serve.

2.5.13 Velindre is currently developing a strategy for the Trust which will set out a mission, vision, and strategic goals between now and 2032.

'*Destination 2032: Helping Us to Deliver Our Strategy for the Next Decade*' sets the following vision for cancer services for the next ten years:

Figure 2-7: VUNHST Vision – Healthy People, Excellent care, Inspirational learning is set out in three areas:

VUNHST Vision Statement:

Healthy People:

We will be an organisation that support s people in being as healthy as possible (mind and body), given their situation in life. By people we mean staff, donors, patients, and the communities we serve

Excellent care:

We will be an organisation that delivers clinical services of the highest quality, safety, and experience with outcomes that compare favourably with those of our national and international peers; is highly regarded by the people we work for and with; exceed expectations and attracts the best people to come and work for us.

Inspirational Learning:

We will be an organisation that develops the culture, facilities and Learning partnerships that provides first class research, development and innovation to thrive and drive up the quality of care; learning opportunities for all our staff, patients, families and donors

2.5.14 At the heart of the TCS Programme is the delivery of a patient centred service model that will allow Commissioners to provide sufficient capacity to deal with growing and changing demand for services, whilst improving clinical outcomes for the population of South East Wales.

2.5.15 ABUHB Cancer Strategy: *Cancer Services: Delivering a Vision 2020-2025* affirms the HB's commitment to continue to deliver the best possible care and support for everyone affected by cancer and sets out its ambition to be an exemplar in its delivery of cancer services. The ABUBH's Cancer Strategy and the HBs plans for Nevill Hall Hospital (NHH) include the development of the RSC as a key driver to deliver its ambitions. In the HB's plan the RSC at NHH will operate alongside key other cancer services including local SACT treatments, Acute Oncology Services (AOS) and specialist palliative care.

2.5.16 This FBC will provide the case for the RSC to support the existing, and in due course new, Velindre Cancer Centre in its provision of Radiotherapy services for the population of South East Wales. The nVCC will provide a hub to deliver the many of specialist non-surgical cancer services for South East Wales but with radiotherapy services closer to home for a proportion of the catchment population delivered via a Satellite Centre. As such it is critical to the delivery of the overall TCS Programme and is therefore aligned to the wider healthcare strategic context, at both a local and national level.

2.6 Existing Arrangements Radiotherapy

2.6.1 The purpose of this section of the business case is to describe the current service delivery arrangements for the services covered within the scope of the RSC Project;

Service Delivery Arrangements, including equipment

2.6.2 VUNHST delivers specialist non-surgical cancer services, including Radiotherapy to a catchment population of 1.5million people using a hub and spoke service model. For some specialist Radiotherapy treatments the catchment population is all of Wales.

2.6.3 Services are currently provided across South East Wales from one of two main treatment locations:

- **Velindre Cancer Centre:** The hub of the Trust's specialist cancer services is a specialist treatment, training, research, and development Centre for non-surgical oncology; and
- **Outreach Centres:** outpatient and SACT treatments are delivered on an outreach basis within facilities across South East Wales, including District General Hospitals and from patients' own homes.

2.6.4 Currently all radiotherapy treatments are provided at VCC hub**.**

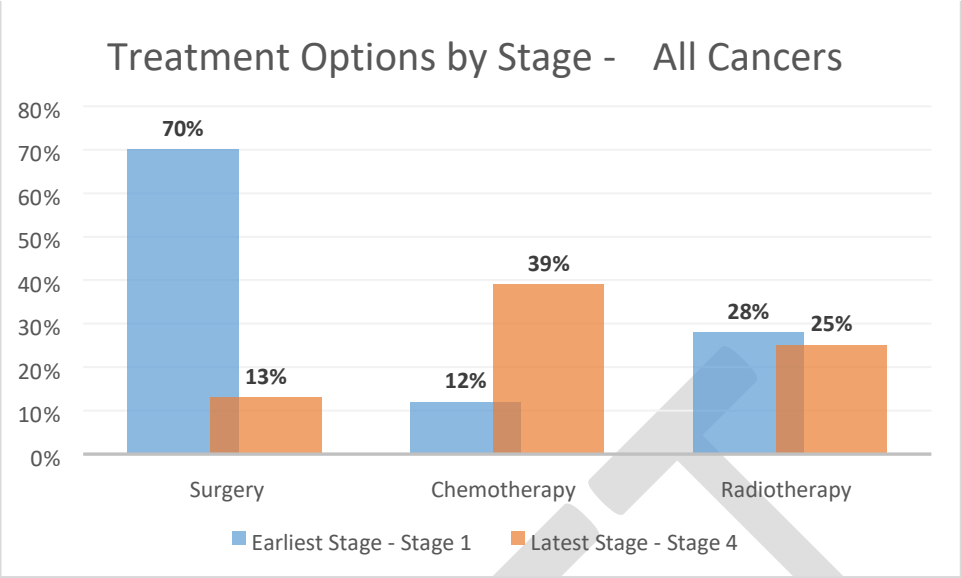
2.6.5 Radiotherapy plays a vital role in the treatment of cancers with:

- 40% of all patients cured of cancer are cured by radiotherapy
- It also can offer patients the choice of organ preservation and avoid the need for major or disfiguring surgery.

2.6.6 With rapid developments in the technology the role of Radiotherapy continues to expand in the treatment of cancers.

2.6.7 Radiotherapy is a flexible treatment modality which is used with a curative or palliative intent, at a consistent rate, regardless of cancer staging as shown by the following graph:

Figure 2.8: Treatment Options by Stage



2.6.8 The current radiotherapy department is based on a single site at the Velindre Cancer Centre (VCC) with a full range of radiotherapy facilities and equipment to deliver the service:

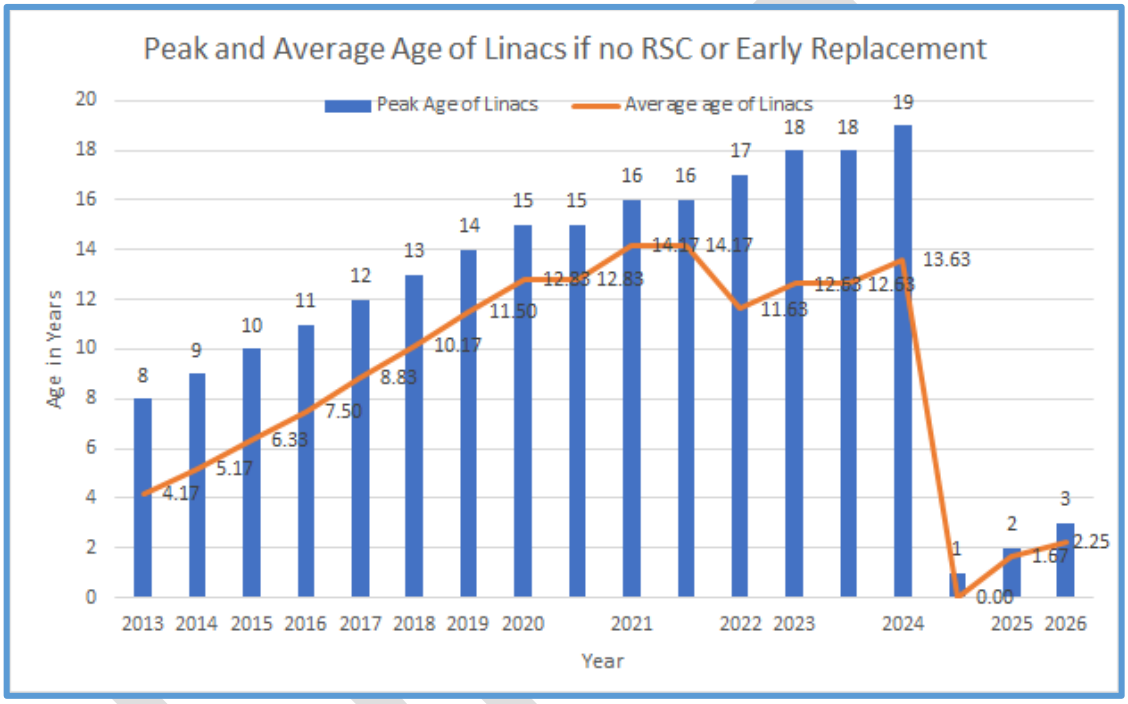
2.6.9 Recent years has seen an increase in the complexity of linear accelerators which impacts on repair, QA and maintenance time to safeguard the reliability and high accuracy of the machines, which is particularly important given the increasing trend of higher doses over less fractions.

2.6.10 The life expectancy of a Linear Accelerator (LINAC) is 10 years and it is important that the linacs are fit for purpose and not beyond their life expectancy which leads to increased risks about breakdowns and failures, which in turn affects the sustainability of a safe and reliable radiotherapy service.

2.6.11 The LINACs at VCC are ageing with an average age of 11.6 as at 2022; with a peak age of 17 years which is well beyond the expected lifespan. The table below show the aging profile of machines at VCC and four of the Trust's treatment machines being considerably over they recommended life in 2023. Should the RSC not go ahead as planned, and no early procurement of treatment machines approved, the situation at Velindre Cancer would worsen.

Table 2-3: Aging Profile of Machines at VCC

Planning Scanario - No Early Replacement of Linacs - wait for RSC 2023 and nVCC 2024 as previosly planned																														
		Location	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020		2021		2022	2023		2024		2025	2026
																		Transition YR		Transition YR			Transition YR		Transition YR			
LA10	Std	RSC																						0	1	1	2	3
LA9	Std	RSC																						0	1	1	2	3
LA8	Std	VCC							0	1	2	3	4	5	6	7	8	9	9	10	10	11	12	12	13	0	1	2
LA7	Std	VCC						0	1	2	3	4	5	6	7	8	9	10	10	11	11	12	13	13	14	0	1	2
LA6	Std	VCC	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	15	16	16	17	18			0	1	2
LA5	Std	VCC								0	1	2	3	4	5	6	7	8	8	9	9	10	11	11	12	0	1	2
LA4	Stereo	VCC										0	1	2	3	4	5	6	6	7	7	8	9	9	10	0	1	2
LA3	Std	VCC			0	1	2	3	4	5	6	7	8	9	10	11	12	13	13	14	14	15	16			0	1	2
LA2	Stereo	VCC												0	1	2	3	4	4	5	5	6	7	7	8	0	1	2
LA1	Std	VCC				0	1	2	3	4	5	6	7	8	9	10	11	12	12	13	13	14	15	15	16	0	1	2
Total											6	7	7	8	8	8	8	8	8	8	8	8	8	8	8	10	10	10
Avg Age											4.17	4.43	5.43	5.63	6.63	7.625	8.625	9.625	9.625	10.625	10.625	11.625	12.625	8.375	9.375	0.2	1.2	2.2
Peak Age											8	9	10	11	12	13	14	15	15	16	16	17	18	15	16	1	2	3



2.6.12 The RSC is an important development to ensure VUNHST is able to continue to deliver safe and effective Radiotherapy services.

Benchmarking

2.6.13 VUNHST regularly submits data into the Radiotherapy Data Set (RTDS) alongside other Radiotherapy centres in Wales and England. This allow the centre to undertake benchmarking against other centres in areas of operational efficiency.

2.6.14 In addition as part of the development of TCS programme we have taken the opportunity to benchmark the efficiency of our service.

2.6.15 Benchmarking exercises were undertaken during recent years with a number of leading Cancer Centres from across the UK including:

- The Beatson West of Scotland Cancer Centre;

- The Clatterbridge Cancer Centre NHS Foundation Trust;
- Leeds Teaching Hospital NHS Trust; and
- The Royal Marsden NHS Foundation Trust.

2.6.16 These benchmarking exercises indicated that VUNHST compares favourably with other UK Radiotherapy centres in respect of throughout and efficiency and, therefore, additional capacity cannot be fulfilled by improved efficiency with the current service.

2.7 Business Needs

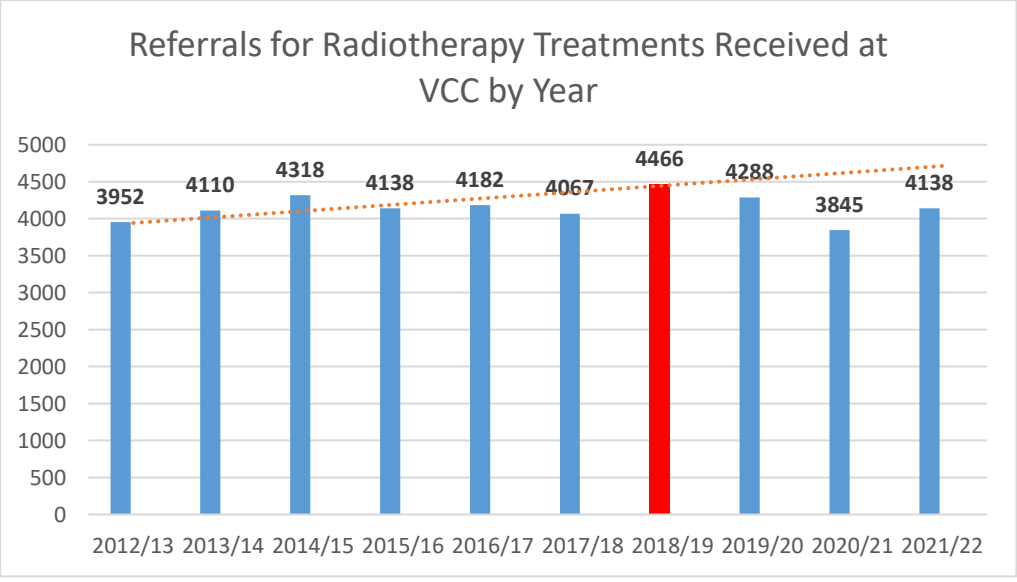
2.7.1 This section will review the clinical growth assumptions and demonstrate that additional capacity is required to meet the forecast increases in demand for Radiotherapy.

2.7.2 Earlier sections outlined the role radiotherapy plays in the treatment of cancers. Regardless of the future delivery of systematically more rapid diagnosis, increased screening capacity and public health initiatives, radiotherapy will remain a valid and effective clinical option for the treatment of a large proportion of all patients with cancer.

2.7.3 There are challenges inherent in attempting to forecast future demand for radiotherapy services given changes in clinical indications, incidence and changing treatment complexity. The TCS Programme has developed clinical growth assumptions which in turn have informed the development of this Full Business Case. TCS assumptions estimate that demand for radiotherapy services in south-east Wales will increase at a rate of 2% per annum to 2030/31.

2.7.4 It is apparent that demand for specialist cancer treatment is increasing. This demand is represented in the most immediate sense by the receipt of increasing numbers of patient referrals. Such an increase has been observed by the radiotherapy service at Velindre Cancer Centre in recent years.

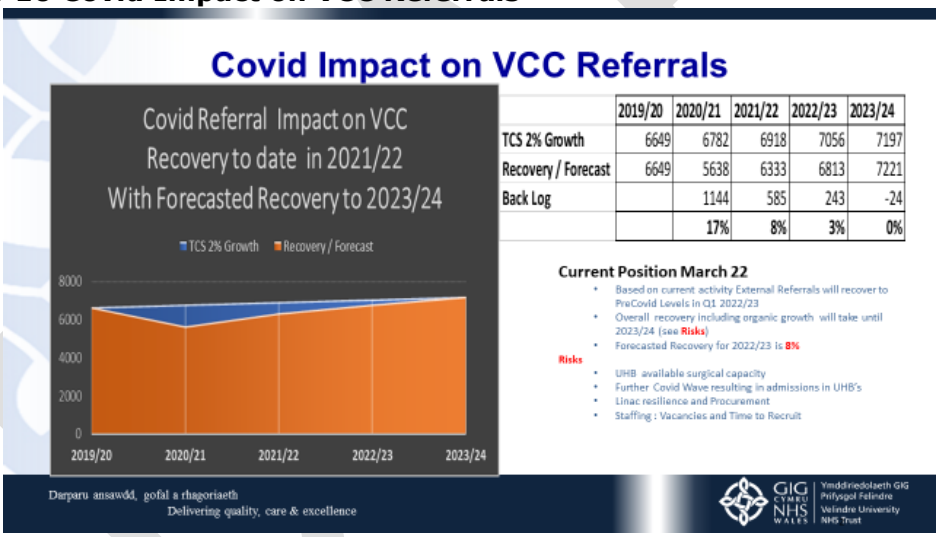
Figure 2-9: Referrals for Radiotherapy Treatments



2.7.5 The graph above details the number of individual patient referrals for treatment with radiotherapy received at Velindre Cancer Centre from 2012/13 to 2021/22, inclusive. The dotted line overlaid on the graph describes an increase in referrals of 2% per annum from a base in 2012/13. Although there are year on year fluctuations, the graph serves to illustrate that the actual historical growth in referrals has been in step with the 2% clinical growth assumption for radiotherapy within TCS plans.

2.7.6 Prior to the pandemic 2018/19 represented the largest number of referrals (4466) received for the radiotherapy treatment at Velindre Cancer Centre in any given year. This follows an earlier peak in 2014/15 (4,318 referrals). Referrals to Velindre Cancer Centre, including Radiotherapy, were impacted by covid in 2020-2022. There was a reduction in referrals in the early days of covid pandemic but the typical month on month referrals have since increased, subject to periodic COVID related fluctuations, and are currently marginally above pre pandemic levels. This is assumed to be due to the well documented backlog in cancer activity that is currently being experienced. Following the pandemic, it is expected that these growth levels will again be seen in radiotherapy. Such marked increases in demand present stark capacity challenges which will become more acute as the clinical growth assumption underpinning the TCS Programme materialise.

Figure 2-10 Covid Impact on VCC Referrals



2.7.7 However, as shown in Figure 2-10 above the original TCS assumptions of 2% average increase in referrals per annum have been assessed as still relevant in projecting capacity requirements.

2.7.8 Following the pandemic it is expected that these growth levels will again be seen in radiotherapy. Such marked increases in demand present stark capacity challenges which will become more acute as the clinical growth assumption underpinning the TCS Programme materialise.

2.7.9 There are a number of factors that influence the demand for Radiotherapy including:

1) Increasing incidence of cancer

It is recognised that the rate of cancer incidence in the United Kingdom and Welsh populations has been increasing over time. Cancer incidence in the United Kingdom increased by 12% between the early 1990s and the late 2010s and is expected to increase by a further 40% by 2035. This would represent 514,000 new cases of cancer in the United Kingdom compared to the 359,960 reported in 2015. Within Wales it is forecast incidence will increase by 2% pa over the next 10 years.

As mentioned earlier in this case the Wales Cancer Quality Statement has a focus on earlier detection and diagnosis of cancer. These patients will then require treatments including Radiotherapy. It is also likely to shift the balance towards a higher number of radical treatments as cancers get detected earlier.

2) Increasing population

The increased rate of incidence is driven, in part, by the fact that the population is growing and ageing. Welsh Government's most recent *Future Trends Report* forecasts that the population of Wales will increase by 5% between the mid2010s and the mid-2030s. Although population level estimates of future changes in incidence take some account of forecast changes in population level and demographic, the anticipated increase to the population of certain areas in south-east Wales in the coming decades are marked. For example local authority population projections, prepared by *Statistics for Wales* on behalf of Welsh Government in 2016, indicate that the population of Newport will increase by approximately 12,000 by 2039 and that of Cardiff will be 26% larger in 2019 than in 2014, an increase which would represent more than 90,000 extra residents.

It is acknowledged that cancer incidence is higher among the over 65s and the same report predicts that the overall proportion of the Welsh population aged 65 and over will increase from 20% to 25% over the same period.

3) Increasing complexity of treatments

New techniques and developments are impacting on cancer treatments, Including radiotherapy.

New techniques in the planning and delivery of Radiotherapy are improving accuracy of treatments for example to avoid critical organs which helps reduce long term side effects which can be debilitating, but also improves survival. Developments continue to lead to growth in complexity and create an increase demand on resources including pre-treatment and treatment capacity, increased time to plan, treat and an increase in the rate of re-planning.

One new technique is hypo fractionation which involves high volumes but over shorter fractionation regimes. Whilst this enables fewer visits

by patients it requires an increase in accuracy and specification of planning and dosimetric delivery of treatments. This demands more high quality treatment planning but also longer set up time and imaging at the time of treatments. Thus it is predicted that the throughput of treatments per hour will reduce. These, together with the commensurate increase for Quality assurance checking to ensure treatments are delivered in an optimum and safe manner, are having an impact on demand for radiotherapy.

Another example of developments is in chemo radiation with the potential for combination drug therapies that may provide opportunity for enhanced update of radiation by cancer cells or to protect healthy tissues during Radiotherapy.

4) Current uptake levels of RT

Analysis of the update rates of Radiotherapy in Wales show it to be about 37% against best practice of approximately 41% which suggest there are people in Wales who could benefit from Radiotherapy that are not currently receiving it.

It is acknowledged that the proximity of the population to specialist services assist in ensuring greater access and uptake of these services. There is evidence that the uptake of RT treatment by patients diminishes with the distance travelled by patients to reach radiotherapy centres. The provision of a satellite will provide improved access to patients as their travel time will be reduced. The Royal College of Radiologists indicate a journey time of less than 45 minutes is appropriate

Previous work analysing potential sites has shown that a satellite centre will improve the number of patients who live within 45 minute drive of a radiotherapy treatment centre in SE Wales. As the population ages to this should ensure that as many patients as possible can access the relevant treatments. Therefore, it is anticipated that a Radiotherapy satellite centre in South East Wales will also lead to an increase in the update of Radiotherapy treatments.

5) Rapid developments in techniques

Velindre Cancer Centre has always had an excellent reputation for delivering high quality radiotherapy to it patients. It has been instrumental in delivering practice changing clinical research and has always been an early adopter of new technologies such as IMRT and stereotactic radiotherapy. The pace of innovation, clinical and technological change and complexity in cancer services is rapid. It is important that the radiotherapy service at Velindre Cancer Centre be at the forefront of cancer treatment, delivering a range of high quality, people centred services, which can benefit the Welsh population, whilst balancing innovation and research with accurate, timely, effective, efficient use of resources.

2.7.10 Within these demand increases it is projected that the most prevalent tumour types will remain as now. In 2035, approximately a third of all cancers reported in men are anticipated to be cancers of the prostate and a similar proportion of all cancers reported in women will be cancers of the breast.

2.7.11 These drivers and demographic developments strongly indicate that over the coming years the demand for RT will continue to rise and require sufficient and resilient capacity to be made available. The need for this increased capacity for Radiotherapy services in South East Wales is shown in graphs below and it is this which underpins the development of this FBC.

Figure 2-11: Radiotherapy Activity

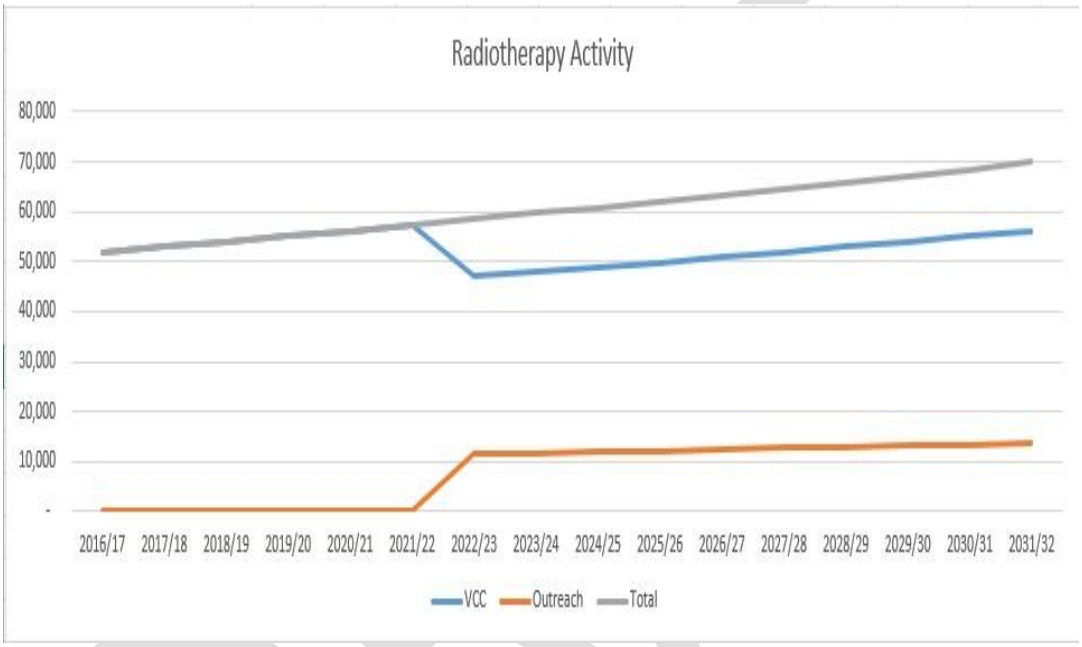
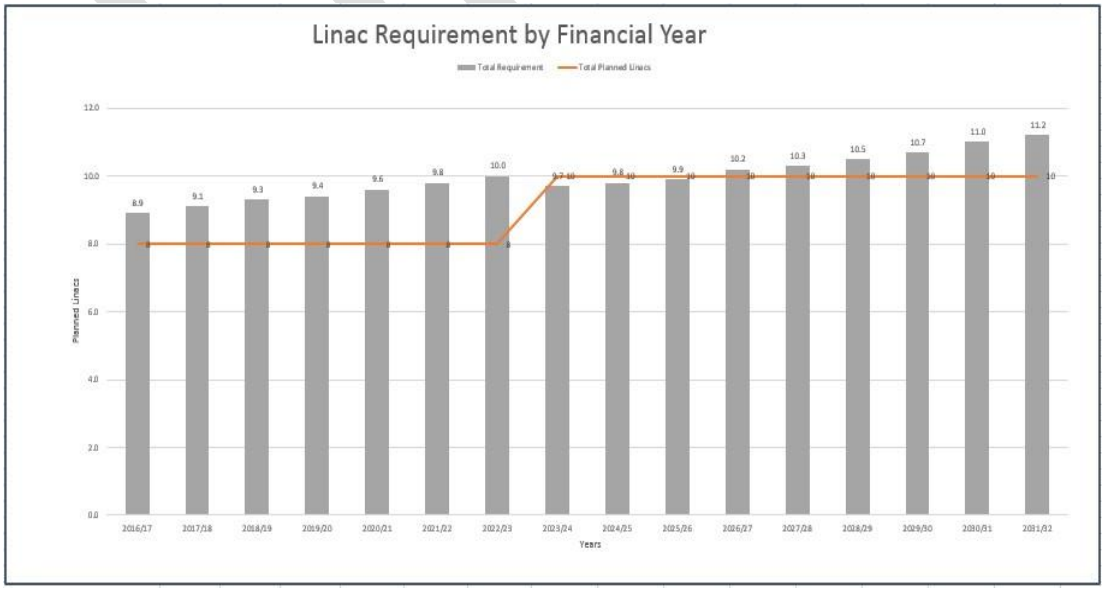


Figure 2-12: Linac Requirement by Financial Year



2.7.12 In summary the key drivers for the drivers for a RSC are:

- Improve access rates for Radiotherapy treatments, as rates are low in Wales compared to best practice and 50% of all cancer patients will benefit from receiving radiotherapy as part of their cancer management and in 40% of cases it contributes to a cure.
- Currently there is a poor patient experience for patients who travel significant distance for radiotherapy, often every weekday for many weeks.
- A RSC will contribute to the National policy: Healthier Wales –as it delivers care at home/locally where possible
- This type of networked model is used by leading cancer centres around the world delivering good outcomes
- Both Organisations are keen to increase access to research and trials and it is planned that local access to radiotherapy will increase availability and update of Radiotherapy trials

2.8 Key Radiotherapy Service and Capacity Requirements

2.8.1 The purpose of this section is to:

- Summarise the methodology which has been applied for forecasting future capacity requirements of South East Wales Cancer Services;
- Provide an overview of the service and capacity requirements and functional requirements; and the Major Medical equipment requirements.

2.8.2 It is important to highlight the relationship between the nVCC FBC, IRS FBC and the RSC FBC in terms of whole system capacity and delivery.

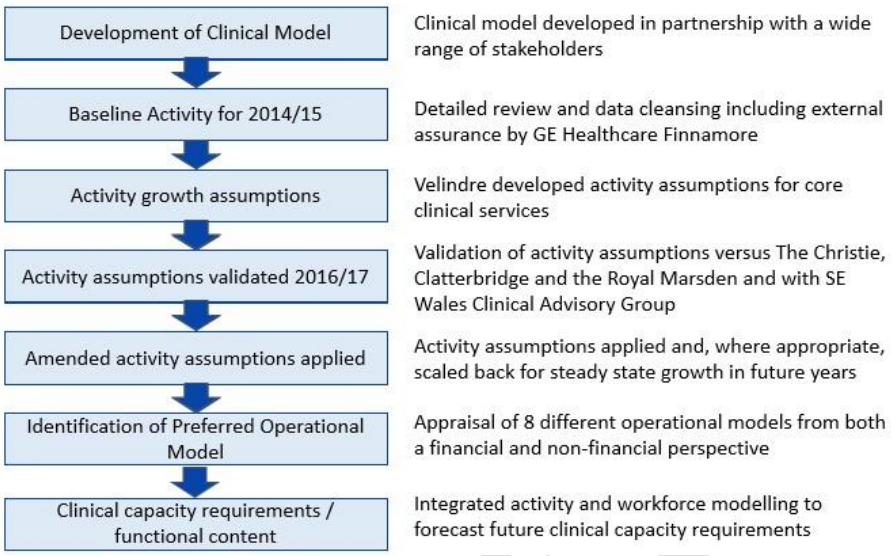
Modelling Future Capacity Requirements

2.8.3 The TCS Programme has developed a comprehensive activity model to forecast future capacity requirements for as set down in the nVCC OBC South East Wales Cancer Services. 2016/17 was been used as the baseline activity year for the model. The 2016/17 data set was been subject to rigorous review, including external validation, to ensure the accuracy of the data.

2.8.4 The functionality of the model has been subjected to quality assurance tests by the Trust's Technical Advisors, by GE Healthcare Finnamore and by the TCS Programme Team.

2.8.5 A summary of the process followed in forecasting future capacity requirements is shown in Figure 2-13.

Figure 2-13: Methodology for Forecasting Future Capacity Requirements



Clinical Growth Assumptions

2.8.6 The TCS Programme has developed a set of clinical growth assumptions for its core services. These clinical growth assumptions have been developed in partnership with clinical colleagues from across South East Wales and are informed by cancer incidence projections provided by the Welsh Cancer Intelligence and Surveillance Unit (WCISU).

2.8.7 The assumptions, following the availability and validation of 2016/17 activity data, have been reviewed by the VCC Senior Management Team and by the VCC service and clinical leads respectively. The main output of this review was a reduction in assumed growth rate for Radiotherapy from 4% to 2% between 2016/17 and 2030/31.

2.8.8 The clinical growth assumptions have been approved by the TCS Programme Management Board and by the TCS Programme Clinical Advisory Board and also reviewed in light of most recent activity.

Table 2-4: Clinical Growth Assumptions for Radiotherapy Services

Service	Annual Clinical Growth Assumption
	2016/17 – 2030/31
Radiotherapy	2%

2.8.9 In addition a validation exercise has been undertaken to compare the Trust's clinical growth assumptions against the following Cancer Centres from across the UK.

- The Beatson West of Scotland Cancer Centre;
- The Clatterbridge Cancer Centre NHS Foundation Trust;
- The Christie Cancer NHS Foundation Trust;
- Leeds Teaching Hospital NHS Trust; and

- The Royal Marsden NHS Foundation Trust.

2.8.10 This validation exercise demonstrated that the clinical growth assumptions were in line with those from other Cancer Centres across the UK, where comparable data is available. It can also be that radiotherapy services at Velindre Cancer Centre has observed growth in recent years in keeping with the assumption.

Forecast Capacity Requirements

2.8.11 Following the activity and capacity modelling process outlined above, the TCS Programme has been able to establish its core capacity requirements. For Radiotherapy these equate to 10 Linear Accelerators.

2.8.12 Given the above activity projections, and based on the agreed operating model referred to above the following planning assumptions were developed for the RSC:

- Radiotherapy Satellite with 2 x operational Linacs. However, there is expansion space to support the installation of two more linacs if required in the future.
- 2 x Operational bunkers on day of opening
- On-treatment review and education
- 1 x CT Simulator
- Good effective and integrated radiotherapy and clinical information systems, for example to enable panning and delivery of treatments.

2.8.13 There will be a phased clinical implementation at the RSC:

- Phase 1 – Less complex / high volume tumour sites
- Phase 2 – Transition to a wider range of tumour sites

Table 2-5: Phased Implementation

Initial Activity	Proposed Activity	Exclusions
Breast Prostate & SABR Planned & unplanned Palliative Emergency	Urology Upper & Lower GI Lung & SABR Gynae Lymphoma Head & Neck Thyroid Neuro Electrons Chemo-radiation Research	Stereotactic Paediatrics Superficial (DXR) Brachytherapy TBI Sarcoma Benign Conditions Whole CNS Research (Early Phase)

Research (subject to risk assessment)

2.8.14 To deliver the required service model the RSC will require access to service provided by ABUHB including pharmacy to enable the delivery of chemoradiation treatments and emergency medical cover. An SLA has been established for the delivery of these.

Workforce

2.8.15 This section of the FBC sets out the Workforce requirements for the Radiotherapy Satellite Centre (RSC) based at Neville Hall Hospital, Abergavenny**.**

2.8.16 Radiotherapy services are provided by 3 main workforce groups: Consultant clinical oncologists, Radiographers, and medical physicists.

2.8.17 Currently all provisions for Radiation Services and the associated workforce are located at Velindre Cancer Centre, Whitchurch Cardiff.

2.8.18 The Workforce requirements for the RSC are based on the following assumptions:

- Radiotherapy planning and treatment based around 2 linear accelerators
- CT simulator with virtual simulation facilities
- Treatment planning
- Mould room
- On- treatment review clinics
- A range of Clinical cases will be treated at the satellite unit, commencing with Breast and Prostate with additional tumour sites being phased in.

Required Workforce Provision

2.8.19 There are two aspects to the workforce required for this business case:

- Ongoing workforce (revenue) requirements for the delivery of the service once the centre opens.

- The workforce requirements to commission the IRS at the RSC, being procured as a contractual option via the IRS business case, and to commission the other associated equipment for installation into the RSC. This expenditure will be capitalised.

Recurring Revenue Workforce

2.8.20 The Workforce for the Satellite Unit will be provided by both Velindre Cancer Centre and Aneurin Bevan Health Board as identified below:

Service	Health Board Provider	Additional Resource
Radiotherapy Service	Velindre Cancer Centre	Yes
Medical Physics Service	Velindre Cancer Centre	Yes
Facilities	Aneurin Bevan	Yes
Therapies – Physiotherapy, Dietetics, Occupational Therapy, Speech & language Therapists, welfare rights	Aneurin Bevan	No – current pathways to provide service
Medical - Emergency	Aneurin Bevan	No - current pathways to provide service
Clinical Psychology	Aneurin Bevan	No - current pathways to provide service
Pharmacy	Aneurin Bevan	Yes
IT	Aneurin Bevan	Yes

Velindre University NHS Trust Workforce

Radiotherapy and Oncology Services

2.8.21 The workforce requirements below takes into account of the Society of Radiographers Principles of Safe Staffing for Radiotherapy and Oncology Services and the legal obligations to comply with HCPC Standards of Conduct, Performance and Ethics. The workforce is consistent with that approved at the OBC Stage.

Job Role	Expected Banding	WTE
Consultant	Threshold 8	1
Medical Sec	Band 4	1
Senior Leader	Band 8B	1
Consultant Radiographer	Band 8B	1
Advanced Practitioner	Band 7	2
Superintendent Radiographer	Band 8A	1
Senior Therapy Radiographer	Band 7	7
Treatment Radiographer	Band 6	8

Treatment Radiographer	Band 5	5
Radiotherapy Helpers/booking clerk	Band 2	2
Review Assistant	Band 4	1
Total		**31**

Medical Physics and Engineering

2.8.22 The numbers below have taken into recommendations for adequate staffing levels set out by the Institute of Physics and Engineering in Medicine and the expectations services to appoint of the Ionising Radiation Medical Exposure Regulations, 2017 and 2018, collectively referred to as IR(ME)R. The workforce is consistent with that approved at the OBC Stage

Job role	Expected banding	WTE
Consultant Clinical Scientist	Band 8c	1
Clinical Scientist/Medical Physics Expert	Band 8a	3
Linac or computer engineer	Band 7	4
Dosimetrist	Band 6	2
Total		**10**

Aneurin Bevan University Health Board Establishment

Job Title	Band	WTE
Domestics	Band 2	2
Porters	Band 2	1
IT Support	Band 5	0.5
Pharmacy technician	Band 5	0.25
Total		**3.75**

Staffing requirements to commission the capital equipment

2.8.23 The commissioning costs for the key equipment for RSC is outlined in the IRS FBC which shows a requirement for the RSC for 9 posts with a financial value of £539k.

2.8.24 ***Appendix 1*** provides full details of the resources identified within the IRS business case for commissioning programme.

2.8.25 Some of the posts identified in the IRS Commissioning Plan for the commissioning of the IRS at both Phases 1 and 2 will cease their commissioning role when the RSC service becomes operational and transfer into posts delivering the clinical service operationally at the RSC. To ensure an accurate interface of revenue and capital costs, the integrated workforce plan has fully identified at a post level the commissioning and operational requirements and the relationship between them. This detailed work has ensured that the commissioning workforce, and their associated costs, have been excluded from the advance recruitment revenue costs that commissioners have agreed to support (with a lead recruitment time of 4.5. months).

Delivering the staffing requirements

2.8.26 Both ABUHB and VUNHST have People Strategies which will provide the framework to deliver the staffing requirements outlined above. Velindre University NHS Trust, which will provide significant majority of the staff for this unit, has a People Strategy that will bring our workforce through to 2032 with the overall mission for people employed by the Trust to be healthy, delivering great care and growing through inspirational learning. The strategy focuses on:

> **Skilled and Developed People:** an employer of choice for staff already employed by us, starting their career in the NHS, or looking for a role that will fulfil their professional ambitions and meet their personal aspirations
>
> **Planned and Sustained People:** having the right people with the right values, behaviours, knowledge, skills, and confidence to deliver evidence-based care and support patient and donor wellbeing.
>
> **Healthy and Engaged People:** Within a culture of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language, and cultural identity

2.8.27 Given that the workforce groups involved in delivering radiotherapy are challenging disciplines to recruit into in the current market, the delivery of the recruitment plan is key to manage this risk. The clinical service has developed an integrated workforce plan, based on the strategy mentioned above, to capture the key drivers increasing demand for the workforce (including the IRS Implementation Plan) that maps out the workforce requirements over the transition and implementation periods, considering the interdependencies of ongoing programmes of work. The integrated workforce plan will not remain static and will be a live document updated on an ongoing basis as activities are delivered and the implementation matures. In addition, in order to manage the recruitment risk to the IRS and RSC Projects, and the critical nature of radiotherapy services in treating cancer, the Trust has recruited a number of key posts at risk.

2.8.28 Workforce growth will be phased in the following way:

- A first wave of recruitment (at Trust Risk) has commenced and is ongoing.
- Radiation Services will develop a further recruitment attraction campaign for prospective candidates to fill expanding establishment.
- A second wave of recruitment is currently being planned.
- Campaigns for a third wave of additional posts will begin in 2023 giving adequate time for advertising, recruitment, and on-boarding processes.
- Lead in time for appointment to posts will be 4.5 months prior to the Satellite Unit opening to allow for training and embedding into the service.

2.9 Spending Objectives

2.9.1 The purpose of this section is to outline the Spending Objectives for the RSC Project. The Project Spending Objectives (PSOs) provide a basis for appraising potential options and for post-project evaluation.

Project Spending Objectives

2.9.2 The following RSC PSOs were developed in partnership at a stakeholder workshop, which was attended by representatives with a broad range of service views. In presenting the RSC PSOs it is important to emphasise that:

- The scope of the FBC is limited to the development of the RSC to support the existing, and in the future, a new VCC; and
- The FBC for the RSC will focus on the additional infrastructure costs directly attributable to the RSC and the variable clinical and facilitate costs that result of a step up in radiotherapy capacity to meet modelled demand.

Table 2-6: Project Spending Objectives

Project Spending Objective	Description
Project Spending Objective 1	To provide access to **quality** and **safe** radiotherapy services that optimises patient **outcomes.**
Project Spending Objective 2	To provide sufficient **capacity** to meet future **demand** for services.
Project Spending Objective 3	To **improve patient, carer** and **staff experience.**
Project Spending Objective 4	To provide **capacity** and **facilities** to support the delivery of high quality **education**, **research**, **technology** and **innovation.**

2.9.3 The PSOs were approved by the RSC Project Board who provided assurance to the Health Board and Trust Board that they were:

- Aligned with the national context for healthcare developments in Wales;
- An alignment with the TCS Programme;
- Aligned with the scope and strategic context of the nVCC Project;
- Specific, measurable, achievable relevant and time-constrained (SMART); and
- Focused on business needs and vital outcomes rather than potential solutions.

Performance Metrics

2.9.4 To support the delivery of these objectives a number of key performance metrics have been developed and mapped against the five drivers for investment outlined within the Welsh Governments Business Case guidance.

Table 2-7: nVCC FBC Project Spending Objectives – Key Performance Metrics

Project Spending Objective	Performance Metrics
PSO1 - To provide access to **quality** and **safe** radiotherapy services that optimise patient **outcomes**	• Percentage compliance with Health Building Notes • Compliance assessment against BREAM • Percentage assessment against WHTM Estate Code (Category A Condition of Buildings) • PROM outcome measures • Access rate to Radiotherapy treatments
PSO2 – To provide sufficient **capacity** to meet future **demand** for services	• Waiting times (reported by HBs) against the Suspected Cancer Pathway targets • Compliance against the COSC quality measures (once formally introduced) • Percentage utilisation of equipment / accommodation: • Linear accelerator utilisation of non-clinical accommodation utilisation
PSO3 – To **improve patient, carer,** and **staff experience**	• Percentage of patients rating their experience as excellent • Percentage staff satisfaction • Percentage recruitment of workforce • Percentage retention of workforce •REM measures •Reduced travel times for patients and carers with resultant better experience and reduction in carbon footprint
PSO4 - To provide **capacity** and **facilities** to support the delivery of high-quality **education**, **research**, **technology,** and **innovation**	• Percentage of patients who have the opportunity to participate in clinical radiotherapy research trials • Percentage of patients for each cancer site entered into radiotherapy clinical trials each year Increased integrated and cross organisation • MDT learning and education

2.10 Scope of the Radiotherapy Satellite Centre Project

2.10.1 As previously described the scope of the Project is limited to the building of an RSC and the following is outside of the scope of the RSC Infrastructure Project:

- All other variable clinical costs of modelled demand growth (excluding radiotherapy which is included within the FBC) which will be considered through the commissioning LTA framework and, therefore, excluded from the RSC FBC;
- All other service development Projects e.g. Rehabilitation which will be subject to separate Business Cases and therefore excluded from the RSC FBC;
- All other outreach capital Projects e.g. SACT services, which will be subject to separate Business Cases and therefore excluded from the RSC FBC; and
- All Digital Projects which the Trust needs to complete irrespective of the RSC Project. These will be the subject of separate Business Cases.

Potential Business Case Options

2.10.2 The scope of the Project is well defined. There are two potential options for delivering the objectives of the Project apart from the Status Quo:

- Do Nothing;
- Option 1: 10 Linear Accelerators at Nvcc
- Option 2: 8 Linear Accelerators at Nvcc and 2 Linear Accelerators within the RSC.

2.10.3 As outlined earlier, the location of the RSC has been previously determined through an independently led options appraisal.

Capacity and Functional Requirements

2.10.4 As outlined earlier the activity and capacity analysis has demonstrated the following Functional Content requirements is 10 linacs i.e. 2 additional linacs from current levels and when compared to the planned Nvcc.

2.11 Project Risks, Constraints, Dependencies and Assumptions

Risks

2.11.1 Identifying, mitigating, and managing the key risks is crucial to successful delivery. Without effective management of the key risks, it is likely that the Project would not deliver its intended outcomes and benefits within the anticipated timescales and spend.

2.11.2 A full risk register for the RSC Project has been developed which includes the following categories:

Business risks: Risks that remain 100% with the Health Board and Trust and include political and reputational risks,
Service risks: Risks associated with the design and build and operational phases of the Project and may be shared with other organisations; and

External Non-System risks: Risks that affect all society and are not connected directly with the proposal. They are inherently unpredictable and random in nature.

2.11.3 The RSC risk register, which is attached at **Appendix 2,** is managed by the Project Team. The role of the Project Team in managing risks is described within the Management Case.

Constraints

2.11.4 The main constraints in relation to the RSC Project are outlined below in Table 2-8:

Table 2-8: Main Constraints of the RSC Project

Constraint	Overview
Financial Constraints	The infrastructure solution for the RSC must be deliverable within the (including VAT but excluding equipment) capital funding agreed with the Welsh Government and the revenue resources agreed with Commissioners.
Timescale Constraints	The RSC must be operational in line with the Programme requirements and as agreed with the Welsh Government.
Service Continuity	Delivery of patient services must be maintained during the period of construction.
Compliance with Statutory Requirements	The RSC must be fully compliant with all relevant statutory compliance requirements.

Dependencies

2.11.5 A number of dependencies have been identified in relation to the RSC Project. These are provided in Table 2-9 below:

Table 2-9: Main Dependencies of the RSC Project

Dependency	Overview
Capital Funding Availability	Access to capital funding is critical to deliver the Project, including the procurement of Major Medical equipment and IM&T and essential Enabling Works.
Revenue Funding Availability	Access to revenue funding is essential to support the recurring revenue implications associated with the RSC Project.

Welsh Government Approval	The Full Business Case must be approved by Commissioners and the Welsh Government.
Partnership Working	Co-production in the design and implementation of the Project that involves all stakeholders is essential to the Project's success.
Wider Health Strategy and Governance	It is important that general health strategy and governance in Wales, that underpins the RSC Project remains broadly consistent over the period of change.

Assumptions

2.11.6 The key assumptions underpinning the RSC Project are provided in Table 2-10 below:

Table 2-10: Main Assumptions for the RSC Project

Assumption	Overview
Implementation of the wider TCS programme	It is assumed that the following capital Projects identified within the TCS Programme are funded and the RSC has been 'sized' on the basis of this assumption. • VCC (and nVCC) at Whitchurch; and • Non-surgical cancer Outreach centres across South East Wales delivering SACT and Outpatient services.
Clinical Growth Assumptions	The RSC has been 'sized' on the basis of a number of clinical growth assumptions (in conjunction with the nVCC OBC), summarised below:
Assumption	**Overview**
	• Radiotherapy activity will increase by 2% per annum through to 2031

Flexibility for Expansion on the Site of the Radiotherapy Satellite Centre

2.11.7 It is important to highlight that there is planned expansion space (equivalent to accommodation for 2 additional linear accelerators plus supporting equipment etc.) on the identified site for the RSC. This expansion capacity is important to the TCS Programme Risk Management Strategy in the event that the clinical growth assumptions prove to be understated.