# TRUST BOARD

## HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

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| **DATE OF MEETING** | 29/09/2022 |
| **PUBLIC OR PRIVATE REPORT** | Public |
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |
| **PREPARED BY** | Alison Hedges, Business Support Officer |
| **PRESENTED BY** | Sarah Morley, Executive Director of OD & Workforce |
| **EXECUTIVE SPONSOR APPROVED** | Sarah Morley, Executive Director of OD & Workforce |
| **REPORT PURPOSE** | FOR NOTING |

| **ACRONYMS** | |
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| LPF | Local Partnership Forum |
| SLT | Senior Leadership Team |
| VCC | Velindre Cancer Centre |
| OCP | Organisational Change Policy |
| WBS | Welsh Blood Service |
| RCN | Royal Collage of Nursing |

## 1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 6th September 2022.

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

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

## 2. HIGHLIGHT REPORT

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| **ALERT / ESCALATE** | There were no items for alerting or escalating to the Trust Board |
| **ADVISE** | There were no items to advise the Trust Board |
| **ASSURE** | There were no items to Assure the Trust Board |
| **INFORM** | **Building our Future Together Portfolio**<br>The LPF were updated on this work that is being collaborated as an organisation to help deliver the Trust Strategy which was signed off by the Board in May 2022.<br>This includes 11 programmes of work which are still under development across a wide range of important areas, including Governance Risk and Assurance, implementation of the Quality Framework, Value Based Health Care and Leadership Development, the Values and Cultures project, Performance Management Framework for the organisation, and Delegation arrangements.<br><br>**Anti-Racist Wales Action Plan**<br>A Presentation on The Anti-Racist Action Plan was brought to the LPF. This Presents a series of ambitions, aims and commitments which can then be followed by the LGBTQ plus action plan. The Vision Purposes and Values Have been amended since 2021 to enhance the development and design of services. This won't be achieved in 10 years but is setting the foundation. A Steering Group has been established and will meet end September 2022. Data quality - WRES should be implemented September 2023.<br><br>**Diversity Networks**<br>The LPF discussed the way forward for staff networks in the Trust, 2 options were presented that enable people with common interests to achieve something positive in the organisation.<br>• A disability network, Black, Asian and Minority Ethnic network and LGBTQ+ network with potential to add others. Then would have a range of networks acting and operating within the organisation. |

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| | • Combine those all into one purpose representative network to discuss protected characteristics. This would also address issues of intersectionality.<br>The LPF felt it would be useful to benchmark this against the rest of NHS Wales and Public Sector Wales.<br><br>**National Trades Union Ballots**<br>The National Ballots will be ongoing until October 2022 and operationally within the<br>Trust an Industrial Action Cell has been formed to look at operational planning in<br>the case of strike action happening and business continuity planning. The<br>Welsh Guidance Document is currently being refreshed by NHS Employers.<br><br>**Welsh Blood Services Update**<br>Blood Service rebounding well from blue alert reported last month. Rebound<br>to the stock position helped by lower demand within the system. Currently looking<br>at plans for demand and capacity. UK position for Blood stocks position still<br>fragile. Wales has got the most improved position currently.<br><br>**Velindre Cancer Centre Divisional Update**<br>Still remains a lot of pressure in system. Clear programmes of work coming<br>together. The replacement of the Digital Health Care Record will go live toward the<br>end of November 2022. Saturday clinics continuing for additional capacity within<br>the SACT Service. Looking to return to Prince Charles Hospital in the outreach<br>settings and in future months to Nevill Hall. Continuing fortnightly meetings<br>around Covid planning.<br><br>**Trade Union Update**<br>A document is being produced for Trade Unions to work from in terms of how joint<br>union arrangements will be set up going forward. Moving towards having an<br>effective side group. Key will be to identify key roles and elect Trade<br>Unions representatives into roles and ensure attendance is covered for the<br>meetings. The Terms of Reference is going to be developed to allow key roles to<br>be elected.<br><br>**Performance Report**<br>Figures remain relatively static over the last 2 months. PADR remains at a Trust<br>wide level at 69%. Sickness remains higher this year than |

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| | over last 18<br>months. Statutory Mandatory Training 86% within compliance.<br><br>**Financial Wellbeing**<br>LPF discussed points of contacts and potential help available to staff, including<br>the Salary Finance Scheme and Money Helper via the intranet.<br><br>**Partnership Working**<br>LPF discussed in relation to Trade Union duties the need to ensure everyone is<br>Sighted on the Policy and the commitment to the organisation and their roles<br>and responsibilities.<br><br>**National Staff Welfare Project**<br>The LPF were updated through a presentation on the Welsh Government Staff<br>Welfare Project - asked by Welsh Government to bring to attention of the LPF.<br><br>**Any Other Business - Vaccination Work Going Forward**<br>All staff will now be invited to local mass vaccination centres in line with National<br>JCVI priorities. Communication for staff will be circulated that will encourage staff<br>to change appointments to fit the needs of the service |

**WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)**
**JOINT COMMITTEE MEETING BRIEFING – 6 SEPTEMBER 2022**

The Welsh Health Specialised Services Committee held its latest public meeting on the 6 September 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 12 July 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. Major Trauma Presentation

Members received an informative presentation on the South Wales major trauma network, which was launched in September 2020. Members noted the comprehensive evaluation process which was underway to review the effectiveness of the network over the last 18 Months.

Members **noted** the progress made.

## 4. Specialised Services Strategy Presentation and Report

Members received a report and a presentation on the planned development of a ten year strategy for specialised services for the residents of Wales, and to describe the proposed approach to communication and engagement with key stakeholders to support its development.

Members **approved** the overall approach to developing a ten year strategy for specialised services and provide feedback on the key documents presented.

## 5. Recovery Update Paediatrics – Presentation

Members received a presentation providing an update on recovery trajectories for paediatric services across NHS Wales, following a request from the JC on the 12 July 2022.

Members **noted** the presentation.

## 6. Chair's Report

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

- Chair's Action taken to appoint James Hehir, Independent Member (IM), CTMUHB as the Interim Chair of the All Wales Individual Patient Funding Request (IPFR) Panel,
- The recruitment process to appoint two new WHSSC IM's,
- Attendance at the Integrated Governance Committee 9 August 2022; and
- Key meetings attended.

Members (1) **noted** the report; and (2) **Ratified** the Chairs action taken.

## 7. Managing Director's Report

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

- The Integrated Commissioning Plan (ICP) 2022-2025 being accepted by the Minister for Health & Social Services,
- A letter received from Welsh Government concerning a review of Secure Services and consideration of a Single Commissioner for Mental Health Services,
- the Managing Director of WHSSC being designated as the Senior Responsible Officer (SRO) for an All-Wales Molecular Radiotherapy (MRT) Programme,
- That feedback on the Mental Health Specialised Services Strategy for Wales 2022-2028 will be presented to the Joint Committee in November 2022,
- WHSSC receiving approval through the Value in Healthcare Bid – for an Advanced Therapy Medicinal product (ATMP) and for the Welsh Kidney Network (WKN) to provide an all Wales Pre-habilitation Programme to support kidney patients to choose and commence the treatment that offers them the best outcomes,
- Work being undertaken to monitor TAVI (Transcatheter aortic valve implantation) activity increases; and
- The appointment of an interim Director of Mental Health & Vulnerable Groups.

Members **noted** the report.

## 8. Neonatal Transport – Update from the Delivery Assurance Group (DAG)

Members received a report providing an update from the Neonatal Transport Delivery Assurance Group (DAG).

Members (1) **Noted** the report, (2) **Noted** the update on the progress of the implementation of the Neonatal Transport Operational Delivery Network (ODN); and (3) **Received assurance** that the Neonatal

Transport service delivery and outcomes is being scrutinised by the Delivery Assurance Group (DAG).

**9. Specialised Paediatric Services 5 year Commissioning Strategy**
Members received a report providing an update on the Specialised Paediatric Services 5 year Commissioning Strategy which was recently issued for a stakeholder feedback for a period of 4 weeks. The Joint Committee were requested to note the comments received, the WHSSC responses and the updated strategy for final publication.

Members (1) **Noted** the report, (2) **Approved** the proposed final version of the strategy; and (3) **Supported** the proposed next steps.

**10. South Wales Cochlear Implant and BAHA Hearing Implant Device Service**
Members received a report presenting an update on discussions with the Management Group regarding the process and outcome of a recent review of the South Wales Cochlear Implant and BAHA Hearing Implant Device Service. The report also presented the proposed next steps including a period of targeted engagement on the future configuration of the Service.

Members noted that on the 28 July 2022 the Management Group discussed the preferred commissioning options as the basis of engagement/consultation and had supported the preferred commissioning option of a single implantable device hub for Cochlear and BAHA for both children and adults with an outreach support model.

Members noted that a report would need to be submitted to HB Board meeting in September 2022 to seek support from Boards on engagement with Health Board residents (each report will include CHC views from the relevant HB area).

Members (1) **Supported t**he management group recommendation, (2) **Agreed** the process to be followed (as advised by the Board of CHCs), (3) **Agreed** the content of the engagement materials as the basis of targeted engagement, (4) **Advised** on processes for individual Health Boards; **and** (5) **Noted** the EQIA.

**11. Designation of Provider Framework**
Members received a report seeking approval to adopt the Designation of Provider Framework as the WHSS team methodology for evaluating the appropriateness of Health Care Providers to become a designated provider of Highly Specialised and Specialised Services.

Members noted that the Designation of a Provider of Specialised Services Framework had been developed as part of the WHSSC Commissioning Assurance Framework (CAF).

Members (1) **Noted** the report and (2) **Approved** the Designation of Provider Framework as the WHSS team methodology for evaluating the appropriateness of health care providers.

## 12. Individual Patient Funding Requests (IPFR) Governance Update

Members received a report providing an update on discussions with Welsh Government (WG) regarding the All Wales Independent Patient Funding Requests (IPFR) Policy and the work undertaken to update the terms of reference (ToR) of the WHSSC IPFR Panel. The report asked for support to undertake an engagement process on updating the ToR and a specific and limited review of the All Wales IPFR policy.

Members (1) **Noted** that Welsh Government (WG) had confirmed that as the All Wales Independent Patient Funding Requests (IPFR) Panel is a sub-committee of the WHSSC Joint Committee, it is within its authority to update and approve the terms of reference (ToR), (2) **Noted** that Welsh Government had confirmed that WHSSC could embark on an engagement process with key stakeholders to update the WHSSC IPFR Panel Terms of Reference (ToR) and to engage on a specific and limited review of the All Wales IPFR Policy, (3) **Approved** the proposal for WHSSC to embark on an engagement process with key stakeholders, including the All Wales Therapeutics and Toxicology Centre, IPFR Quality Assurance Advisory Group (AWTTC QAG), the Medical Directors, Directors of Public Health and the Board Secretaries of each of the Health Boards (HBs) and Velindre University NHS Trust (VUNT), to update the WHSSC IPFR Panel Terms of Reference (ToR) and on the specific and limited review of the All Wales IPFR Policy; and (4) **Noted** that the revised documents will need to be supported by the Joint Committee prior to referral to the Health Boards for final approval; and as requested in the letter of 28th July the revised documents will be shared with Welsh Government.

## 13. WHSSC Annual Report 2021-2022

Members received the WHSSC Annual Report 2021-2022.

Members **approved** the WHSSC Annual Report 2021-2022.

## 14. COVID-19 Period Activity Report for Month 3 2022-2023 COVID-19 Period

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity.

Members **noted** the report.

## 15. Financial Performance Report – Month 4 2022-2023

Members received the financial performance report setting out the financial position for WHSSC for month 4 2022-2023. The financial position was reported against the 2022-2023 baselines following approval

of the 202-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The financial position reported at Month 4 for WHSSC was a year-end outturn forecast under spend of £12,693k.

Members **noted** the current financial position and forecast year-end position.

**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.

# ASSURANCE REPORT

## NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

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|---|---|
| **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** | 21 July 2022 |

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

**Matters Arising – Procurement Update**

Jonathan Irvine, Director, Procurement Services, provided an update on the New Operating Model for Procurement. This built on an initial presentation given to the Committee in January of this year, and particularly focused on the perspective of NHS Wales organisations as customers of the service.

The objectives for the new model include greater exploitation of opportunities for regional and all-Wales procurement; ensuring support for national initiatives such as decarbonisation, the foundational economy and social value, and utilising expert procurement resource more effectively. Progress will be monitored through a revised suite of KPIs.

The Committee **NOTED** the update.

**Matters Arising – Recruitment Update**

Gareth Hardacre, Director of People, Organisational Development and Employment Services, gave a verbal overview on progress with the modernisation plan for Recruitment. There has been effective dialogue with Workforce Directors, leading to the establishment of a Programme Board to oversee the development of the plan. Moves to implement technology to facilitate more effective checking of ID is still on track for August and is awaiting final Government sign-off.

The Committee **NOTED** the presentation.

**Chair's Report**

The Chair updated the Committee on the activities that she had been involved with since the May meeting. These have included:

- Attending a development session with the Velindre Trust Board on 28 June

to update Board members on recent developments within NWSSP and to assess how the Trust and NWSSP can work more effectively together;
- Continuing to meet with NWSSP Directors and undertaking a further visit to IP5; and
- Attending the Audit Committee and the Welsh Risk Pool Committee during July.

The Chair also had two papers as part of her presentation as follows:

- The first related to the re-negotiation of the contract for the Microsoft Licences for NHS Wales where the work had been led by DHCW. This included the financial allocations for all NHS Wales organisations, and due to the need to agree this by the end of May, the paper had been approved previously via a Chair's Action. The Committee ratified the action taken and endorsed the paper;
- The second paper concerned the proposal for the Committee to have a development session(s) in the autumn to provide time for Committee members to debate how it can be more effective in its role for the benefit of all NHS Wales organisations. The paper suggested the option of either a full-day session or a number of half-day sessions. There was universal support for the session(s) but mixed views on which option to select. It was hoped that the sessions would be in person and further work would be undertaken outside the meeting to progress this.

The Committee **NOTED** the update and **Endorsed** the Chair's Action.

**Managing Director Update**

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

- The recent Joint Executive Team meeting with Welsh Government was very constructive with positive feedback provided on progress to date and future plans;
- The proposal for Welsh Government to take back the revenue savings resulting from the purchase of Matrix House did however come as a surprise and will adversely impact the NWSSP financial position;
- The risk-sharing agreement on the Welsh Risk Pool will be invoked again this year and is forecast to be £25m;
- We continue to work with the Chief Pharmacists Peer Group to develop the product ranges being developed through the Medicines Unit in IP5. The validation of the new automated filling equipment is going well and should become available for use in the next few weeks; and
- The expansion of SMTL services within IP5 is also going well, with the new equipment being validated and an expectation that additional testing facilities and methodology will be in place by August.

The Committee **NOTED** the update.

**Items Requiring SSPC Approval/Endorsement**

**Laundry Outline Business Case**

The Programme Business Case for the Laundry Service concluded that a total of three units would be required in the future to serve Wales as follows:

- A new build facility in South-West Wales to replace the laundries at Glangwili Hospital and Llansamlet;
- A new build facility in North Wales to replace Glan Clwyd Laundry;
- A refurbishment of Green Vale to upgrade the existing laundry facility and to allow closure of Church Village Laundry.

Following feedback the Welsh Government required the new facilities in South-West Wales and North Wales to proceed as Outline Business Cases, whereas the refurbishment at Green Vale is subject to a separate Business Justification Case.

The paper presented to the Committee concerned only the Outline Business Cases for South-West and North Wales. Governance of the Transformation Programme is through the Laundry Programme Board who approved these outline business cases on the 22nd of June. The outline business cases have also been subject to two Gateway reviews and an assessment by Internal Audit.

The main benefits in taking over the Laundries was to ensure that the Laundries were compliant with relevant standards and legislation and not to deliver a cheaper service although efficiencies would be made. There has been a lack of investment in Laundry services for a very long time and the three business cases require capital investment of £77m. NHS Wales is hugely dependent on the laundries – as an example the two current sites in South-West Wales process over 9m items per annum. The outline business cases, whilst undoubtedly requiring capital investment, do make sound economic sense and they tick all the environmental boxes, and provide the workforce with much better working conditions. The All-Wales capital position may mean that Welsh Government may not be able to afford to fund the business cases concurrently, so NWSSP will need to explore the options with them.

The Committee **APPROVED** the Outline Business Cases to proceed to Full Business Cases to enable formal requests for funding from Welsh Government to be submitted.

**Patient Medical Record Accommodation Business Case**

The Patient Medical Records Store in Brecon House, Mamhilad, has now reached maximum capacity and consequently no additional records are able to be accommodated without additional space being procured. In practice this means that not only will no additional GP practices be able to take advantage of this service, which frees up space for additional clinical services, but NWSSP will also be unable to take additional medical records from GP Practices who already use the service, from deceased patients, patient movements or practice mergers for example.

A number of options for expansion of the scheme have been explored in the business case but the preferred option is the acquisition of a further warehouse on a 10-year lease providing a further 75,000 square feet of storage space. Whilst this acquisition provides some funding challenges, these will be met through the generation of additional income; savings resulting from moving PPE from commercial storage facilities to this new warehouse (until capacity is reached on the PMR scheme) and internal savings on the Primary Care budget.

Questions were raised by Committee members as to whether future plans should focus more on digitisation rather than acquiring more space to store paper records. AB confirmed that this is the aspiration for the longer-term, but for the time being GP Practices are requesting that paper records continue to be stored, and the costs of digitisation are very substantial.

The Committee **APPROVED** the Business Case.

**Annual Review 2021/22**

The Annual Review for the 2021/22 financial year was reviewed by Committee members who commented favourably on both the content and presentation and suggested that this should be shared more widely where possible.

The Committee **APPROVED** the Annual Review.

**Audit Committee Terms of Reference**

The Audit Committee Terms of reference were reviewed and approved by the Partnership Committee.

The Committee **APPROVED** the Terms of Reference.

**Finance, Performance, People, Programme and Governance Updates**

**Finance –** The Month 3 financial position is a cumulative non-recurrent underspend of £1.338m after anticipating £0.943m of WG funding for the 1.25% NI increase, Covid recovery support costs and energy pressures. This funding can only be anticipated at risk at present – the financial position would have been £0.395m underspent without the assumption of this funding or any utilisation of centrally held reserves. The year-to-date position includes a number of non-recurrent savings that will not continue at the same level during the financial year. The position also does not reflect the claw back of £176k of funding from WG in respect of Matrix House, notified in July 2022. Directorates are currently reviewing budgets with a view to accelerating initiatives to generate further benefits and savings to NHS Wales. The forecast outturn remains at break-even with the assumption of exceptional pressures funding from Welsh Government. £10.277m Welsh Risk Pool expenditure has been incurred to 30th June 2022. A high-level review of cases due to settle in 2022/23 indicates that the £134.8m included in our IMTP remains within the forecast range, requiring £25.3m to be funded under the Risk Share Agreement in 2022/23. The 2022/23 risk share apportionment has been revised to reflect the updated cost driver information

from the 2021/22 outturn position. This has resulted in some changes to the contributions from organisations as a result of movements in the actual 2021/22 data. The updated shares are being reported to the Welsh Risk Pool Committee on 20th July 2022 and will be subsequently shared with Directors of Finance. Our current Capital Expenditure Limit for 2022/23 is £1.473m. The NWSSP discretionary allocation for 2022/23 has been reduced by Welsh Government to £0.457m from £0.6m and the IP5 discretionary allocation reduced from £0.25m to £0.19m. Capital expenditure to Month 3 is £0.297m. A review of all discretionary capital funding requests is being undertaken which includes any capital funding requirements identified in the IMTP and any new requests flagged by our Services. Since the transfer of the All-Wales Laundry Service in 2021/22 there is increased pressure on the discretionary capital allocation as this was not increased following the transfer of the new Service. Attached to the report were the Audit Wales Management Letter and review of Nationally Hosted Systems that both provided positive opinions on the integrity of NWSSP systems and procedures.

**IMTP Q1 Update –** The first formal quarterly update against the IMTP was presented to the Committee. 2022/23 is a year of transition as new measures of performance are developed. The update looks at how NWSSP adds value in terms of quality and socio-economic benefit alongside cost reductions and savings. At the end of Quarter 1, 1% of divisional objectives have been 'completed and closed', 76% of objectives are 'on track' to be completed, 15% are 'at risk of being off track', 4% are 'off track for delivery' and 4% have 'not yet started'. The Committee were also asked to feedback on the content and format of the report.

**Performance** – 34 KPIs are reported of which 31 are rated as green and three as amber. Two of these relate to the number of calls handled which should be at 95% but this is not being met in either Payroll (73%) or Student Awards Services (92%). The remaining amber indicator is in Recruitment where the average time to create an unconditional offer from first creating the vacancy should be no more than 71 days and this is currently measuring 91 days. Work is on-going to address all these areas and improvements are already being noted. The report also included an assessment of Professional Influence Benefits to NHS Wales which are calculated at £35m for the first quarter of the financial year.

**Project Management Office Update** – Of the 24 schemes being managed by the PMO, there is only one that is currently rated as red. This is the project for the replacement of the Student Awards System which is approaching end-of-life and with no option to extend the support contract arrangements beyond March 2023. NWSSP are currently undertaking a procurement exercise to source a replacement system

**People & OD Update –** The report is in a new dashboard format which was commented on favourably by Committee members. Sickness absence rates continue to be very low, but improvement is needed in the timeliness of reporting absence. PADR rates continue to improve but still require more work – a particular focus recently has been on Laundry Services where compliance was initially very low but is now at 73%. Headcount is now nearly at 5,300 following

the transfer of the final cohorts of the Single Lead Employer Scheme. Questions were asked on how NWSSP can undertake research to look at better facilitation of apprenticeships and new ways of working to make NHS Wales an attractive employer in the future. This is something that will be considered going forward.

**Corporate Risk Register –** there remains one red risk relating to the inflationary impact on goods and services, particularly relating to energy. This continues to be mitigated as far as possible through the actions of the Energy Price Risk Management Group. There is one new risk that has been added relating to the reputational risks associated with NWSSP's role in helping to establish the Citizens' Voice Body. The risks associated with the replacement of the GP Payments system in Primary Care Services, and the upgrade of CLERIC in Health Courier Systems, have both been removed from the Corporate Risk Register as the new systems are working successfully in both cases.

**Declarations of Interest –** the Committee reviewed a report summarising the recent declarations of interest exercise within NWSSP. This has now been extended to all staff on the basis that they complete a lifetime declaration which only needs updating if circumstances change. However, Directors and Independent Members will be required to continue to provide an annual Declaration and an appendix containing details of their most recent declarations was included in the report.

**Papers for Information**

The following items were provided for information only:

- Decarbonisation Action Plan;
- Annual Governance Statement 2021/22;
- Health & Safety Annual Report 2021/22
- Finance Monitoring Returns (Months 2 and 3)

**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

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| **Date of next meeting** | 22 September 2022 |

# TRUST BOARD

# TRUST SEAL REPORT – APRIL 2022 – AUGUST 2022

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| **DATE OF MEETING** | 29/09/2022 |

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| **PUBLIC OR PRIVATE REPORT** | Public |

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| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |

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

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| **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** | |
|---|---|
| TCS | Transforming Cancer Services |
| nVCC | New Velindre Cancer Centre |
| NWSSP | NHS Wales Shared Services Partnership |

## 1. SITUATION/BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal request (period April to August 2022).

1.2 Board members are asked to view the contents of the report and further information or queries should be directed to the Director of Corporate Governance and Chief of Staff.

## 2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal/Analysis: Please refer to the Seal Register at Appendix 1.

## 3. IMPACT ASSESSMENT

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| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
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| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request. |
| **FINANCIAL IMPLICATIONS / IMPACT** | There is no direct impact on resources as a result of the activity outlined in this report. |
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## 4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the contents of the Trust Board Seal Register included in Appendix 1.

## Appendix 1 – Seal Register

| Date | Document Details | Signed |
|---|---|---|
| 06 April 2022 | HM Land Registry [TRI] Engrossment Transfer of whole registered titles | Prof Donna Mead OBE, Chair<br>Mr Steve Ham, Chief Executive |
| 09 August 2022 | Deed of Rectification between Jarrington Properties Limited and Velindre University National Health Service Trust | Mr Steve Ham, Chief Executive<br>Mr Stephen Harries, Acting Chair |
| 26 August 2022 | Renewal Lease relating to Unit 4, Llanelli Gate Dafen Llanelli between the Trustees of the MMR Holdings Retirement Benefit Scheme and Velindre University NHS Trust | Mr Steve Ham, Chief Executive<br>Mr Stephen Harries, Acting Chair |

# Trust Board

# CHAIR REPORT

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|---|---|
| DATE OF MEETING | 29/09/2022 |

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| PUBLIC OR PRIVATE REPORT | Public |

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| IF PRIVATE PLEASE INDICATE REASON | Not Applicable - Public Report |

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| PREPARED BY | Lenisha Wright, Business Support Officer &<br><br>Lauren Fear, Director of Corporate Governance & Chief of Staff |
| PRESENTED BY | Professor Donna Mead OBE, Chair |
| EXECUTIVE SPONSOR APPROVED | Lauren Fear,<br><br>Director of Corporate Governance & Chief of Staff |

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|---|---|
| REPORT PURPOSE | FOR NOTING |

| Committee/Group who have received or considered this paper PRIOR TO THIS MEETING | | |
|---|---|---|
| Committee or Group | DATE | OUTCOME |
| N/A | | |

| ACRONYMS | |
|---|---|
| | |

## 1. SITUATION/BACKGROUND

This report provides information to the Board from the Chair on a number of matters. A summary of activities and engagements is included to advise of areas of focus since the last Trust Board meeting held in July 2022.

Matters addressed in this report cover the following:

- Extraordinary Board Meetings
- Independent Members Group
- Chair Appraisal with the Health and Social Services Minister
- Health Technology Wales
- Health and Social Care Research Wales Advisory Board
- Service of Pray and Refection for Her Majesty

## 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.

### 2.2. Extraordinary Board Meetings

On 6th September 2022, an Extraordinary Board meeting was held to accelerate the replacement of the Linear Accelerator (LINAC 6) 6 radiation treatment Machine, in order to

meet patient demand and deliver timely treatment.

## 2.2 Independent Members Group

On 8th September 2022, the Independent Members Group met and as well as discussing the standard agenda items regarding sharing from external peer groups and Board Champion roles, there was discussion on a number of specific items, including: next steps on aspects of the organisational development work; the agenda for the October Board Development day; and the approach going forwards to meeting in person or online for Committee meetings.

## 2.3 Chair Appraisal with the Health and Social Services Minister

The Chair would like to share with the Trust Board that her appraisal process for 2022-23 has been completed with the Minister. In a meeting and follow up letter, the Minister has confirmed agreement that the following objectives have been fully met:

**Strategy, Planning and Delivery**

- *Provide and ensure board leadership in the required oversight and scrutiny on planning, strategy and performance requirements*
- *Demonstrate innovative and clear leadership in working both regionally with local authority and third sector partners and other NHS bodies*
- *Continue to ensure assurance that strategy and planning drives a shift to introducing and embedding new ways of working, enabled by technology and digital where appropriate*
- *Where changes have been delivered at pace in response to Covid-19, ensure assurances that the required controls and quality systems are in place.*

**Governance and Accountability**

- *Demonstrate a strong commitment and drive to good governance, and high standards of safety and legislative compliance whilst the organisation responds and recovers from the pandemic.*
- *Lead on ensuring there is a Board Development Plan and Individual Performance Objectives which take into account the requirements of the Minister and the delivery of the annual plan.*

**Culture**

- *Lead and support the organisations workforce through compassionate leadership principles and a strong focus on health and wellbeing to maintain resilience of the workforce*
- *Consider and report on personal contribution to the Diversity and Inclusion Strategy for Public Appointments in Wales*

There was only one objective which was agreed as partially met:

- *Provide leadership to ensure the organisation contributes to the foundational economy in partnership and for the benefit of the people and economy of Wales*

In the discussion and following exchange of letters, the Chair commented that there is further scope for progress in this objective in terms of the development of the new Velindre Cancer Centre. The opportunities are great, driven by place-making, to work collaboratively across our communities and contribute to the foundational economy.

There were no objectives that were judged not to be met.

The Minister specifically commented on the importance of governance and assurance arrangements in respect of the new Velindre Cancer Centre. There was also an invitation

to suggest personal objectives to add to the generic NHS Chair ones. The Chair has suggested two personal objectives:

- Reflecting on the importance of the governance and assurance arrangements for the development of the new Cancer Centre and associated programmes;
- and secondly regarding how the whole Board is leading a development of the organisation to ensure we are in the best shape to meet our 2032 strategy. The Chief Executive Officer, along with the whole Board, has recently initiated this as an organisational design programme of work, 'Building our Future Together'. Therefore an objective around the collective leadership of this portfolio achieving it's objectives over the agreed timeframe.

**2.3.**

**2.4. Health Technology Wales**

The Chair recently held one of her regular meetings with Professor Peter Groves, Chair of Health Technology Wales (HTW). The recent audit across Wales of adoption of evidence from technology appraisals has been completed. Prof Groves will present the results and lessons learned to the Trust Board shortly.

**2.5. Health and Social Care Research Wales Advisory Board**

Prof Donna Mead, OBE has been invited by the Director of Health and Care Research Wales Prof Kieran Walshe, to become a member of the Health and Care Research Wales Advisory Board. Health and Social Care Research Wales is a networked organisation, supported by Welsh Government, bringing together a wide range of partners across the NHS in Wales, local authorities, universities and research institutions.

As a member of the Office for Strategic Coordination of Health Research (OSCHR), Health and Care Research Wales also works with UK government health and relevant UK Research and Innovation (UKRI) partners as well as key third sector and commercial partners.

### 2.6. Service of Prayer and Refection for Her Majesty

The Chair and Chief Executive were honoured to be invited to attend the Service of Prayer and Reflection for the Life of Her Majesty Queen Elizabeth II held at Llandaff Cathedral, on 16 September 2022. The Service was held in the presence of His Majesty King Charles III and the Queen Consort. It was a solemn yet glorious service of prayer, thanksgiving and reflection. The thoughts and prayers of us all at the Trust are with the Queen's family at this sad time.

## 3. IMPACT ASSESSMENT

| | |
|---|---|
| QUALITY AND SAFETY IMPLICATIONS/IMPACT | There are no specific quality and safety implications related to the activity outlined in this report. |
| | |
| RELATED HEALTHCARE STANDARD | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| EQUALITY IMPACT ASSESSMENT COMPLETED | Not required |
| | |
| LEGAL IMPLICATIONS / IMPACT | There are no specific legal implications related to the activity outlined in this report. |
| | |
| FINANCIAL IMPLICATIONS / | There is no direct impact on resources as a result of the activity outlined in this report. |

| | |
|---|---|
| IMPACT | |

## 4. RECOMMENDATION

4.1. 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 | 29.09.2022 |

| | |
|---|---|
| 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:

- COVID-19 Vaccination letter of thanks to the Welsh Blood Service
- Partnership with the Acorn Consortium
- Integrated Medium Term Plan Requirements and Accountability Conditions
- Work arrangements for 19th September 2022
- Pride 2022
- New Appointment – Speciality Doctors and Associate Specialists (SAS)
- Down to Earth Visit

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

### 2.1 COVID-19 Vaccination letter of thanks to the Welsh Blood Service

The Chief Executive noted to the Board that a letter of thanks had been received from the Director of Covid-19 Vaccination Policy regarding the Welsh Blood Service support for the Wales COVID-19 vaccination programme. The hard work of staff at the Welsh Blood Service supporting the vaccination programme was highly praised.

### 2.2 Partnership with the Acorn Consortium

The Trust announced the Acorn consortium as the successful participant of the competition to design, build, finance and maintain the new Velindre Cancer Centre on 27 July 2022, following a robust nine month competition. The Chief Executive would like to emphasise to the Board that this work benefitted greatly from the incredible dedication of staff enthusiasm and expertise, all in the face of service pressures during the pandemic. There will be further proactive communication of the Trust's partnership with Acorn as part of the schedule of community and staff drop in events in October, including with the media, as part of this next phase.

**2.3 Integrated Medium Term Plan Requirements and Accountability Conditions**

As noted in the Chief Executive's report to the trust Board in July, the Integrated Medium Term Plan 2022-2025 was approved by the Minister for Health and Social Service in July 2022.

The approval was followed by a letter to the Chief Executive from the Director General and NHS Wales Chief Executive, which set out some general comments regarding expectations regarding the Trust Board's role in the process and a series of Requirements and Accountability conditions on which the approval was made. This is attached as appendix 1.

An overview of how requirements and conditions will be fulfilled will be for discussion to the Strategic Development Committee in October and noted at next quarterly reporting cycle into Trust Board in November.

**2.4 Work arrangements for 19th September 2022**

Having received the announcement of the Bank Holiday due to the State Funeral of Her Majesty Queen Elizabeth II, discussions were held with NHS Wales Colleagues regarding working arrangements. The usual working arrangements for bank holidays were applied, however, arrangements were put in place to ensure the continuation of essential services.

The Velindre Cancer Service, in line with Welsh Government guidelines, ensured that scheduled appointments for cancer treatment continued as planned. This was only made possible with excellent support of colleagues. The Chief Executive expressed gratitude to everyone for pulling together during this difficult time and at such short notice.

**2.5 Pride 2022**

The Chief Executive, with other members of the Executive team and wider Trust colleagues celebrated Pride this year by joining the Pride March through Cardiff on 27 August 2022. There was also Virtual Pride, a massive quiz and fun sessions which took place on 24 August 2022.

In celebration of Pride the Welsh Blood Service shared the story of Carl and his husband Martin, who were two of the first new donors welcomed as changes to donation rules were introduced. It was announced in June 2021 that all donors, regardless of gender, will now be asked a new set of questions about sexual behaviours, focused mainly on the last three months, meaning that more people from LGBTQ+ communities will be eligible to donate.

**2.5 New Appointment – Speciality Doctors and Associate Specialists (SAS)**

Velindre University NHS Trust is proud to welcome Dr Nikki Pease into her new additional role, SAS Doctor Advocate from 1st September 2022. This is an exciting new opportunity for both Nikki and the Trust, as she will be the dedicated link working closely with our

Specialty Doctors and the Organisation. Her primary focus in this role will be to provide support, empower and network, with an emphasis on wellbeing and visibility of SAS roles.

### 2.6 Down to Earth Visit

The Chief Executive joined Julie Morgan MS and other Trust colleagues at Down to Earth's site on the Gower in August. Down to Earth is a social enterprise with whom the Trust has an existing strong relationship and is currently looking at opportunities to develop the partnership further. The team also visited houses which have been built by Down to Earth and Coastal Housing to see the inspiring designs of new eco-homes that the partnership is building in a collaborative way with the local community.

## 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

Steve Ham
Chief Executive
Velindre NHS Trust

Our Ref: JP/BS/SB

22nd July 2022

Dear Steve

**Integrated Medium-Term Plan 2022-2025**

I am pleased to confirm that the Minister for Health and Social Service has approved your Integrated Medium-Term Plan (IMTP) which you submitted on the 31 March 2022. This is in recognition of the development of integrated planning within Velindre NHS Trust and demonstrates the position that the organisation is in as we move from the COVID pandemic towards recovery.

I expect the Board to scrutinise the plan and that progress is monitored effectively over the forthcoming year, in particular against the Ministerial Priorities set out in the NHS Planning Framework, the Minister's delivery measures and the specific accountability conditions for Velindre NHS Trust which are attached. Where necessary, any risks or challenges that need to be further addressed will need to be discussed and agreed at your Board and communicated to Welsh Government via the routine governance arrangements (e.g., IQPD meetings or quarterly reporting against your IMTP). Where this necessitates any material changes to your IMTP in year will require you to advise me of these changes through an Accountable Officer letter.

There are a number of generic risks and challenges which all organisations are facing. These include the concerns about how COVID-19 will continue to impact on the NHS, planned care recovery and the way in which the system is able to respond to patients and their needs. Board oversight and management of risk in these areas remains crucial.

The triangulation of activity, workforce and finance has improved the alignment of plans. The development and support of the Minimum Data Set and the trajectories to deliver against the Ministerial priorities and delivery measures is key to successful delivery of a plan. I expect to see the Board owning the plan which your organisation has submitted and for you and the senior team to lead on meeting the needs of the populations you serve and the commitments set out in the IMTP.



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It was encouraging to see that a number of areas of good practice were highlighted by policy leads as part of the review process of the Velindre plan. These included having a clear balanced plan albeit with risks around proposed savings delivery. The plan was strong in terms of your intentions to develop your Value Based Healthcare approach to reduce variation and harm and the sustainability and decarbonisation programmes are well referenced and robust. The foundational economy and Velindre's role as an anchor institution is well documented and welcomed. Quality of services is recognised in the plan as is the need to articulate this through the organisation to reap benefits and change. Engagement with other health boards is demonstrated in the plan and the need to use enablers such as digital and new models of care closer to home to deliver better care for patients.

However, there were a number of areas which the assessment highlighted as not covered sufficiently robustly in the IMTP. Reference to the cancer quality statement was not as strong as would have been expected, similarly mental health in terms of its impact for patients. Workforce challenges affect everyone but the lack of detail was of concern and the need to align to the detail shown in the MDS with growth in nursing staff and reductions in agency spend brought into question the deliverability of the plan. The need to use this next period of the IMTP to begin to transition to the new Cancer Centre was light in this current plan as was risks associated with the new commissioning model.

The wider recovery of the waiting list position will have an impact for you, both for cancer and blood services, as you deliver crucial parts of the care pathway for other organisations. I expect to see these vital contributions delivered and assurance provided that you have a robust plan to meet demand by the end of Quarter 1.

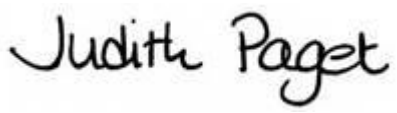
The approval of the Velindre IMTP for 2022-2025 is therefore subject to a number of accountability conditions which I have set out in **Annex 1**. These are areas unique to your organisation and I expect to see demonstrable improvement over the next 12 months. The Minister is clear that the accountability conditions will also form part of the ongoing conversation that she will have with Chairs and delivery against these will be measures of success in their own right. The Accountability Conditions will form the agenda for our Joint Executive Team (JET) meetings going forward and be the basis of the ongoing engagement with the Welsh Government Planning team, policy leads and in terms of performance and delivery discussions via the regular IQPD meetings.

As articulated in the Ministerial letter, the approval of the Integrated Medium-Term Plan does not equate to agreement to the detailed service changes, business case proposals or capital assumptions indicated within it. Nor does the plan approval confirm any validity in funding assumptions around additional revenue or capital funding other than that specified below. All service change and business case proposals will still be subject to:

- compliance with extant requirements set out in guidance or in legislation, and
- business cases and bids being subject to the normal business case approval process, including capital, and Invest to Save bid approval processes.

You have not requested financial flexibility as part of your IMTP, and none has been granted. I trust that this letter provides clarity on our expectations, but should you have any queries then please do not hesitate to contact me.

Yours sincerely



**Judith Paget CBE**

cc: Nick Wood, Deputy Chief Executive NHS Wales
Samia Edmonds, Planning Director
Jeremy Griffiths, Director of Operations
Andrew Sallows, Director of Recovery
Steve Elliott, Director of Finance, HSSG
Hywel Jones, Director of Finance, FDU

**Annex 1**

**Velindre NHS Trust - Integrated Medium-Term Plan 2022-2025**

# Requirements and Accountability Conditions

The following requirements and accountability conditions should form the basis of the discussions at JET meetings and other planning and delivery meetings throughout the year as well as your internal monitoring and Board assurance.

## General requirements

- The **'Five Ways of Working'** and the Well-being of Future Generations Act must be central to the trust's approach. It is essential that your organisation continues to build on the progress made to utilise the five ways of working, sustainable development principles, to deliver your integrated plan. The organisation should ensure its well-being objectives are consistent with and continue to be supported by its planning arrangements.

- The **IMTP must be published** on your organisation's public facing website.

- **Reporting** must be submitted quarterly to provide an update on the plan. There should be reporting against the key milestones associated with that quarter, any slippage against the plan, next milestones and the mitigation of any new/emerging risks. Details of the reporting arrangements will be circulated in due course.

- The **Minimum Data Set (MDS)** must be refreshed on a quarterly basis.

## Accountability Conditions

**Cancer care**

a) Demonstrate how key attributes of the quality statement for cancer are being taken forward.

b) Demonstrate how access to cancer treatment is contributing to achievement of the suspected cancer waiting time target for the region.

c) Demonstrate what mental health support is being provided to patients.

**Workforce**

a) Demonstrate workforce intelligence that has identified key workforce risks and workforce planning that includes actions to address these key risks.

**nVCC**

a) Demonstrate effective management oversight of the development and transition to the new Velindre Cancer Centre, Radiotherapy Satellite Centre and Integrated Radiotherapy Solution.

**Commissioning**

a) Demonstrate leadership in the further development of the networked clinical model, including the Nuffield recommendations.

b) Secure agreement to the new commissioning model for radiotherapy with partner organisations.

**Finance**

a) Demonstrate action is being taken to mitigate exceptional costs throughout the year.

b) Demonstrate action is being taken to mitigate COVID costs throughout the year as the pandemic response continues to evolve.

c) Risks to delivery of saving plan delivery must be reduced to increase confidence in the plan - to be monitored by FDU on a quarterly basis.

d) Ensure clear agreements are in place with commissioners to support delivery of COVID recovery and required activity.

# TRUST BOARD

# JULY 2022 Performance Management Framework COVER PAPER

| | |
|---|---|
| **DATE OF MEETING** | 29/09/2022 |

| | |
|---|---|
| **PUBLIC OR PRIVATE REPORT** | Public |

| | |
|---|---|
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |

| | |
|---|---|
| **PREPARED BY** | Wayne Jenkins, Head of Planning and Performance<br>Alan Prosser, Director WBS<br>Amanda Jenkins, Head of WOD |
| **PRESENTED BY** | Cath O'Brien, Chief Operating Officer<br>Sarah Morley, Director WOD |
| **EXECUTIVE SPONSOR APPROVED** | Cath O'Brien, Chief Operating Officer |

| | |
|---|---|
| **REPORT PURPOSE** | FOR DISCUSSION / REVIEW |

| **COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING** | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| WBS SMT MEETING | 10.8.22 | Reviewed and Noted |
| VCC SLT | 17.8.22 | Reviewed and Noted |
| WBS PERFORMANCE REVIEW | 17.8.22 | Reviewed and Noted |
| VCC PERFORMANCE REVIEW | 19.8.22 | Reviewed and Noted |
| EMB RUN | 1.9.22 | Reviewed and Noted |
| QSP COMMITTEE | 15.9.22 | Reviewed and Noted |

| ACRONYMS | |
|---|---|
| VUNHST | Velindre University NHS Trust |
| UHB | University Health Board |
| VCC SLT | Velindre Cancer Centre Senior Leadership Team |
| WBS SMT | Welsh Blood Service Senior Management Team |
| QSP | Quality, Safety & Performance Committee |
| RCR | Royal College of Radiologists |
| JCCO | Joint Council for Clinical Oncology |
| PADR | Performance Appraisal and Development Review |
| KPIs | Key Performance Indicators |
| SACT | Systemic Anti-Cancer Therapy |
| WTE | Whole Time Equivalent (staff) |
| EMB | Executive Management Board |
| COSC | Clinical Oncology Sub-Committee |
| IPC | Infection Prevention Control |
| RCC | Rutherford Cancer Centre |

## 1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports provide an update to the Trust Board with respect to Trust-wide performance against key performance metrics through to the end of July 2022 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The reports set-out performance at Velindre Cancer Centre **(*appendix 1*),** the Welsh Blood Service **(*appendix 2*)** and the Workforce **(*appendix 3).*** Each report is prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance. A number of areas from the reports are highlighted below.

### 2.1 Velindre Cancer Centre:

We continue to experience service challenges in providing capacity to meet the overall demand for services and also to meet targets for treatment due to the variation in referral patterns for patients with different tumour sites due to the specific needs of these patients. For example, the LINAC for radiotherapy are configured for certain treatment sites.

With referrals expected to continue to increase as Health boards target their waiting lists, regular operational meetings are taking place with the three Health Boards we work with and these will enable us to gain a clearer picture of what the demand and referral numbers will be going forward, building on the work done previously to create data on the system wide referral pathways and patient numbers. These meetings are enabling us to have more detailed discussions with health board colleagues to understand the team by team changes in their services that impact on the demand profile for patients coming to Velindre.

Alongside better intelligence on demand to support planning, we have a comprehensive programme of work underway to expand capacity and to maximise the use of the capacity that we have by ensuring that we are as efficient as we can be.

Below we outline the details of the factors influencing performance in July 22, however we have also provided a fuller summary of the activity underway to increase capacity and efficiency in a separate paper which will be presented at September's QSP meeting (see *appendix 4*)

**Demand and Capacity**

Alongside better intelligence on demand to support planning, we have a comprehensive programme of work underway to expand capacity and to maximise the use of the capacity that we have by ensuring that we are as efficient as we can be.

There are a number of focused immediate actions that are underway as part of the ongoing service capacity task forces in Radiotherapy and SACT. This includes incremental release of capacity through review of variations in practice by each SST as well as identifying

options for increasing planning capacity. These are being reviewed on a weekly basis by the SLT in VCC and by the Executive team.

In SACT, a redistribution of patient treatments to outpatient, ambulatory care and clinical trial areas has supported an increase in activity. Additional weekend clinics have been established from August to expand capacity using overtime and drawing on as many staff as possible with the appropriate skills. This is an interim arrangement pending the next stage plan of increasing SACT delivery at Prince Charles Hospital by 100% and the ultimate plan of reopening capacity in ABUHB. Discussions are also taking place in relation to an interim option for services within ABUHB whilst the new satellite centre is in progress.
In Radiotherapy, a gradual increase in LINAC capacity by 8% is underway, through extending working days and a gradual increase in utilisation of LINAC capacity from 73.5 planned hours in June to 79.5 planned hours in October. 75 hrs has been delivered in July in line with plans. Risks remain however to provide specific Brachytherapy capacity and Medical Physics capacity and there are significant risks and challenges associated with the age of the equipment and potential breakdown.

**Radiotherapy Waiting Times**

Overall referrals to radiotherapy for July (387) were marginally lower than those received in June (388).

With the exception of urology, referrals across all tumour sites has seen an increase in the monthly average number of referrals for that site when compared to 2020/21 and 2021/22.

We have already seen higher than anticipated and planned referrals for breast cancer patients as Health Boards are commencing a range of activity to target the increasing patient referrals for diagnosis for patients with suspected breast cancer and increase capacity in the initial parts of their treatment pathway.

**Patient receiving radical radiotherapy within 28 day**

Of the 197 patients referred for radical radiotherapy, 55 did not begin treatment within the 28 day target leading to a performance of 72%. The target is 98%. We have looked at the breach data at an individual patient level to determine why they occurred. There are various reasons; lack of planning and deep x-ray capacity and process issues relating to

re-scans and re-plans. However the prime issue in July was the capacity for treating Breast Cancer patients. There were 38 breast cancer patients in the 55 breaches. All of these were treated within 7 days of the target. All these patients would have been clinically prioritised by the clinical teams.

There are a number of focused immediate actions that are underway as part of the ongoing service capacity review. This includes incremental release of capacity through review of variations in practice by each SST as well as identifying options for increasing planning capacity. These are being reviewed on a weekly basis by the SLT in VCC and by the Executive team.

**SACT Waiting Times**

July's performance improved to 58%. Of the 389 patients referred for non-emergency SACT treatment, 134 patients did not start their treatment within 21 days. The longest wait for a patient was 59 days.

This is the first month since December 2021 where performance has improved from the previous month, arresting a 7 month decline. Breach numbers have also reduced to 134 in July from 147 in June and 158 in May.

All new patients and urgent patients are prioritised using Welsh Cancer Network guidance and available clinical information. Escalation and capacity needs are continually reviewed and change frequently throughout the day at an operational level within the clinic.

Additional booking clerks have been appointed to fill vacancies and interviews for additional nursing vacancies were held in July with an expectation that they will boost the workforce team by October.

Internal mutual aid is being provided from nursing within other departments to support maintaining activity.

A taskforce has been established to identify short to medium term options to address shortfall in capacity and this is being reviewed weekly by the SLT and Executive team. A redistribution of appropriate patient treatments to outpatient, ambulatory care and clinical trial areas has supported an increase in activity. Additional weekend clinics have been established from August to expand capacity using overtime and drawing on as many staff as possible with the appropriate skills. This is an interim arrangement pending the next stage plan of increasing SACT delivery at Prince Charles Hospital and the ultimate plan of reopening capacity in ABUHB. Discussions are also taking place in relation to an interim option for services within ABUHB whilst the new satellite centre is in progress.

### Outpatients

Data collection relating to the 30 minute target, was paused in December 2021, due to operational pressures and staff absence as manual collection of individual patient attendances is required. This has now been reinstated in this month's report, but is still limited in sample size. We are reviewing a number of new outpatient KPIs as part of the new PMF development that will enable a wider view of the service delivery in this area.

## Other areas

### Falls

During July 2022, 2 falls were reported on first floor ward, involving 2 patients who mobilised independently and did not use the call bells available. The falls scrutiny panel deemed the both falls as unavoidable. The patients were unharmed.

### Pressure Ulcers

There were no pressure ulcers reported in July 2022.

### Healthcare Acquired Infections

There was 1 reported case of E.coli bacteraemia in July 2022.

The root cause analysis and review by MDT identified it as bowel source probable malignant translocation.

### SEPSIS bundle NEWS score

14 patients initially met the criteria for administration of the sepsis treatment bundle in July 2022. All 14 patients received all elements of the bundle within 1 hour.
6 patients received a diagnosis of sepsis and all of them had received all elements of the bundle within 1 hour.

### Delayed Transfers of Care (DTOC's)

There was no Delayed Transfer of Care was reported in July 2022.

**Further detailed performance data is provided in Appendix 1**

## 2.2 Welsh Blood Service

Performance for July remains encouraging overall despite experiencing high sickness levels in collection teams and the current pressures on demand and capacity within the blood supply chain.

### 2.2.1 Supply Chain Performance

Whilst Covid and general sickness continues to be challenging, during July the service continued to meet demand.

Stock dropped below the 3 day benchmark on 6 occasions for the O- and O+ due to pressures on the blood supply chain. As a result, a total of 97 units of red cells were provided as part of our mutual aid support.

Blue Alerts continued due to ongoing low stock levels for the O+ blood group, and were also extended to O- and A+ blood groups for periods in the month.

The WBS having stood up a daily emergency planning team has been able to recover the stock position for the service following a number of fast acting initiatives ranging from changing messages to donors to standing up staff volunteers to open up more capacity in donor clinics, which has resulted in the lifting of the Blue alert notice on August 4th.

The service is now looking towards medium to long term solutions in terms of ensuring demand is met moving forwards. This includes re assessing the demand forecast, streamlining the scrutiny, on boarding and training requirements for new staff and creating a staff bank.

In addition, the service will focus on reducing donor non attendance and deferrals, and assessing donor behaviour changes.

The service is also re-modelling its collection footprint and assessing the balance of larger venues versus a community footprint, whilst also considering a future model for plasma collection across Wales. The service will bring back the 6 bedded collection vehicles from September and revisiting high footfall areas such as supermarkets.

### 2.2.2 Whole Blood Collection Productivity

The collection productivity rate dropped slightly from last month, however efficiency varies between teams (0.79% for Bangor to 1.21% for East B).

Data analysis is being undertaken on Donor Non Attendance trends to identify if the efficiency can be improved by over booking of appointments or 'controlled walk ins' at carefully selected clinics. In addition, the 6 chair mobile units are scheduled to return to

service from September following post COVID modifications and a review of individual venue capacity continues with a view to reintroducing 10 chair clinics across south and west Wales where possible.

A revised training schedule is also in development to accelerate timescales for new staff to become fully trained/operational.

### 2.2.3 Recruitment of new bone marrow volunteers

The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 215 in July compared to 200 in June but is still below target.

The action plan to promote recruitment at universities, colleges and sixth forms on the return of students in September continues, along with profiling on social media and improving content and visibility on the WBS website. WBMDR staff are promoting bone marrow donor recruitment at national events. Alongside this, the team have issued a tender to work with an external company to develop a donor recruitment campaign and the production of promotional material. The expectation remains that increases in bone marrow donors will be evident once the campaign launches.

### 2.2.4 Reference Serology

In July, Reference Serology turn around performance reached its target of 80% for the first time this year.

This is due, in part, to a concerted effort by senior staff to remove the backlog of reporting, which is not sustainable in the longer term. However, it is hoped that continued implementation of the findings of the recent ‘Out of Hours Referrals' audit and the solutions outlined in the recent paper regarding service pressures will support maintaining target on an ongoing basis.

### 2.2.5 Time Expired Platelets

Platelet expiry did not reach target in July. This was due to an unpredicted drop in demand to 167 per week (against planned production of 215 per week). This month’s demand was lower again than May (216 units per week) and June (173 units per week). As the impact of production on supply is delayed by 2.5 days, any excess supply cannot be reduced as the excess is usually nearing expiry, and there is not a strong correlation between weekly issues to inform demand.

Given the variability of expired platelets over the past 12 months, the service is carrying out a review to look at improving wastage rates. A platelet group has recently been established to look at improvements in wastage, apheresis clinic collection times and additional areas for improvement. The work will include international benchmarking and

liaising with other blood services to see if any improvements in platelet planning can be made.

### 2.2.6 Quality

**Incidents reported to Regulator/Licensing**

There was 1 Serious Adverse Event (SAE) reported to regulators during July: A Critical core temperature alarm limit was breached for a plasma freezer. The investigation determined that affected plasma was safe for transfusion. A full root cause analysis investigation has been undertaken and this incident added to the scenario-based training to ensure a correct response going forward.

**Incidents closed within 30 days**

99% of Quality Incident Records were closed within 30 days (for the three month rolling period to July) against a target of 90%. The number of quality incidents not closed in the required timeframe decreased from 3 in the previous reporting period to 1. The overdue Datix incident is now closed, but exceeded the 31-day closure requirement. This was a no harm event investigation which was awaiting closure from the incident owner.

**Number of Concerns Received**

4 concerns (0.05%) were reported within this period and were closed as early resolutions.

**Donor Satisfaction**

At 96.0% donor satisfaction continued to perform strongly at a national level despite the COVID restrictions in place.

## 3. WORKFORCE

### 3.1 PADR

Trust Wide 70.45%, increase on previous month (Target 85%)
WBS 76.90%, compliance rates declined compared to last month.
VCC 71.30%, increased compared to last month

**Sickness Absence**

Trust wide 6.81%, sickness increased on last month. (Target 3.54%)
WBS 8.49%, sickness rates increased compared to last month
VCC 6.83%, sickness increased compared to last month.

### 3.2 Statutory & Mandatory Compliance

Trust Wide 85.46%, above target (Target 85%)
WBS 92.18%, well above target but decrease on previous month
VCC 84.75%, slight dip since last month taking below target.

## 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:<br>• Staff and Resources<br>• Safe Care<br>• Timely Care<br>• 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 May PMF Report
2. WBS May PMF Report
3. Workforce Monthly PMF Report
4. Capacity and Demand Update

# Velindre Cancer Centre Monthly Performance Report Summary Dashboard (July 2022)

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| | | | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Radiotherapy | Patients Beginning Radical Radiotherapy Within 28-Days (page xx) | Actual | 96% | 97% | 96% | 92% | 78% | 92% | 92% | 92% | 87% | 92% | 83% | 72% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Patients Beginning Palliative Radiotherapy Within 14-Days (page xx) | Actual | 82% | 82% | 82% | 74% | 84% | 90% | 90% | 81% | 79% | 81% | 83% | 83% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Patients Beginning Emergency Radiotherapy Within 2-Days (page xx) | Actual | 100% | 97% | 100% | 85% | 89% | 100% | 93% | 88% | 84% | 88% | 100% | 100% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| SACT | Patients Beginning Non-Emergency SACT Within 21-Days (page xx) | Actual | 99% | 98% | 99% | 99% | 99% | 94% | 91% | 71% | 69% | 61% | 58% | 66% |
| | | Target | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| | Patients Beginning Emergency SACT Within 2-Days (page xx) | Actual | 100% | 100% | 100% | 86% | 100% | 100% | 100% | 83% | 100% | 100% | 86% | 100% |
| | | 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 xx) | Actual | 53% | 53% | 65% | 65% | Data Collection (Paused) | Data Collection (Paused) | Data Collection (Paused)- | Data Collection (Paused)- | Data Collection (Paused)- | Data Collection (Paused)- | Data Collection (Paused) | 70% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

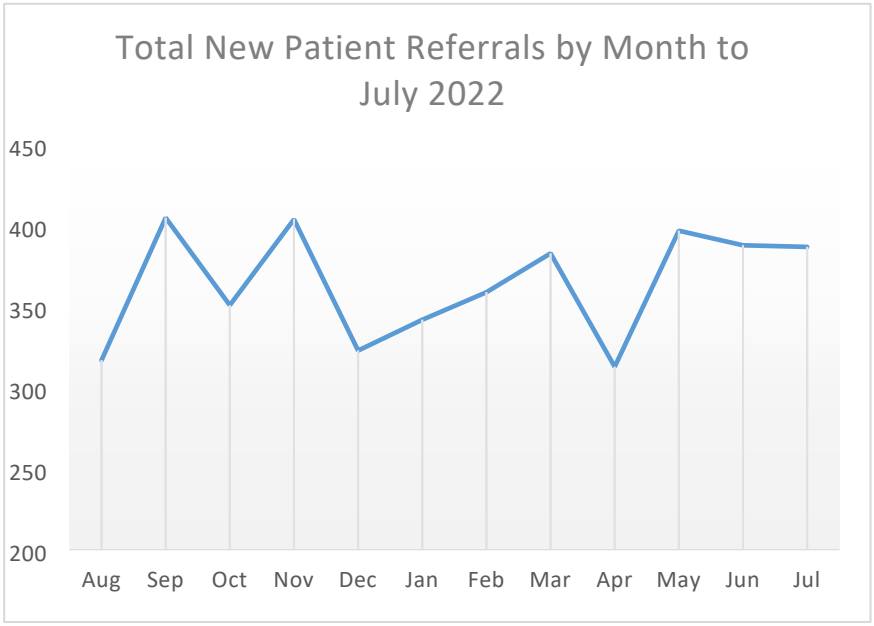
| | | | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Did Not Attend (DNA) Rates | Actual | 5% | 5% | 5% | 5% | 3% | 3% | 3% | 3% | 3% | 3% | 3% | 5% |
| | | Target | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% | 5% |
| Therapies | Therapies Inpatients Seen Within 2 Working Days (page xx) | Actual (Dietetics) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Physiotherapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Occupational Therapy) | 100% | 100% | 95% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Speech and Language Therapy) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 67% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | Therapies Outpatient Referrals Seen Within 2 Weeks (page xx) | Actual (Dietetics) | 94% | 98% | 97% | 100% | 95% | 98% | 100% | 98% | 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% | 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% |

| | | | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Routine Therapies Outpatients Seen Within 6 Weeks (page xx) | Actual (Dietetics) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Physiotherapy) | 100% | 100% | 100% | 100% | 100% | 86% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | Actual (Occupational Therapy) | 96% | 33% | 78% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 97% |
| | | Actual (Speech and Language Therapy) | 100% | 100% | 96% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 96% |
| | | 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 xx) | Actual | 2 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 0 |
| | | 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 | 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 |
| | Number of VCC Inpatient Falls (page xx) | Actual (Total) | 4 | 2 | 3 | 1 | 4 | 3 | 2 | 9 | 4 | 1 | 1 | 2 |
| | | Unavoidable | 4 | 1 | 3 | 1 | 4 | 2 | 2 | 9 | 3 | 0 | 1 | 2 |
| | | Avoidable | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Number of Delayed Transfers of Care (DToCs) | Actual | 1 | 0 | 4 | 0 | 0 | 1 | 4 | 1 | 1 | 0 | 0 | 0 |

| | | | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-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 than or Equal to Three Who Receive all 6 Elements in Required Timeframe (page xx) | Actual | 100% | 75% | 100% | 100% | 100% | 100% | 100% | 100% | 88% | 100% | 100% | 100% |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | Healthcare Acquired Infections (page xx) | Actual | 0 | 0 | 0 | 0 | 0 | 1 (*C.diff*) | 0 | 0 | 0 | 0 | 0 | 1 (E.Coli bacteremia) |
| | | 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% | 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

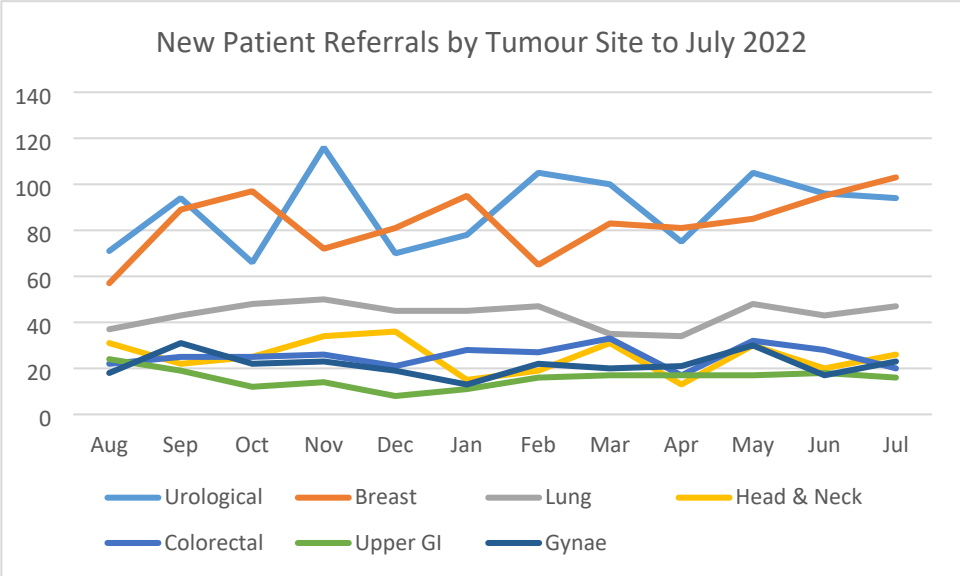



| Monthly Average (2020-21) | Monthly Average (2021-22) | Total New Patient Referrals (July 2022) |
|---|---|---|
| 315 | 364 | 387 |

The total number of referrals received in July 2022 (387) was marginally lower than those received in June 2022 (388). The number of referrals remains high compared to the average number received, during 2020-21 and 2021-22.

## Radiotherapy – Operational Context

### Referral Trends - Tumour Site

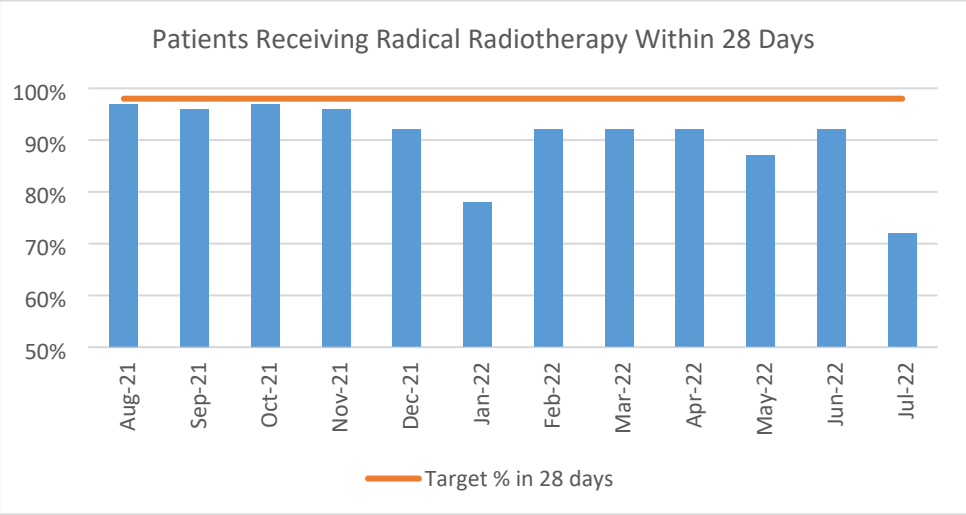



| Site | Monthly Average (2019-20 | Monthly Average (2020-21) | Monthly Average (2021-22) | 2021-22 Average Relative to 2020-21 Average | New Patients (July 2022) |
|---|---|---|---|---|---|
| **Breast** | **88** | **60** | **84** | **29%** | 103 |
| **Urology** | **82** | **82** | **89** | **8%** | 94 |
| **Lung** | **47** | **38** | **44** | **14%** | 47 |
| **Colorectal** | **20** | **22** | **25** | **12%** | 20 |
| **Head and Neck** | **23** | **23** | **25** | **8%** | 26 |
| **Gynaecological** | **18** | **18** | **22** | **18%** | 23 |
| **Upper Gastrointestinal** | **16** | **13** | **16** | **19%** | 16 |
| **Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals** | **82%** | **81%** | **82%** | | **84%** |

*The graph and table show the number of patients scheduled to begin treatment in July by the tumour sites most commonly referred for radiotherapy treatment.*

- Referrals overall have returned to pre-covid levels and across some tumour sites, (Breast, Urology, Colorectal) they now exceed Pre Covid levels.
- Breast referral increases are a significant service challenge.
- 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 Site Specialist Teams (SST's) 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 |




| Intent | Monthly Average (2020-21) | Monthly Average (2021-22) | Patients Scheduled to Begin Treatment (July 2022) |
|---|---|---|---|
| Radical | 177 | 183 | 197 |
| | Patients Scheduled to Begin Treatment (July 2020) | Patients Scheduled to Begin Treatment (July 2021) | |
| | 140 | 229 | |

197 patients were referred for treatment with radical intent. 55 did not begin treatment within 28-days (performance rate of 72%).

Breakdown of breach length of waits and Reasons:

| Treatment Intent | < 35 days | < 40 days | < 45 days | < 50 days | > 50 days |
|---|---|---|---|---|---|
| Radical (28-day target) | 37 | 4 | 5 | 3 | 6 |

38 as a result of Linac capacity (Breast) (all patients prioritised to minimise clinical significance)
2 booking process failure as a result of booking capacity,
7 orthovoltage (DXR) capacity,
3 rescan/ replan required,
4 were as a result of pre-treatment breast planning capacity,
1 due to the consultant requesting treatment to commence on a Monday.

We have maintained the position of over 90% of patients treated in July within 35 days (179 of 197).

Outsourcing of RT for Breast and prostate patients to RCC ceased - all RCC patients repatriated to VCC which has increased demand-maximising capacity options under revision.

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 RMG and the pathway sub group

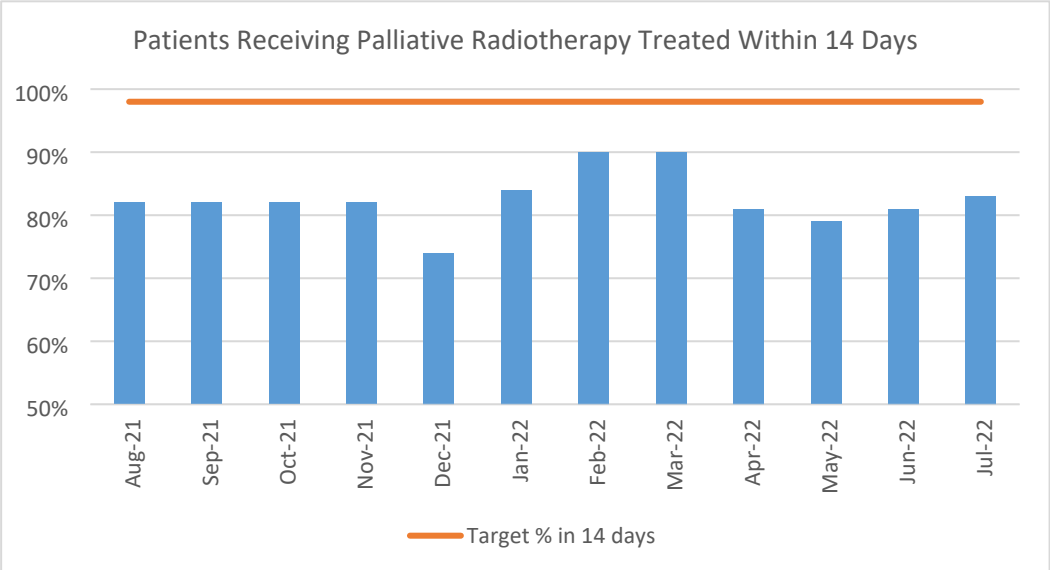
| | |
|---|---|
| | Areas of risk:<br>Breast capacity- loss of RCC outsourcing and increased Breast referral- has resulted in escalation process being implemented for breast referrals, all potential breaches are reviewed for clinical harm and prioritised accordingly.<br><br>A revised demand and capacity structure has been established to ensure demand is fully understood and its implications in different tumour sites and all options for increasing capacity and maximising use of our capacity are explored and secured.<br><br>One area of work us to focus on DNA's and patients who become too ill to attend. Capacity losses due to both these areas are not fully understood and discussions underway with clinical teams to review protocols in place and minimise lost capacity.<br><br>**Short term actions:**<br><br>• Gradual increase in LINAC capacity by 8% is planned from Mid-July onwards. Work being undertaken within the Directorate to extend working days and gradual increase utilisation of LINAC capacity from 73.5 planned hours in June to 79.5 planned hours in October. 75 hrs delivered in July. This is reliant on new staff commencing in post in October and identifying sufficient treatment planning capacity. Risks remain however to provide specific Brachytherapy capacity and Medical Physics capacity and there are significant risks associated with the age of the equipment and potential breakdown.<br><br>• Fleet configuration changes to support Breast patient treatment options in progress.<br><br>• DXR capacity to be extended by 1.5 hrs per day subject to appointment of advanced practitioner. |

| | |
|---|---|
| | • Treatment planning taskforce established to identify opportunities to release non-medical treatment planning.<br><br>• Escalation processes continue to monitor predicted breaches and prevent breaches where possible through weekly capacity meetings. Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group. |
| | 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.<br>• Recruitment and appointments in progress for additional front-line resources. However, this will not create capacity increases until Q3/4 of 2022 due to lead in time. |

**Patients Receiving Palliative Radiotherapy Within 14-Days**

**Target: 98%**

Trend




The number of patients scheduled to begin palliative radiotherapy treatment in June 2022 (88) was above the monthly average observed in 2021-22 (71) and was higher than the number scheduled to begin treatment in May (84).

| Intent | Monthly Average (2020-21) | Monthly Average (2021-22) | Patients Scheduled to Begin Treatment (July 2022) |
|---|---|---|---|
| Palliative | 99 | 87 | 102 |
| | Patients Scheduled to Begin Treatment (July 2020) | Patients Scheduled to Begin Treatment (July 2021) | |
| | 116 | 105 | |

**SLT Lead: Radiotherapy Services Manager**

Current Performance

102 patients were referred for treatment with palliative intent. 17 did not begin treatment within 14-days (performance rate of 83%). Of these 17 patients:

Breakdown of breach length of wait and reason:

| Treatment Intent | 15- 20 days | 21-25 days | 26- 31 days |
|---|---|---|---|
| Palliative (14-day target) | 9 | 4 | 4 |

Palliative breach data- 17 breaches on validation-
13 as a result of requiring a complex 3D plan all were treated within the locally agreed timeframe which is in compliance with the Wales time to radiotherapy metrics (COSC).
1 was as a result of capacity on orthovoltage,
1 was as a result of consultant requested treatment start dates due to complexity of plan,
1 was as a result of a rescan, and
1 was as a result of change of intent

As a result of breaches primarily reflecting issues in areas of patient pathway not necessarily Linac capacity, a taskforce has been established to target the areas where there are process variation. This taskforce commenced in August 2022.

Medium Term Actions

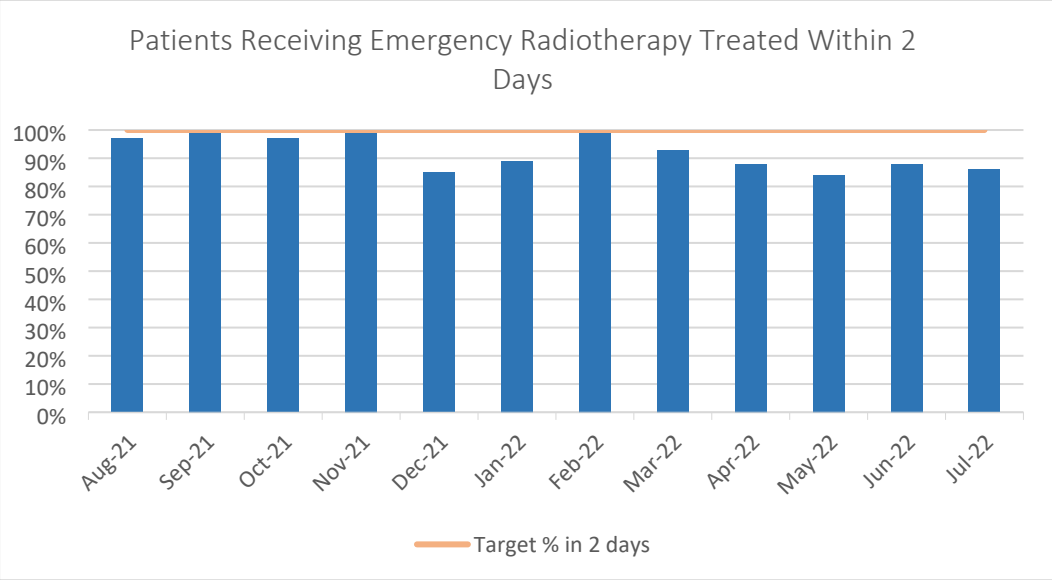
Refer to 28 day medium term actions.

**Patients Receiving Emergency Radiotherapy Within 2-Days**

**Target: 98%**

**SLT Lead: Radiotherapy Services Manager**

Trend




The number of patients scheduled to begin emergency radiotherapy treatment in June 2022 (25) was fewer than the number scheduled to begin treatment in the previous month (17).

| Intent | Monthly Average (2020-21) | Monthly Average (2021-22) | Patients Scheduled to Begin Treatment (July 2022) |
|---|---|---|---|
| Emergency | 29 | 24 | 21 |
| | Patients Scheduled to Begin Treatment (July 2020) | Patients Scheduled to Begin Treatment (July 2021) | |
| | 28 | 32 | |

Current Performance

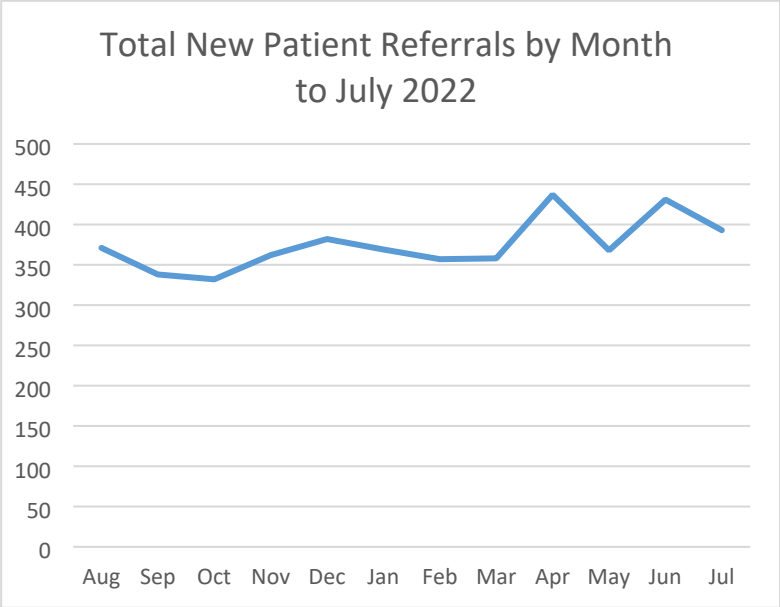
21 patients were referred for emergency treatment. 3 did not receive treatment within 2-days of referral for emergency radiotherapy treatment (performance 86%).
Of these 3 patients:
1 was treated within 3 days, 1 treated within 4 days and 1 treated within 6 days.

1 as a result of the patient requiring assessment prior to treatment,
1 as a result of pre-treatment capacity ( Covid absence for out of hours service), and
1 due to change of intent from palliative to emergency- treated on the same day

Action:

Service capacity challenges across all services are causing a number of breaches that are not specifically due to radiation services capacity. As a result, further active engagement of the Site Specific Team (SST) leadership in monitoring and responding to capacity and planning to avoid breaches is being undertaken.

## **SACT** Referral Trends - Overall



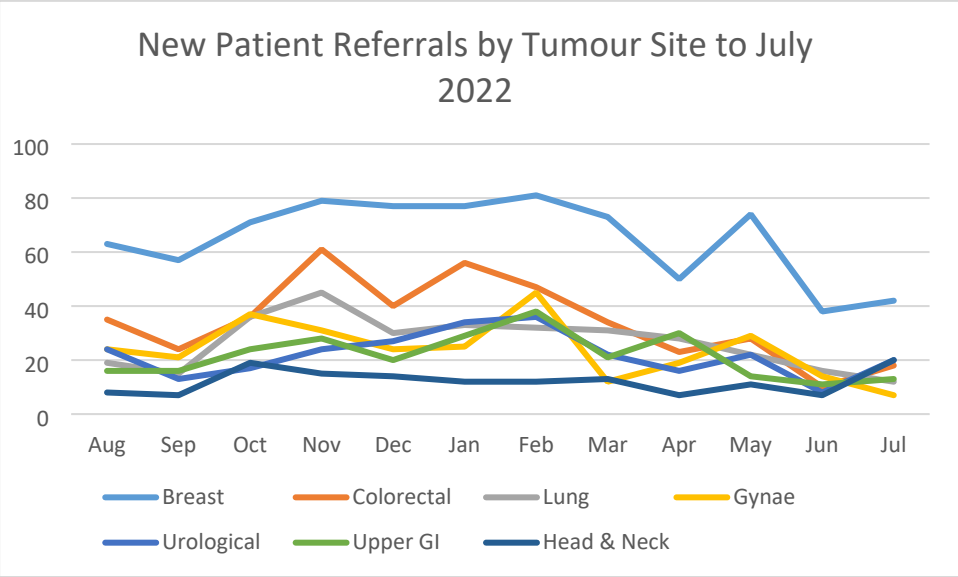

| Monthly Average (2020-21) | Monthly Average (2021-22) | Total New Patient Referrals (July 2022) |
|---|---|---|
| 300 | 345 | 389 |

The total number of SACT referrals received in July 2022 (389) was greater than the average number received in any given month during 2021-22 (345), but was less than the total received in June 2022 (393).

Increased cycles of treatment per patient is a major factor driving SACT demand, compared to the rate of new patient referrals, which has not increased significantly from pre covid levels to date across the board.

There are a few exceptions such as Breast, where patients requiring neo adjuvant treatment are increasing. This group of patients requires timely treatment pre surgery within 14 days, much shorter than the overall 21 day wait and this places increasing pressure on the service at the moment. We are currently managing 67% of these patients to treatment within 14 days. (Up from 60% in June 2022.)

## Referral Trends - Tumour Site




| Site | Monthly Average (2019-20) | Monthly Average (2020-21) | Monthly Average (2021-22) | 2021-22 Average Relative to 2020-21 Average | New Patient Referrals (July 2022) |
|---|---|---|---|---|---|
| **Breast** | **92** | **76** | **90** | **+16%** | 42 |
| **Colorectal** | **54** | **55** | **50** | **-10%** | 18 |
| **Lung** | **33** | **32** | **38** | **+16%** | 20 |
| **Gynaecological** | **31** | **31** | **30** | **-3%** | 12 |
| **Urological** | **36** | **26** | **27** | **+4%** | 20 |
| **Upper Gastrointestinal** | **18** | **26** | **30** | **+14%** | 13 |
| **Head and Neck** | **16** | **14** | **13** | **-8%** | 7 |
| **Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals** | **86%** | **87%** | **89%** | | **88%** |

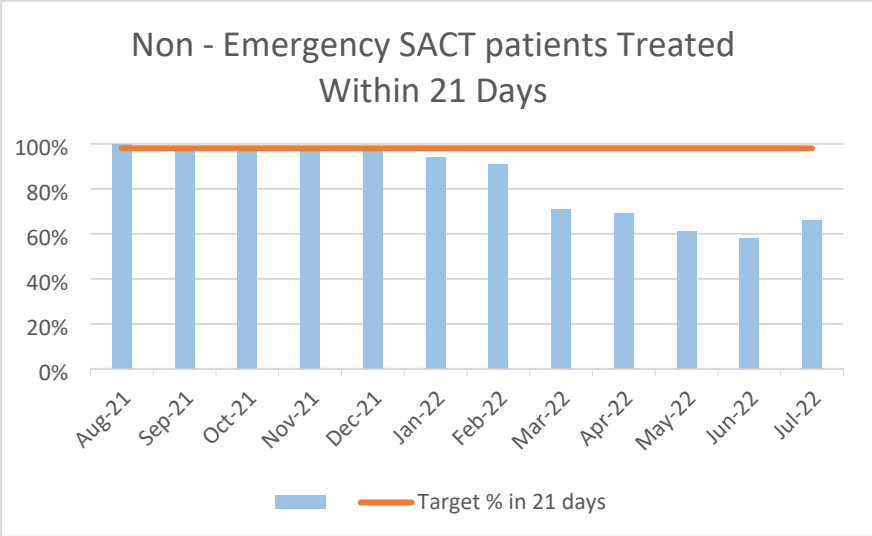
The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.

SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

**Non-Emergency SACT Patients Treated Within 21-Days**

**Target: 98%** | **SLT Lead: Chief Pharmacist**

Current Performance




The number of patients scheduled to begin non-emergency SACT treatment in July 2022 (389) was higher than the number in June (355).

| Intent | Monthly Average (2020-21) | Monthly Average (2021-22) | Patients Scheduled to Begin Treatment (July 2022) |
|---|---|---|---|
| Non - | 299 | 345 | 389 |

Trend

Of 389 patients treated, 134 patients waited over 21 days = performance of 66%.

| Intent / Days - | 22-28 | 29-35 | 36-42 | 43-49 | 50-56 | 57-59 |
|---|---|---|---|---|---|---|
| Non-emergency (21-day target) | 33 | 47 | 22 | 20 | 11 | 1 |

The longest wait experienced by any patient to begin treatment was 59-days. The length of wait is also reducing overall with 60% of breaches in July within 35 days (80 0f 134) compared to only 37% in June (55 of 147).

This is the first month since December 2021 where performance has improved from the previous month, arresting a 7 month decline. Breach numbers have also reduced to 134 in July from 147 in June and 158 in May.

Shortage of capacity in the service to deliver the volume of referral increase is the reason for the number of patient breaches. Plans are in place as outlined below to address the capacity challenge.

All patients within a Clinical Trial are booked within the trial timeframes.

Due to current capacity constraints within the SACT & Medicines Management team, all new patients and urgent patients are prioritised

| | | | |
|---|---|---|---|
| emergency | Patients Scheduled to Begin Treatment (July 2020) | Patients Scheduled to Begin Treatment (July 2021) | |
| | 279 | 383 | |

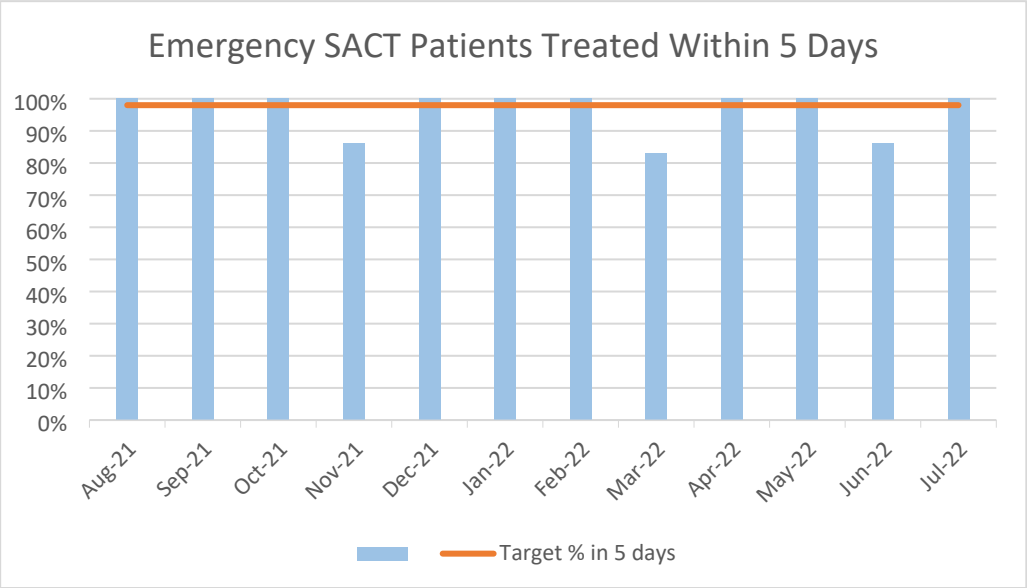
using Welsh Cancer Network guidance and available clinical information. Daily escalation meetings continue and capacity needs are continually reviewed and change frequently throughout the day. The clinical priority process commenced on 20th December 2021.

A review of the process for measuring and managing potential harm to patients as a result of longer waiting times has commenced, along with an audit of the application of the clinical prioritisation process to ensure patients at most risk are managed appropriately. This will be concluded in early September.

Short Term Actions

- SACT taskforce established (June 2022) and activity plan developed which includes weekend clinics from August and plans to expand capacity at PCH from October.
- Incremental gains in pharmacy capacity are being delivered through reviews of working practices and the focus on maximising SACT provision.
- Additional capacity for new patients sourced from RD&I (8 attendances per week)
- Modelling work of booking clerks has been completed and similar work will take place for nursing and pharmacy to ensure that staffing is available to support additional clinics and maximising throughput.
- Ongoing management within the week is supported by mutual aid from other parts of the centre
- Treatment regimens which can be delivered in other clinical areas have been actioned and further are being explored to release capacity in the SACT clinic area.
- Discussions with Aneurin Bevan UHB regarding the reintroduction of services at Nevill Hall Hospital (NHH) as an interim solution taking place.

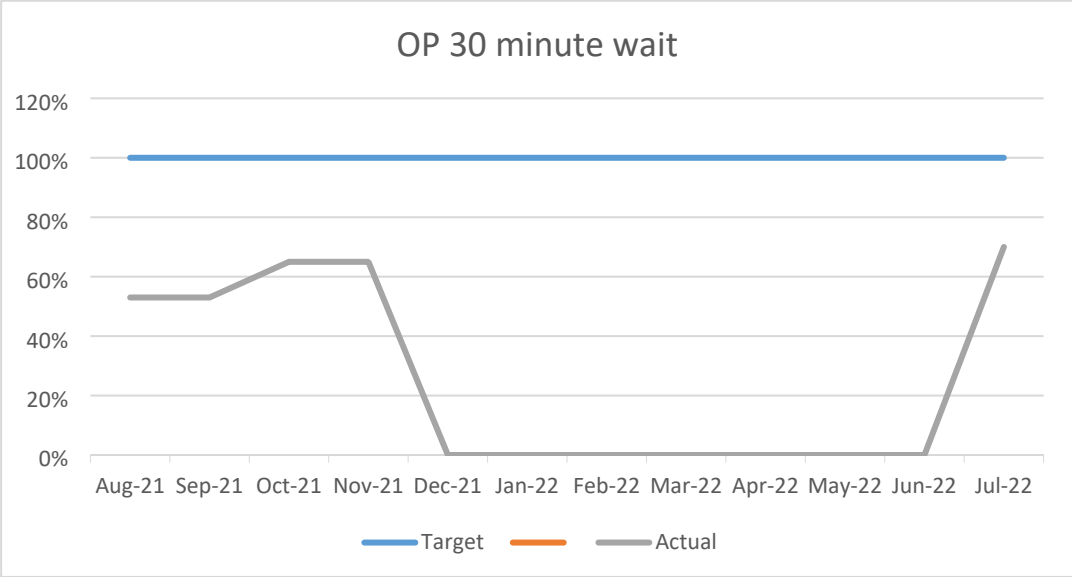
| | |
|---|---|
| | |

| **Emergency SACT Patients Treated Within 5-Days** | |
|---|---|
| **Target: 98%** | **SLT Lead: Chief Pharmacist** |
| Current Performance | Trend |
|  | 5 patients referred for emergency SACT treatment were scheduled to begin treatment in July 2022. All were treated in target with 100% performance. |
| The number of patients scheduled to begin emergency SACT treatment in July 2022 (5) was lower than in June (7). | Actions |
| | • Continue to balance demand and ring fencing with capacity. |

| Intent | Monthly Average (2020-21) | Monthly Average (2021-22) | Patients Scheduled to Begin Treatment (July 2022) |
|---|---|---|---|
| Emergency | 4 | 5 | 5 |

| | Patients Scheduled to Begin Treatment (July 2020) | Patients Scheduled to Begin Treatment (July 2021) | |
|---|---|---|---|
| | | 10 | |

**Outpatient 30 minute wait**

| **Target: 100%** | **SLT Lead: Outpatient Manager** |
|---|---|
| Current Performance | Trend |
|  <br>Performance reported for July 2022 was 70%.<br><br>Note: This is based on a sample size of 2% of the total number of patients seen at outpatients in July. (208 of 9412 patients) | Performance was the highest reported in the last twelve months.<br><br>Monitoring of indicator reinstated but remains limited as only a snapshot of clinics at particular times.<br><br>Actions<br>Focus Groups to be established with patient involvement to define performance measures reflecting the entire patient experience at outpatients. as part of the Trust wide PMF review. |

| | |
|---|---|
| Reporting had been paused between December 2021 and June 2022 over concerns regarding the representativeness of the sample size and ongoing discussions to move the data collection to an integral part of outpatient processes. These discussions have not produced a sustainable solution to date. | |

**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

| | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-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% | 95% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| SLT | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 67% | 100% | 100% | 100% |

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

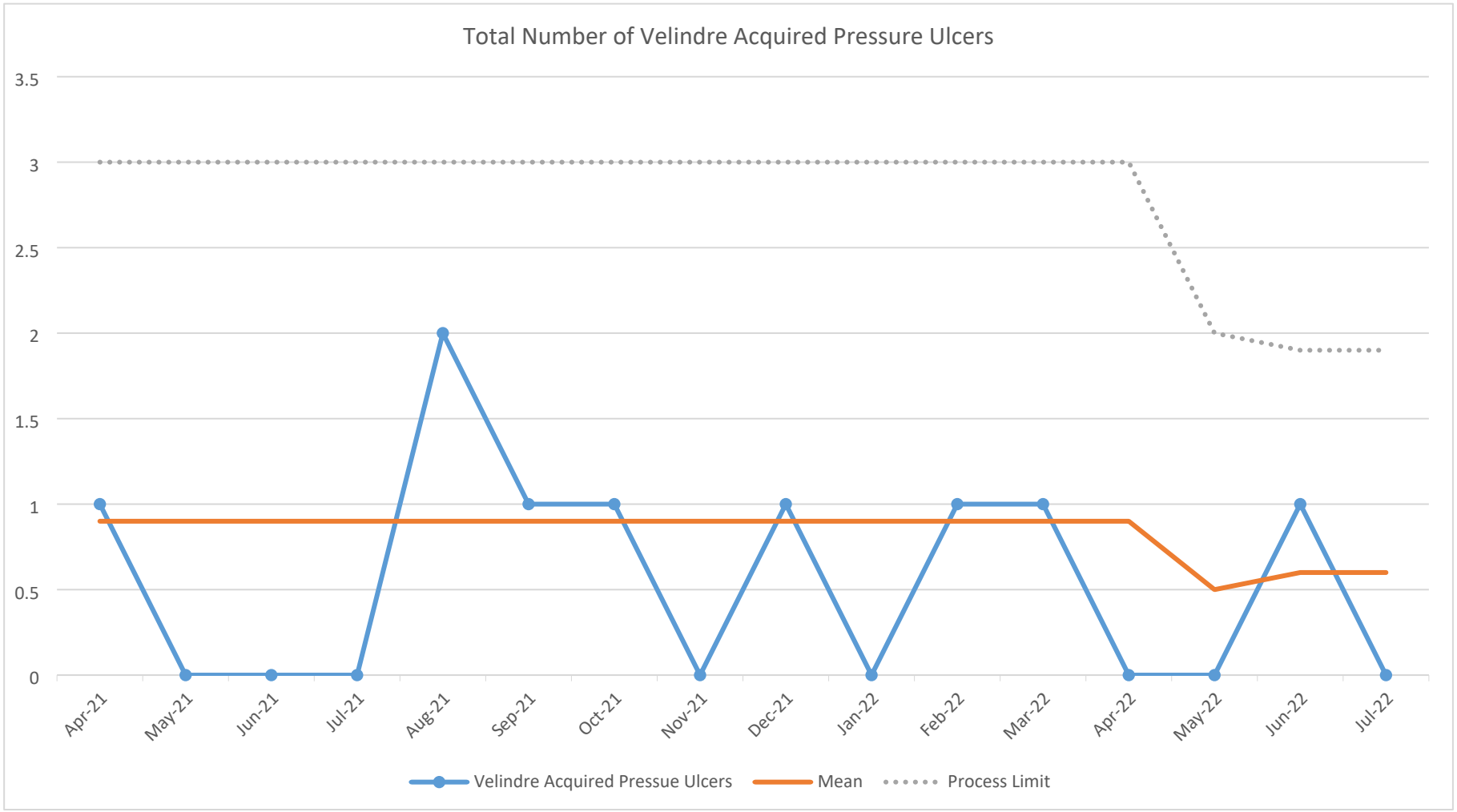
| | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dietetics | 94% | 98% | 97% | 100% | 95% | 98% | 100% | 98% | 100% | 100% | 100% | 100% |
| Physiotherapy | 100% | 100% | 100% | 100% | 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

| | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dietetics | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Physiotherapy | 100% | 100% | 100% | 100% | 100% | 86% | 100% | 100% | 100% | 100% | 100% | 100% |
| OT | 96% | 33% | 78% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 97% |
| SLT | 100% | 100% | 96% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 96% |

| | |
|---|---|
| Therapies had the following breaches:<br>• OT routine outpatients x 1 patient breach. 9 day delay, seen on day 39. Communication oversight within the team.<br>• SLT routine outpatients x 1 patient breach. 4 day delay, seen on day 34. Communication oversight within the team. | Actions:<br>Review processes for communication regarding appointments. |

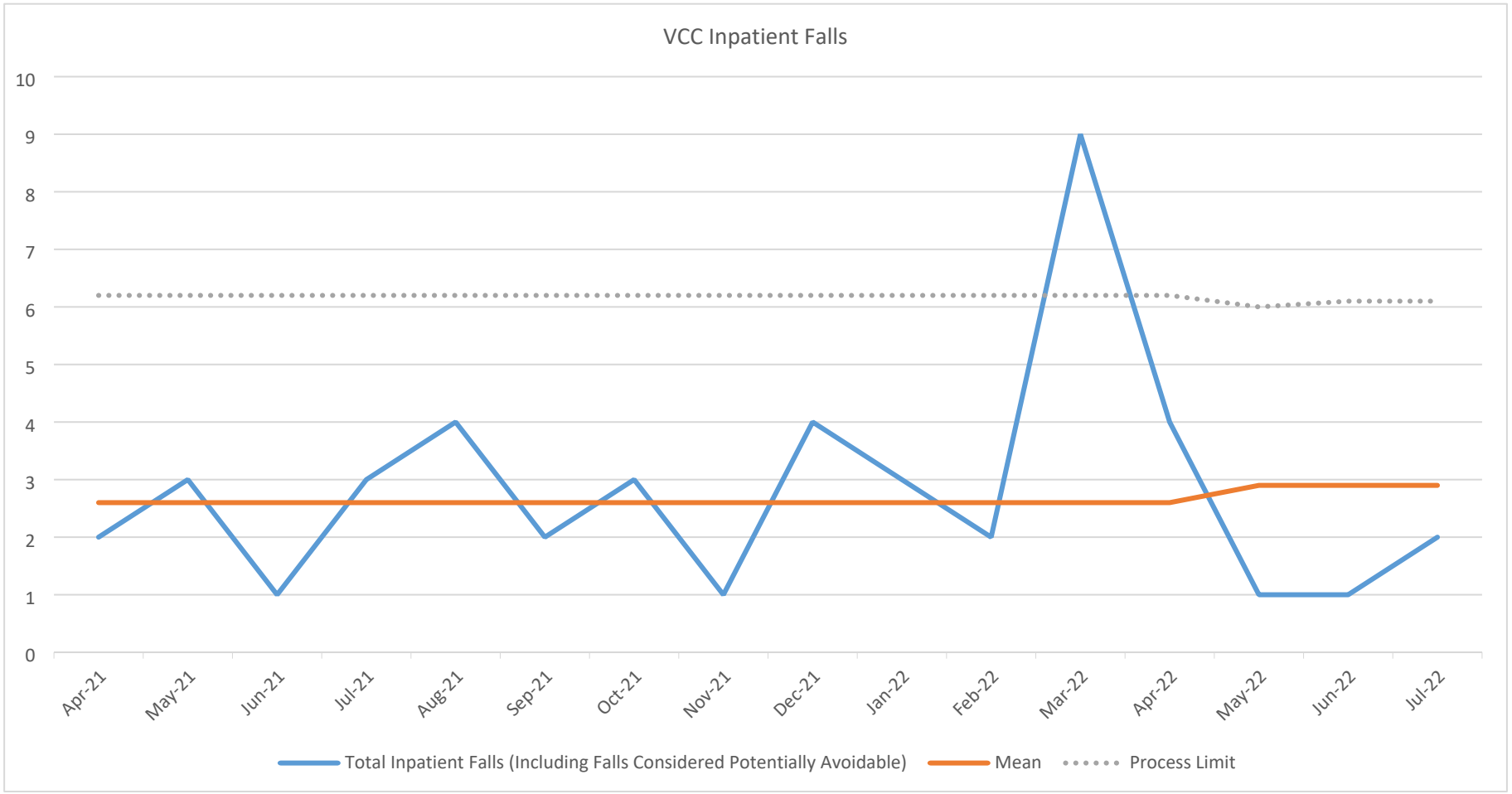
| Velindre Acquired Pressure Ulcers | |
|---|---|
| **Target: 0** | **SLT Lead: Head of Nursing** |
| Current Performance | |



| | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Velindre Acquired Pressure Ulcers (Total) | 1 | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 0 |
| Potentially Avoidable Velindre Acquired Pressure Ulcers | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 |

| Trend | Action |
|---|---|
| • During July 2022, there were 0 Velindre acquired pressure ulcers on first floor ward. | No specific action in month |

| Velindre Inpatient Falls | |
|---|---|
| **Target: 0** | **SLT Lead: Head of Nursing** |
| Current Performance | |



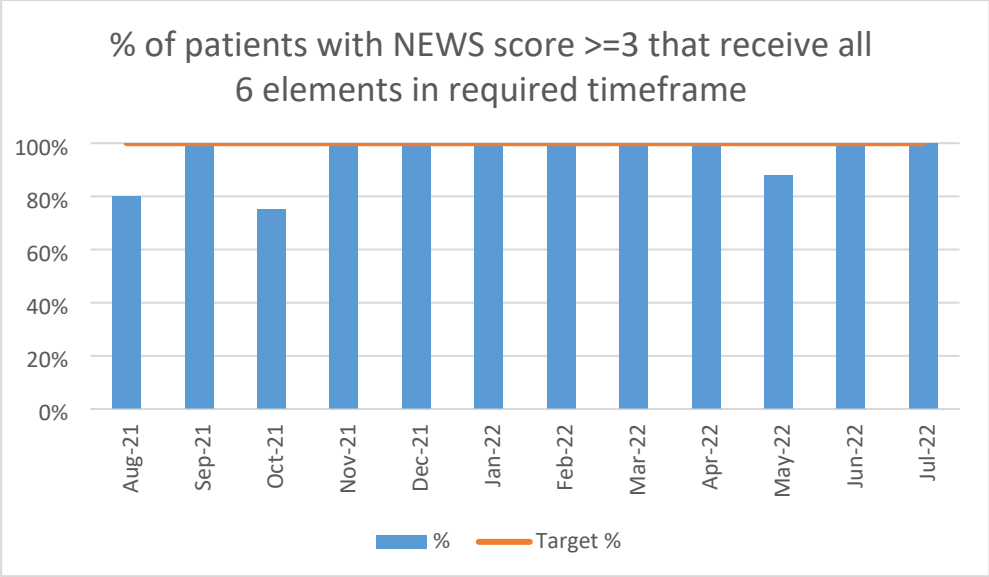
| | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov - 21 | Dec - 21 | Jan - 22 | Feb - 22 | Mar - 22 | Apr - 22 | May - 22 | Jun - 22 | Jul - 22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Inpatient Falls | 3 | 1 | 3 | 4 | 2 | 3 | 1 | 4 | 3 | 2 | 9 | 4 | 1 | 1 | 2 |
| Potentially Avoidable Inpatient Falls | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 2 |

| Trend | Action |
|---|---|
| Patient A – Falls risk assessment completed on admission and the patient was identified as a risk of falls. Patient did not have any cognitive impairment therefore deemed to have capacity. Patient mobilised without calling for assistance. Falls care pathway commenced. No injury sustained. Notably neuro observations were ceased on medical advice out with policy and this has been taken forward as a learning action for reinforcement of policy. **Outcome of scrutiny panel review: UNAVOIDABLE** because patient had capacity and attempted by himself to get out of bed and did not use the call bell that was available to him.<br><br>Patient B - Falls risk assessment completed on admission and patient deemed at risk of fall due to a previous syncopal episode on the ward. Call bell was in reach but not used by patient.<br>**Outcome from the scrutiny panel review: UNAVOIDABLE** because the patient got up without assistance and did not use the call bell to hand. | **Learning:**<br>• Staff to continue neuro observations as per falls policy regardless if medical staff suggest discontinuing early.<br>• Further, work to investigate if there is a correlation between falls when patients get out of bed and no longer using slipper socks (All Wales decision to stop using slipper socks). The outcome of this work will be reported back to the falls scrutiny panel.<br><br>• |

**Delayed Transfer of Care**

| Target: 0 | SLT Lead: Head of Nursing |
|---|---|
| Current Performance | |
| No Delayed Transfers of Care (DToC) were reported in July 2022. | |

| Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe | |
|---|---|
| **Target: 100%** | **SMT Lead: Clinical Director** |
| Current Performance | Trend |




**Measure 23 - % of patients who receive antimicrobial within 1 hour:**
= 14 patients met criteria for response to sepsis and all 14 received antibiotics within 1 hour where appropriate = 100%

**Measure 24 - % of patients who receive diagnosis of sepsis & all 6 elements within 1 hour**
= 6 patient received diagnosis of sepsis all 6 received all 6 elements within 1 hour = 100%

**% of patients who receive antimicrobial within VCC clinical guidelines** = 100%

**% of patients who receive correct investigations in accordance to VCC guidelines** = 100%

Actions

No improvement actions required.

| **Healthcare Acquired Infections (HAIs)** | |
|---|---|
| **Target: 0** | **SLT Lead: Clinical Director** |
| Current Performance | |

| | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C.diff | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 |
| 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 bacteremia | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 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 1 reported E.coli bacteremia in July 2022.<br>The root cause analysis and review by MDT identified it as bowel source probable malignant translocation. | No specific action required. |

# TRUST BOARD

# Velindre Cancer Service (VCS)
# Demand and Capacity Update for Radiotherapy and SACT

| | |
|---|---|
| **DATE OF MEETING** | 29/09/2022 |

| | |
|---|---|
| **PUBLIC OR PRIVATE REPORT** | Public |

| | |
|---|---|
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |

| | |
|---|---|
| **PREPARED BY** | LISA MILLER/WAYNE JENKINS |
| **PRESENTED BY** | Rachel Hennessy, Acting Director |
| **SMT SPONSOR APPROVED** | Cath O'Brien, Chief Operating Officer |

| | |
|---|---|
| **REPORT PURPOSE** | FOR DISCUSSION / REVIEW |

| **COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING** | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| Quality, Safety and Performance Committee | 15/09/2022 | DISCUSSED AND REVIEWED |

| **ACRONYMS** | |
|---|---|
| VCC | Velindre Cancer Centre |
| SACT | Systemic Anti-Cancer Therapy |

| | |
|---|---|
| RCC | Rutherford Cancer Centre |
| DHCR | Digital Health and Care Record |

## 1. SITUATION

1.1 Waiting times for patients obtaining a cancer diagnosis and receiving cancer treatment have been increasing across all Health Boards and Trusts in Wales as recovery from the COVID-19 Pandemic continues and recovery plans to reduce the backlog of patients are being delivered.

1.2 The Cancer Service has faced challenges in delivering timely SACT and radiotherapy treatments which have been impacted by limitations in capacity, growth and variation in demand, particularly following the loss of the opportunity to use the Rutherford Cancer Centre which had been a key part of the plan for the year. This has resulted in increases in waiting times for patients

## 2. BACKGROUND

### 2.1 Radiotherapy

Wales Cancer Network and Cancer Research UK have forecast an increase in demand for Radiotherapy services of 8% by the end of March 2023 from outturn at the end of March 2022. In year to July 2022, referrals for radiotherapy are up by 3%.Demand into the radiotherapy service has been fairly consistent in quarter 1 and 2 of 2022 at circa 97% of 2019/20 levels for the same period.

Capacity restrictions have been experienced as a result of increased sickness absence rates and the need for the newly qualified staff to take up the hard to fill specialist posts. Discussions are currently ongoing with HEIW in relation to understanding the number of vacancies, which will be filled from the new cohort of qualified student in September 2022. It is anticipated that there will remain a number of vacant post but this is under discussion and a clear picture should be available by the end of September. The service continues to use long-term agency staff in specialist areas to support capacity across pre-treatment, radiotherapy physics planning and treatment delivery. We are undertaking a recruitment campaign on an ongoing basis for the specialist post, but there are national shortages in these roles.

A Task and Finish group is focusing on improving patient flows and improving efficiency through new ways of working such as extended days and reviewing existing pathways, which should lead to increased capacity.

**Increase in Breast Referrals**

Within the overall position there has been a higher than anticipated increase in demand in breast referrals as a result of additional surgical treatment for breast cancer patients. As the number of referrals to VCC varies depending on the additional work being undertake this has led to increased pressure on radiotherapy.

This increase in demand for radiotherapy services for breast patients has coincided with the loss of additional capacity, which had been contracted from the Rutherford Cancer Centre (RCC) for breast treatment this financial year. This activity was lost as a result of the company going into administration in June 2022.

Constraints on Linac capacity for the relevant machines and treatment planning capacity to manage breast patients at VCC has also had an impact on breast cancer treatments, which in turn has impacted on the overall waiting times.

2.2 **SACT**

Wales Cancer Network and Cancer Research UK have forecast an increase in demand for SACT services of 12% by the end of March 2023 from outturn at the end of March 2022. Referrals for SACT have increased by 2% in year up to end of July.

Demand into the SACT service has been growing consistently and in quarter 1 and 2 of 2022 was at circa 108% of 2019/20 levels for the same period. The demand for oral SACT has increased circa 30% since 2019/20.This has presented significant challenges within the service to manage demand with the limits of its capacity.

A multi-disciplinary task and finish group has been working on a revised plan for the year to increase available capacity and compensate for the planned utilization of the Rutherford Cancer Centre. The task and finish group has been focused on building increased capacity at VCC and in outreach units whilst also continuing to work on improving efficiency through reviewing working practices and utilising other areas within VCC to deliver SACT treatments.

3.0 **ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION**

3.1 **Radiotherapy Recovery Plan**

Following the loss of the capacity, which was planned to be delivered in the Rutherford Cancer Centre, there has been a focus on developing a revised capacity plan to address the immediate future. The immediate changes which have been implemented are as follows:

- In order to increase activity within Radiotherapy, a phased extension of working hours of the LINAC has been taking place. This commenced in July and is due to reach maximum capacity in September/October 2022. However delivery of this model is subject to identifying additional treatment planning capacity and the recruitment of newly qualified trainees in September 2022

In addition the Task and finish group has been reviewing pathway issues where particular bottlenecks can be improved on to improve flow where planning may not be ready on time or where rescan or re-planning is required.

**3.3 Impact of Initiatives on waiting times**

Initial modelling identified that with extended working days, which supports increased activity on the LINAC machines, waiting time breaches should be minimized and mitigated from October 2022. The extended working days are being supported by staff working additional hours and temporary changes to working patterns (e.g. part time staff moving to full time on a temporary basis). The ability to deliver the extended hours by October 2022 is reliant on the contingent of newly qualified students being secured in to the vacancies during the month of September. As discussed earlier discussions are ongoing with HEIW to understand our allocation and it will be possible to provide more detail in the November Committee meeting.

However, further work is being developed to model the impact of both the implementation of the Digital Health and Care Record in November and the planned Linac replacement programme in the New Year and consider options for meeting demand and the Committee will be updated at its next meeting

**3.4 Risks to recovery plan**

- Delivery of extended working days and utilization of the LINAC capacity is subject to recruitment and identification of treatment planning capacity and recruitment to key posts by the end of September 2022.

## 4. SACT Recovery Plan

Detailed capacity planning has identified the requirement for a 12% increase in non-oral SACT treatment over the year to meet demand.

The work of the task and finish group has focused on delivering the following changes which will increase capacity:

| | Action | Start Date |
|---|---|---|
| 1. | Review of booking capacity, practices and processes, which concluded 20th July 2022 | 6th July 2022 |
| 2. | Utilisation of clinical trials unit to deliver SACT treatments on a regular basis | 1st August 2022 |
| 3. | Increased use of ambulatory care and outpatient treatment areas to deliver injectable or short regimens | 29th August 2022 |
| 4. | Establishing Saturday clinics to increase capacity which are planned to be in place until 29th October whilst other capacity is established. | 6th August 2022 |
| 5. | Changes to to the way in which presciptions are issued. This will release pharmacy staff to support additional SACT activity. | 8th August 2022 |
| 6. | An increase from 5 to 10 chairs in Prince Charles Hospital (PCH). | October 2022 (exact date to be confirmed) |

Note: Actions 1 to 5 have been fully implemented at the identified date.

### 4.1 Impact of Initiatives on waiting times

The initiatives introduced to date have had a positive impact on reducing the number of patients waiting longer than 21 days for patients waiting for non-emergency SACT. However, it is anticipated that re-instating the ten chairs at Prince Charles Hospital in October 2022 will provide the additional capacity needed to address the remaining backlog and ensure that patients will be seen within the required 21 days on a sustainable basis given current forecast demand.

### 4.2 Risks to Delivery of Recovery Model

- The ability to support the increase in chairs in Prince Charles Hospital is reliant on the newly appointed nursing being fully trained and introduction of the Organisational Change Process (OCP) undertaken in pharmacy.

- There are four nurses in total of which one has started, two will be in post by the 26th September, and the fourth will start in October. A training needs analysis will be undertaken as it is understood that they have previous experience and therefore training needs to be adapted appropriately. The nursing review will also be concluded by end of September. Together we will have a clear picture of the workforce available to support PCH

  The Pharmacy OCP concluded in September. Implementation of the OCP will change the working patterns of pharmacy staff (to routinely include Saturday and bank holidays and longer working days), which will support the proposed increase in treatments as part of this development. This should be fully implemented by the end of September 2022.

### 4.3 Next steps

There is ongoing work to further develop a sustainable SACT service for patients referred to the Velindre Cancer Service. This includes:

- Review being undertaken of nursing workforce capacity
- Pharmacy capacity review due to commence September 2022
- Further discussions have been held with Aneurin Bevan University Health Board and Neville Hall Hospital representatives to plan a return to that unit. These proposals are being developed at present.
- Review to determine which treatments can only be undertaken in the SACT assessment unit and which treatments can be undertaken elsewhere due to the fact they are less complex or are not a first treatment in which case they can attend the service provided in the Tenovus bus.

## 5.0 IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Yes (Please see detail below) |
| | |

| | |
|---|---|
| **RELATED HEALTHCARE STANDARD** | Timely Care |
| | Safe care<br>Staff and Resources<br>Individual care<br>Effective care |
| **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. |
| | |

## 6.0 RECOMMENDATION

The Trust Board is asked to:

- **NOTE** the developments established in respect of SACT and radiotherapy waiting times capacity and the planned impact of these plans on waiting times.

# Welsh Blood Service Monthly Report
# July 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

- The Welsh Blood Service continuously monitors the availability of blood for transfusion through its daily resilience group meetings and plans its collection model to meet demand. Whilst COVID related sickness continues to be challenging, during July, all clinical demand was met. Stock dropped below the 3 day benchmark on 6 occasions for the following priority blood groups, O- (13/07/2022, 18/07/2022, 19/07/2022, 21/07/2022, 22/07/2022) and O+ (19/07/2022, 20/07/2022) due to pressures on the blood supply chain. As a result, in July, the service received 97 units of mutual aid. Blue Alerts continued due to ongoing low stock levels for the O+ blood group, which were also extended to O- and A+ blood groups for periods in the month. WBS continues to work closely with blood banks across Wales and they have reduced their stockholding, which in turn, provides WBS with flexibility in managing the current situation. Demand in July averaged at 1480 units per week which was a reduction from June (1527). Daily emergency planning meetings have been convened by the WBS Director to consider the current challenges in meeting demand and to address stock recovery. It should be noted that all UK services are experiencing similar issues and a weekly UK Forum has been established to consider current challenges, mutual aid and shared learning across nations.

-The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 215 in July compared to 200 in June but is still below target. There were no university, college or sixth form sessions due to the end of the academic year. Coupled with a lower number of eligible (17-30 year old) bone marrow volunteers at community collection sessions, this has resulted in only a modest increase in bone marrow volunteers in July. The action plan to promote recruitment at universities, colleges and sixth forms on the return of students in September continues, along with profiling on social media and improving content and visibility on the WBS website. WBMDR staff are promoting bone marrow donor recruitment at national events. Alongside this, the team have issued a tender to work with an external company to develop a donor recruitment campaign and the production of promotional material. The expectation remains that increases in bone marrow donors will be evident once the campaign launches.

- Stem cell collections in Wales continue to be affected by the COVID pandemic which has impacted on unrelated donor stem cell transplants globally, resulting in lower stem cell collection requests. No stem cells were collected in July due to the one request being cancelled by the transplant centre, however, 8 requests for stem cell products were received for collection in August and September. The service has also 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 'work up' two donors simultaneously in order to ensure sufficient number of donors available at the required point of a patient's treatment . The five year strategy, currently in development, will reappraise the existing collection model and its ambition. The move to Velindre Cancer Centre (VCC) has enabled WBS to offer more options and additional capacity for collections going forward.

- In July, Reference Serology turn around performance reached its target of 80% for the first time this year. This is due, in part, to a concerted effort by senior staff to remove the backlog of reporting, which is not sustainable in the longer term. However, it is hoped that continued implementation of the findings of the recent 'Out of Hours Referrals' audit and the solutions outlined in the recent paper regarding service pressures will support maintaining target on an ongoing basis. The number of samples referred for July (269) continues to be to be high compared to the average of hospital patient referrals at 226/month for 2021 and 181/month in 2020.

- Platelet expiry did not reach target in July. This was due to an unpredicted drop in demand to 167 per week (against planned production of 215 per week). This months demand was lower again than May (216 units per week) and June (173 units per week). As the impact of production on supply is delayed by 2.5 days, any excess supply cannot be reduced as the excess is usually nearing expiry, and there is not a strong correlation between weekly issues to inform demand. Given the variability of expired platelets over the past 12 months, the service is carrying out a review to look at improving wastage rates. A platelet group has recently been established to look at improvements in wastage, apheresis clinic collection times and additonal areas for improvement. The work will include international bencharking and liaising with other blood services to see if any improvements in platelet planning can be made.

- The collection productivity rate dropped slightly from last month, however efficiency varies between teams (0.79% for Bangor to 1.21% for East B). Data analysis is being undertaken on Donor Non Attendance trends to identify if the efficiency can be improved by over booking of appointments or 'controlled walk ins' at carefully selected clinics. In addition, the 6 chair mobile units are scheduled to return to service from September following post COVID modifications and a review of individual venue capacity continues with a view to reintroducing 10 chair clinics across south and west Wales where possible. A revised training schedule is also in development to accelerate timescales for new staff to become fully trained/operational.

- 99% of Quality Incident Records were closed within 30 days (for the three month rolling period to July) against a target of 90%. The number of quality incidents not closed in the required timeframe decreased from 3 in the previous reporting period to 1, with performance for QPulse at 100% and 95% for Datix. The overdue Datix incident is now closed, but exceeded the 31-day closure requirement. This was a no harm event investigation which was awaiting closure from the incident owner. New reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The process will be revised to address the findings of the recent MHRA inspection.

- There was 1 Serious Adverse Event (SAE) reported to regulators during July: A Critical core temperature alarm limit was breached for a plasma freezer. The investigation determined that affected plasma was safe for transfusion. A full root cause analysis investigation has been undertaken and this incident added to the scenario-based training to ensure a correct response going forward.

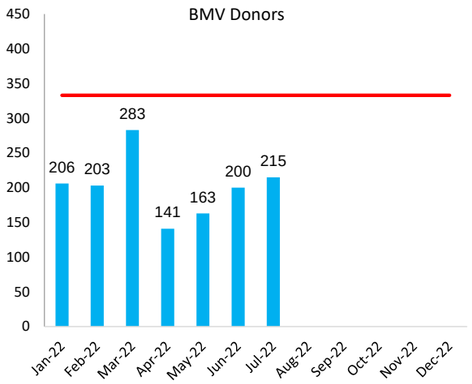
- In July 2022, 8,094 donors were registered at donation clinics. 4 concerns (0.05%) were reported within this period and were closed as early resolutions. The 2 concerns reported in June 2022, being managed under 30-day timeline, were resolved in July ahead of 30-day timeline and in line with the Putting Things Right (PTR) regulations. 541 new donors completed a donation in July, 7.59% of the total donations received in the month. At 96.0% donor satisfaction continued to be above target for July with 1,201 respondents to the donor survey.

## 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 |

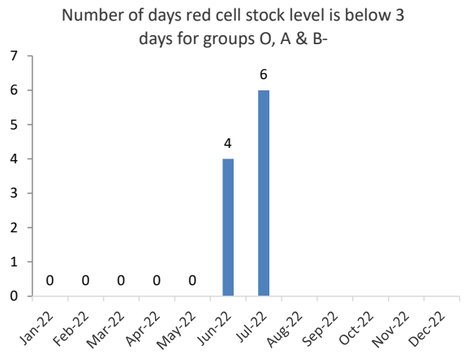
# Monthly Reporting

## Equitable and Timely Access to Services



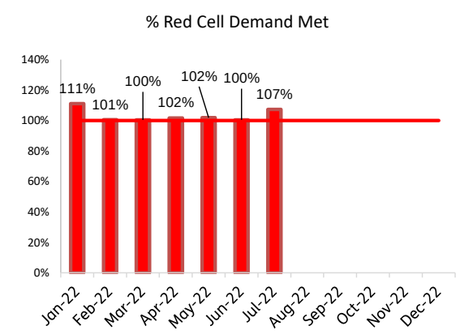

| Annual Target: 4000 (ave 333 per month) | SMT Lead: Jayne Davey / Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| The number of new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reached 215 in July compared to 200 in June, but is still below target.<br><br>There were no university, college or sixth form sessions due to the end of the academic year. Coupled with a lower number of eligible (17-30 year old) bone marrow volunteers at community collection sessions, this has resulted in only a modest increase in bone marrow volunteers in July. | The action plan to promote recruitment at universities, colleges and sixth forms on the return of students in September continues, along with profiling on social media and improving content and visibility on the WBS website.<br><br>WBMDR staff are promoting bone marrow donor recruitment at national events. Alongside this the team have issued a tender to work with an external company to develop a donor recruitment campaign and the production of promotional material. The expectation remains that increases in bone marrow donors will be evident from September onwards. | Quarter 3 |

## Safe and Reliable Service

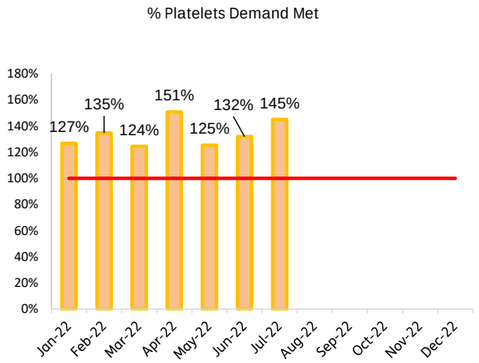



| Monthly Target: 0 | SMT Lead: Jayne Davey / Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| All clinical demand was met, however, during July total stock dropped below 3 days on 6 occasions (Group O). As a result, in July, the service received 97 units of mutual aid.<br><br>This measure is reviewed on a daily basis at resilience meetings and any concerns are escalated via WBS Senior Management Team (SMT) leads for immediate action.<br><br>Blue Alerts continued in July due to continued low stock levels for the O+ blood group, which was also extended to Blue Alerts on the O- and A + blood groups for periods in the month. | The WBS 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 includes the Collections, Manufacturing, Distribution and Blood Health Teams.<br><br>At the meetings, business intelligence data is 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.<br><br>There were three Blue Alert updates to NHS Wales.<br><br>Daily Emergency Planning meetings have been convened by WBS Director to consider the current challenges in meeting demand and to address stock recovery. | Reviewed daily to support responses to changes in demand |

## Safe and Reliable service

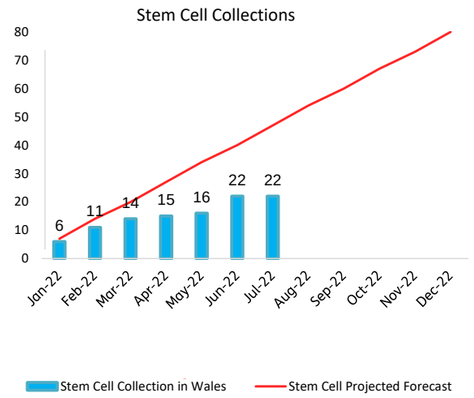



| Monthly Target: 100% | SMT Lead: Jayne Davey/ Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Actions(s) being taken to improve performance** | **By When** |
| All hospital demand for red cells was met.<br><br>Stock management continues to be closely monitored and discussed at daily resilience meetings with immediate escalation to SMT if required.<br><br>Demand in July (full weeks) averaged at 1480 units per week which was a reduction from June. | 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 includes the Collections, Manufacturing, Distribution and Blood Health Teams.<br><br>Daily Emergency Planning meetings have been convened by WBS Director to consider the current challenges in meeting demand and to address stock recovery. | Reviewed daily to support responses to changes in demand |



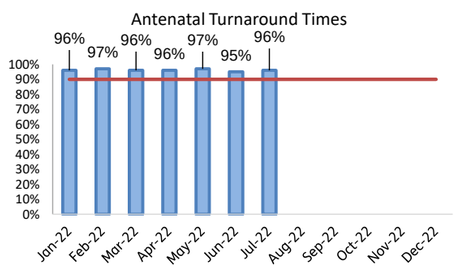

## Safe and Reliable service

| 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.<br><br>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.<br><br>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.<br><br>For July, platelet demand was 167 units per week on average - this is an unpredicted reduction from May (216) and June (173) issuing.<br><br>A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets. | The Ambient Overnight Hold (AONH) production process continues to allow flexibility in the production plan for platelets. Adjustments (i.e. increased production) on the weekly targets can to be made to align with increased demand. | Reviewed daily |




## Safe and Reliable service

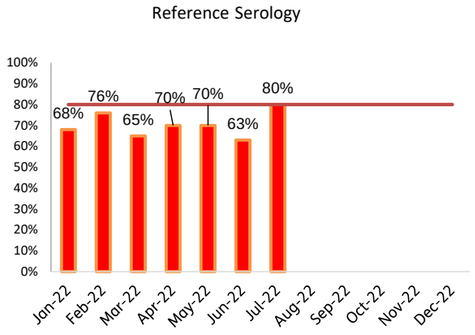
| Annual Target: 80 (ave 7 per month) | SMT Lead: Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| The pandemic has impacted on unrelated donor stem cell transplants globally, which has reduced the number of stem cell collection requests. In addition, the Service continues to experience a cancellation rate of around 30% compared to 15% pre COVID pandemic levels.<br><br>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.<br><br>No stem cells were collected in July due to the one request being cancelled by the transplant centre.<br><br>Eight requests for stem cell products were received in July, due for collection in August and September. | The five year strategy, currently in development, will reappraise the existing collection model and its ambition.<br><br>The move to Velindre Cancer Centre (VCC) has enabled WBS to offer more options and additional capacity for collections going forward. | Action plan monitored monthly |




## Safe and Reliable service

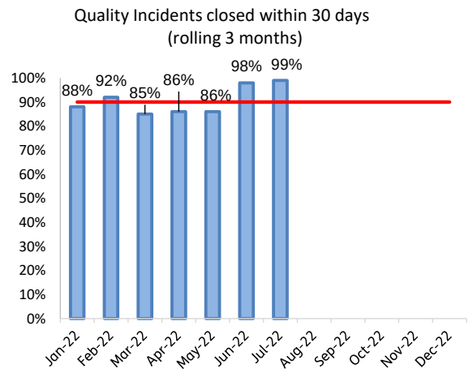
| Monthly Target: 90% | SMT Lead: Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| At 96%, the turnaround time for routine Antenatal tests in July remains above the target of 90%. | Efficient and embedded testing systems are in place.<br><br>Continued monitoring and active management remains in place, maintaining high performance against current target. | Business as Usual, reviewed daily |

## Safe and Reliable service

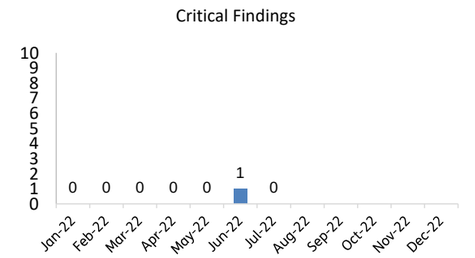



| Monthly Target: 80% | SMT Lead: Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| The Service conducts specialist tests to confirm hospital results that are difficult to interpret or will undertake additional 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.<br><br>Turnaround performance reached target at 80% for July for the first time this year. This is due, in part, to a concerted effort by senior staff to remove the backlog of reporting, which is not sustainable in the longer term. However, it is hoped that continued implementation of actions from the recent paper outlining service pressures will support maintaining the target on an ongoing basis.<br><br>The number of samples referred for July (269) continues to be to be high compared to the average of hospital patient referrals at 226/month for 2021 and 181/month in 2020.<br><br>Work continues to be prioritised based on clinical need, and all compatibility testing is completed to the required time/date. | The Service continues to prioritise compatibility referrals and safe provision of red cells for transfusion. All referrals are prioritised based on clinical need.<br><br>The findings of the recent 'Out of Hours Referrals' audit are being implemented. In addition, the solutions outlined in the recent paper regarding service pressures are also being implemented with a view to improving the performance in the short, medium and long term.<br><br>Validation the new automated analyser, which will improve efficiency, remains on schedule to be completed in the Autumn. | Quarter 3 |

## Safe and Reliable service



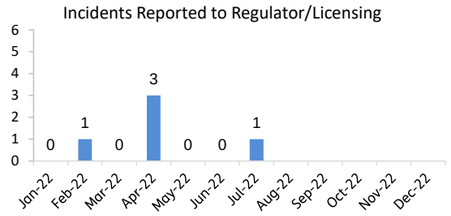

| Monthly Target: 90% | SMT Lead: Peter Richardson | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| At 99% the performance has met target (90%) for the three-month rolling period to July. The number of quality incidents not closed in the required timeframe decreased from 3 in the previous reporting period to 1 (0 QPulse and 1 Datix).<br><br>Performance for incidents reported via QPulse is at 100% and 95% for Datix.<br><br>The overdue Datix incident is now closed, but exceeded the 31-day closure requirement. On investigation this was a no harm event which was awaiting closure.<br><br>All QPulse incidents have been risk assessed, investigated and closed. QPulse does not permit closure of the report until all CAPA are completed. | New reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The process will be revised to address the findings of the recent MHRA inspection, i.e. to update the WBS incident management process and ensure that all low and moderate risk incidents have root cause assigned.<br><br>The QA team continue to send weekly updates alerting owners of incidents recorded within QPulse that are likely to breach close-out deadlines with progress of actions to address these incidents closely monitored. | Continue with close monitoring and early recognition of potential timeline breaches. |




## Safe and Reliable service

| Target: 0 | SMT Lead: Peter Richardson | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| There were no external audits undertaken during July. | A formal response to the findings from the MHRA regulatory inspection undertaken in June was submitted and has been reviewed by MHRA . The inspectors have requested further information for three of the proposed actions; these are being addressed following discussion with the Head of QA&RC. | The response to the request for further information is due by 04/08/2022.<br><br>Completion of all action plans for external audits is monitored via the monthly RAGG meeting. |

## Safe and Reliable service

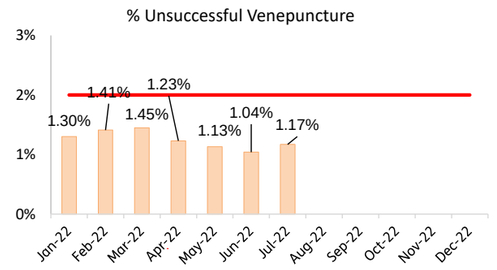



| Annual Target: 0 | SMT Lead: Peter Richardson | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| There was one Serious Adverse Event (SAE) reported to regulators during July.<br><br>Critical core temperature alarm limit was breached for a plasma freezer. The investigation determined that affected plasma was safe for transfusion. | A full root cause analysis investigation has been undertaken and this incident added to the scenario-based training to ensure a correct response going forward. | Preventive actions due for completion 31/08/2022 |

## Spending Every Pound Well

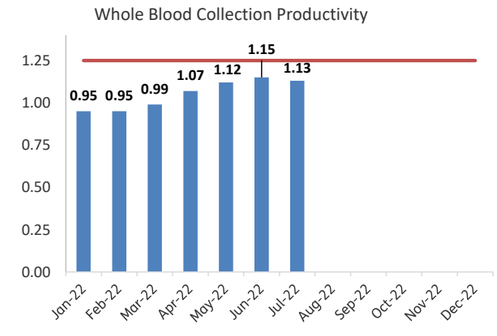

| Monthly Target: Maximum 3% | SMT Lead: Janet Birchall | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| The All Wales combined 'Part Bag' rate for whole blood teams remains within the required tolerance level (3%) at 2.09% during July 2022.<br><br>Analysis of the part bag rates shows no individual team breaches for July 2022.<br><br>Causes of Part Bags are various (needle placement, clinical risk, donor is unwell, donor request to stop donation, late donor information and equipment failure) and at times cessation of donation resulting in a part bag is clinically appropriate. This is a separate factor to Failed Venepuncture (FVPs). | Continue to monitor trend analysis - escalate to Collections if required. | Continued close monitoring and intervention where required |

## Spending Every Pound Well

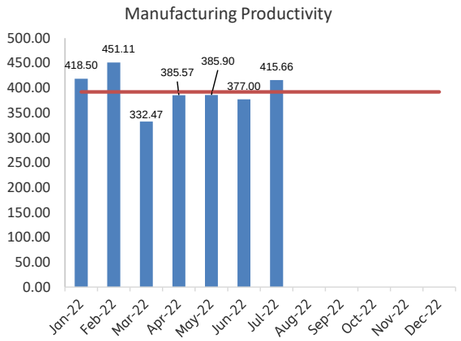



| Monthly Target: Maximum 2% | SMT Lead: Janet Birchall | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| The All Wales combined Failed Venepuncture (FVP) rate for all whole blood teams for July 2022 remains within the required tolerance (2%) at 1.17%.<br><br>Analysis of the FVP rates shows no individual team breaches for July 2022. | Continue to monitor trend analysis - escalate to Collections if required. | Continue with close monitoring and intervention where required |

## Spending Every Pound Well

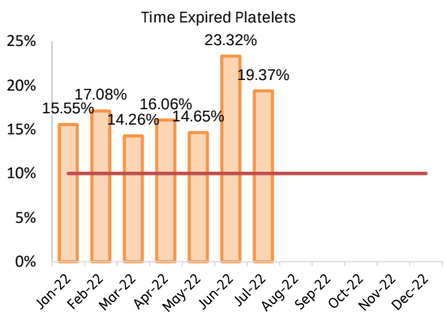



| Monthly Target: 1.25 | SMT Lead: Jayne Davey | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| The collection productivity rate dropped slightly from last month, however efficiency varies between teams (0.79% for Bangor to 1.21% for East B). | Data analysis is being undertaken on Donor Non Attendance trends to identify if the resulting gap can be mitigated by over booking of appointments or 'controlled walk ins' at carefully selected clinics. The 6 chair mobile units are scheduled to return to service from September following post COVID modifications and a review of individual venue capacity continues with a view to reintroducing 10 chair clinics across south and west Wales where possible. A revised training schedule is also in development to accelerate timescales for new staff to become fully trained/operational. | Quarter 2 |



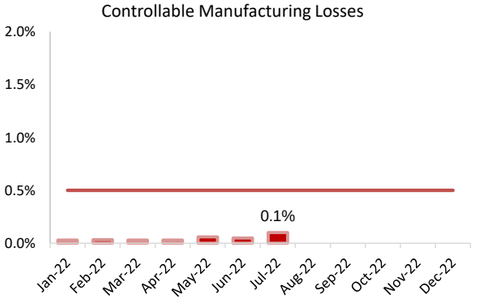

## Spending Every Pound Well

| Monthly Target 392 | SMT Lead: Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Actions(s) bring taken to improve performance** | **By When** |
| At 416 the Manufacturing Efficiency reading for July is higher than June but still close to the 392 benchmark target level.<br><br>The higher value will be reflective of increased collection activity particularly towards the end of July and emphasis on FFP and Cryoprecipitate production to support the provision of Hepatitis B core tested products to Welsh hospitals. There were no significant changes in staffing.<br><br>NB. This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department. | This target is based on the Pre COVID operating model and is due to be reviewed as part of the ongoing development of the reporting framework. | Quarter 2 |




## Spending Every Pound Well

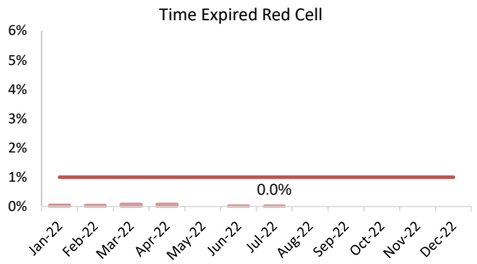
| Monthly Target: Maximum 10% | SMT Lead: Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| Platelet expiry did not reach target in July. This was due to an unpredicted drop in demand to 167 per week (against planned production of 215 per week). This months demand was lower again than May (216 units per week) and June (173 units per week).<br><br>However, the figure for July did reduce from June figure, which was cnsiderably higher due to requirement to increase production prior to Jubilee bank holiday in order to build stock.<br><br>As the impact of production on supply is delayed by 2.5 days, any excess supply cannot be reduced as the excess is usually nearing expiry, and there is not a strong correlation between weekly issues to inform demand.<br><br>Production is on a flat weekly rate taking into account the average expected issues and the standard deviation of those issues. Therefore decreasing production will reduce waste but increase the probability of shortage, which in turn may create a need to rely on mutual aid support.<br><br>NB: All demand continues to be met without the need to rely on any mutual aid support. | 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.<br><br>The introduction of Ambient Overnight Hold process for the manufacturing of blood components has increased flexibility in production of pooled platelets.<br><br>Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs.<br><br>Adjustments to the platelet manufacturing targets can be 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.<br><br>Given the variability of expired platelets over the past 12 months, the service is carrying out a review to look at improving wastage rates.<br><br>A platelet group has recently been established to look at improvements in wastage, aphesis clinic collection times and additonal areas for improvement. The work will include international bencharking and liaising with other blood services to see if any improvements in platelet planning can be made. | Ongoing and reviewed daily<br><br>Quarter 3 |




## Spending Every Pound Well

| Monthly Target: Maximum 0.5% | SMT Lead: Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| Controllable losses were extremely low at <0.1% and remain within tolerance of below 0.5%.<br><br>The losses were (units):<br><br>M&D Heat sealer : 2 units<br>M&D Operator - Automated Blood Press : 1 unit<br><br>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.<br><br>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



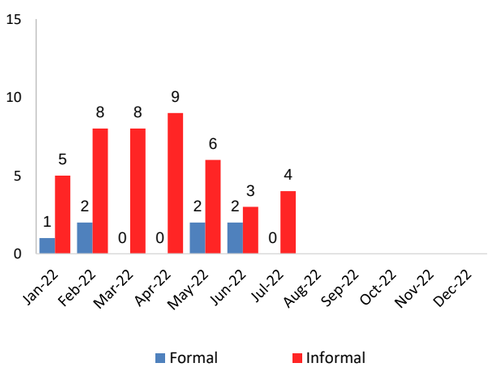

| Monthly Target: Maximum 1% | SMT Lead: Tracey Rees | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| Red cell expiry was 0.01%.<br><br>COVID challenges continue to affect the blood collection numbers resulting in faster stock turnover preventing red cells stocks from ageing in storage.<br><br>This metric remains 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.<br><br>Red Cell Shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly.<br><br>Continued effective management of blood stocks to minimise the number of wasted units. | Business as usual, reviewed daily |

## First Class Donor Experience




| Monthly Target: Minimum 71% | SMT Lead: Jayne Davey | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| At 96.0% donor satisfaction continues to be above target for July.<br><br>In total there were 1,201 respondents to the donor survey (some of which are non attributable), 222 from north Wales, and 962 from south Wales where location was able to be defined. | Findings are reported to the Senior Management Team (SMT) at the Collections meeting to address any actions for individual teams. | Business as usual, reviewed monthly |

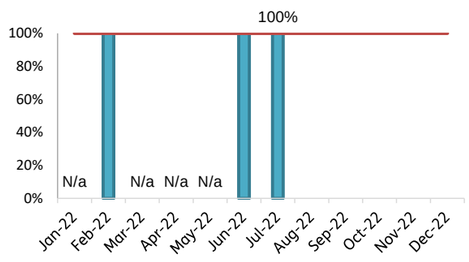
## First Class Donor Experience




| Target: N/A | SMT Lead: Alan Prosser | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| In July 2022, 8,094 donors were registered at donation clinics. Four concerns (0.05%) were reported within this period and were closed as early resolutions.<br><br>The two concerns reported in June, being managed under 30-day timeline, were resolved in the month of July ahead of 30-day timeline, under the Putting Things Right regulations (PTR).<br><br>1. Complainant raised concerns around the positioning of the clinic screening booths and trailing electrical cables whilst visiting the donation venue for a non-donation related event. resulting in the potential breach of confidential and trip hazard.<br><br>2. Donor unhappy he has active deferral on his record due to a technical glitch in the WBS computer system.<br><br>3. Donor unhappy to be turned away from session for being late for appointment.<br><br>4. Donor and his wife were unhappy they were turned away from the donation session due to their age. | Individual concerns have been addressed by Heads of Departments and / or Operational Managers. Where donors were unable to be reached, messages inviting the donor to return the calls were left.<br>The two concerns received in June 2022, were closed in July 2022, ahead of the PTR 30-day timeline.<br><br>All early resolution concerns have been closed to donor satisfaction within the required timescales.<br><br>1. Operational Manager has reviewed complainants concerns and as a result is developing a new master venue layout plan, to ensure the reconfiguration of screening area.<br><br>2. Specialist Nurse in Donor Care in collaboration with the IT department have ensured donor a configuration update is planned for the 21st of August 2022.<br><br>3. Operational Manager discussed concern with donor, who admitted he was 15 minutes later and not the 5 minutes he had originally declared. Operational Manager explained the donor's appointment ran into the team's lunch time so were unable to accept him. Donor was offered alternative appointment after lunch but was unable to accept. Donor appreciated call back and has since booked another appointment.<br><br>4. WBS Medical Director has reviewed donors' complaint and as a result the donor and his wife are now able to donate. An updated process is in place to actively identify and contact donors from the age of 69.5 who are not regular donors to make them aware of the donation guidelines for the age group. | Business as usual, reviewed daily |

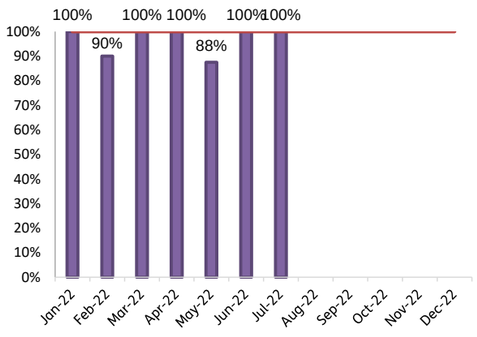
## First Class Donor Experience

% Responses to Concerns within 30 Working Days




| Monthly Target: 100% | SMT Lead: Alan Prosser | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| Two formal concerns received in June, one due to be completed in July and the other in August, were closed ahead of the 30 day timeline under 'Putting Things Right' (PTR) guidelines.<br><br>* Under PTR guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods. | Continue to monitor formal complaint response progress, and 30 day target compliance. | Business as Usual |

% Concerns Acknowledged within 2 Working Days




| Monthly Target: 100% | SMT Lead: Alan Prosser | |
|---|---|---|
| **What are the reasons for performance?** | **Action(s) being taken to improve performance** | **By When** |
| All concerns received in July 2022 were managed within 2 working days as required by PTR regulations. | Continue to monitor this measure against the 'two working day' target compliance.<br><br>Timescale requirements communicated to all involved in concerns management. | Ongoing, reviewed daily |

Canolfan Ganser Felindre
Velindre Cancer Centre

# Workforce Monthly Report

## July 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

**Workforce Report provides the following:**

- Overview of Key Performance Indictors for Sickness, PADR, Statutory and Mandatory training in all Divisions of the Trust, including Corporate Divisions, TCS and Research and Development (excluding hosted);
- Corporate Divisions include Finance, Workforce and OD, Corporate Estates and Planning, Corporate IT, Clinical Governance, Infection Control, Fundraising and Trust Management and Board;
- The report provides a 12 monthly trend report for Sickness, 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 |
|---|---|---|---|
| | Jul-22 | Jun-22 | |
| PADR | 69.29 | 69.81 | 85% |
| | | | |
| Sickness | 6.51 | 6.42 | 3.54% |
| | | | |
| S&M Compliance | 85.27 | 86.20 | 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 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
| Corporate | 48.33 | 50.43 | 45.69 | 46.58 | 44.59 | 45.64 | 44.08 | 50.33 | 53.02 | 51.01 | 53.38 | 54.05 | 52.74 |
| Research, Development & Innovation | 61.70 | 65.96 | 66.67 | 72.09 | 90.91 | 88.37 | 84.09 | 80.00 | 60.87 | 60.98 | 64.29 | 56.10 | 57.14 |
| Transforming Cancer Services | 66.67 | 60.00 | 56.25 | 43.75 | 62.50 | 75.00 | 63.16 | 57.89 | 57.14 | 57.89 | 55.00 | 52.38 | 65.22 |
| Velindre Cancer Centre | 74.31 | 75.17 | 76.40 | 73.77 | 70.90 | 67.61 | 65.16 | 65.25 | 63.56 | 68.69 | 68.62 | 69.04 | 71.30 |
| Welsh Blood Service | 79.78 | 78.27 | 77.93 | 77.52 | 82.19 | 83.06 | 83.73 | 81..75 | 78.44 | 78.16 | 79.26 | 77.53 | 76.90 |
| Velindre Organisations | 73.28 | 73.58 | 73.67 | 71.69 | 72.11 | 70.83 | 69.21 | 69.75 | 66.86 | 69.24 | 69.81 | 69.29 | 70.45 |
| 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) | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
| Corporate | 69.26 | 70.45 | 71.36 | 74.54 | 72.32 | 74.40 | 72.17 | 73.64 | 74.51 | 73.48 | 74.31 | 74.41 | 73.06 |
| Research, Development & Innovation | 86.00 | 85.80 | 86.25 | 84.89 | 84.58 | 85.83 | 84.26 | 80.42 | 80.21 | 80.23 | 79.56 | 82.95 | 81.09 |
| Transforming Cancer Services | 76.84 | 85.26 | 82.50 | 82.86 | 83.33 | 81.43 | 77.86 | 77.39 | 77.39 | 78.64 | 80.91 | 76.96 | 75.65 |
| Velindre Cancer Centre | 82.70 | 83.16 | 82.89 | 83.11 | 84.91 | 84.93 | 84.73 | 84.18 | 84.88 | 85.17 | 85.46 | 85.22 | 84.68 |
| Welsh Blood Service | 93.38 | 92.66 | 92.21 | 92.54 | 93.36 | 93.56 | 93.78 | 92.02 | 92.30 | 92.19 | 92.44 | 93.17 | 91.72 |
| Velindre Organisations | 84.97 | 85.24 | 84.95 | 85.10 | 86.06 | 86.40 | 85.97 | 85.26 | 85.77 | 85.76 | 85.08 | 86.20 | 85.27 |

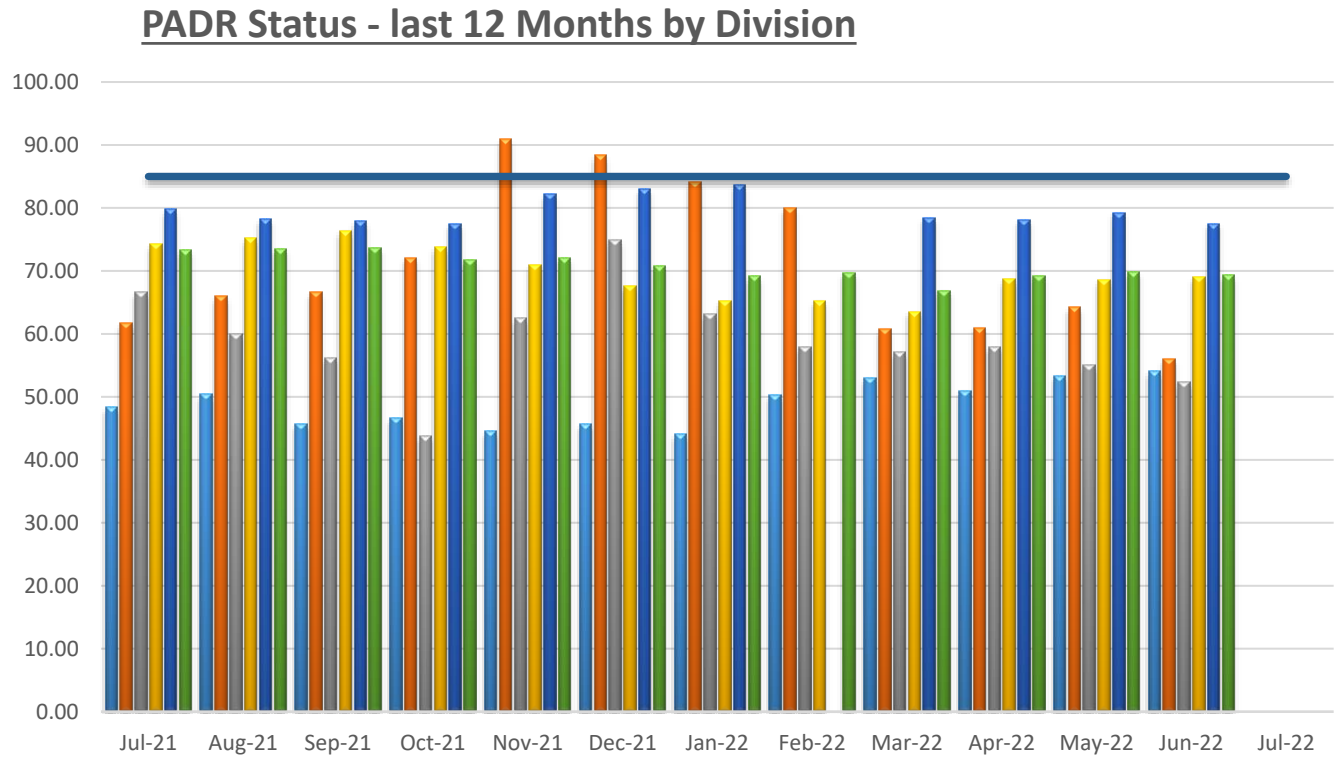
| Key | 0% - 3.54% | | 3.55% - 4.49% | | 4.5 % & Above | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sickness Rolling % | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
| Corporate | 4.64 | 4.49 | 4.58 | 4.68 | 5.01 | 5.34 | 5.48 | 5.53 | 5.56 | 5.63 | 5.59 | 5.36 | 5.22 |
| Research, Development & Innovation | 3.34 | 3.55 | 3.96 | 4.29 | 4.41 | 4.31 | 4.51 | 4.81 | 5.41 | 6.24 | 6.86 | 7.30 | 7.30 |
| Transforming Cancer Services | 0.32 | 0.33 | 0.41 | 0.86 | 1.29 | 1.01 | 0.98 | 1.05 | 1.10 | 1.24 | 1.25 | 1.22 | 1.18 |
| Velindre Cancer Centre | 5.47 | 5.47 | 5.52 | 5.57 | 5.63 | 5.51 | 5.56 | 5.63 | 5.92 | 6.16 | 6.24 | 6.30 | 6.40 |
| Welsh Blood Service | 4.82 | 5.11 | 5.42 | 5.73 | 5.99 | 6.27 | 6.45 | 6.53 | 6.80 | 7.06 | 7.06 | 7.20 | 7.41 |
| Velindre Organisations | 5.05 | 5.13 | 5.28 | 5.43 | 5.58 | 5.63 | 5.73 | 5.81 | 6.07 | 6.31 | 6.36 | 6.42 | 6.51 |
| Target 3.54% | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 | 3.54 |

| Monthly Sickness Rolling Covid Only Absence % | 0.00 | | 0.01% - 0.49% | | 0.50 % & Above | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sickness Leave Covid Related | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
| Corporate | 0.99 | 1.16 | 1.34 | 1.46 | 1.57 | 1.64 | 1.71 | 1.73 | 1.69 | 1.66 | 1.63 | 1.57 | 1.54 |
| Research, Development & Innovation | 0.45 | 0.43 | 0.43 | 0.43 | 0.53 | 0.66 | 0.87 | 1.08 | 1.33 | 1.59 | 1.68 | 1.96 | 2.21 |
| Transforming Cancer Services | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.01 | 0.01 | 0.01 | 0.01 |
| Velindre Cancer Centre | 0.87 | 0.88 | 0.85 | 0.86 | 0.84 | 0.73 | 0.82 | 0.89 | 1.07 | 1.17 | 1.17 | 1.23 | 1.32 |
| Welsh Blood Service | 0.29 | 0.29 | 0.36 | 0.39 | 0.38 | 0.36 | 0.38 | 0.42 | 0.60 | 0.79 | 0.85 | 0.93 | 1.13 |
| Velindre Organisations | 0.67 | 0.69 | 0.72 | 0.75 | 0.74 | 0.70 | 0.77 | 0.83 | 0.98 | 1.10 | 1.12 | 1.18 | 1.30 |

| Monthly Special Leave Absence Rolling % | 0.00 | | 0.01% - 0.49% | | 0.50 % & Above | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Special Leave Non Covid Related | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
| Corporate | 0.06 | 0.05 | 0.03 | 0.09 | 0.09 | 0.09 | 0.09 | 0.10 | 0.10 | 0.12 | 0.13 | 0.15 | 0.13 |
| Research, Development & Innovation | 0.60 | 0.74 | 0.92 | 1.08 | 1.25 | 1.37 | 1.57 | 1.62 | 1.69 | 1.89 | 1.89 | 1.81 | 1.74 |
| Transforming Cancer Services | 0.53 | 0.56 | 0.55 | 0.54 | 0.41 | 0.25 | 0.08 | 0.07 | 0.07 | 0.07 | 0.07 | 0.06 | 0.05 |
| Velindre Cancer Centre | 0.43 | 0.46 | 0.48 | 0.53 | 0.57 | 0.61 | 0.66 | 0.67 | 0.73 | 0.79 | 0.79 | 0.80 | 0.79 |
| Welsh Blood Service | 0.57 | 0.58 | 0.59 | 0.59 | 0.58 | 0.56 | 0.53 | 0.51 | 0.49 | 0.50 | 0.48 | 0.47 | 0.43 |
| Velindre Organisations | 0.45 | 0.47 | 0.49 | 0.53 | 0.55 | 0.56 | 0.58 | 0.59 | 0.61 | 0.65 | 0.65 | 0.65 | 0.63 |

| Monthly Special Leave Absence Rolling % | 0.00 | | 0.01% - 0.49% | | 0.50 % & Above | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Special Leave Covid Related | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
| Corporate | 0.11 | 0.03 | 0.01 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.02 | 0.02 | 0.05 | 0.07 | 0.08 |
| Research, Development & Innovation | 0.21 | 0.13 | 0.13 | 0.15 | 0.10 | 0.15 | 0.20 | 0.20 | 0.21 | 0.30 | 0.30 | 0.30 | 0.31 |
| Transforming Cancer Services | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Velindre Cancer Centre | 0.90 | 0.70 | 0.69 | 0.71 | 0.64 | 0.65 | 0.70 | 0.69 | 0.75 | 0.83 | 0.85 | 0.88 | 0.90 |
| Welsh Blood Service | 0.68 | 0.62 | 0.67 | 0.67 | 0.68 | 0.65 | 0.63 | 0.61 | 0.59 | 0.63 | 0.69 | 0.69 | 0.68 |
| Velindre Organisations | 0.72 | 0.58 | 0.59 | 0.60 | 0.56 | 0.56 | 0.58 | 0.57 | 0.60 | 0.65 | 0.68 | 0.70 | 0.71 |

## PADR – The Figures




| | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 48.33 | 50.43 | 45.69 | 46.58 | 44.59 | 45.64 | 44.08 | 50.33 | 53.02 | 51.01 | 53.38 | 54.05 | |
| Research, Development & Innovation | 61.70 | 65.96 | 66.67 | 72.09 | 90.91 | 88.37 | 84.09 | 80.00 | 60.87 | 60.98 | 64.29 | 56.10 | |
| Transforming Cancer Services | 66.67 | 60.00 | 56.25 | 43.75 | 62.50 | 75.00 | 63.16 | 57.89 | 57.14 | 57.89 | 55.00 | 52.38 | |
| Velindre Cancer Centre | 74.31 | 75.17 | 76.40 | 73.77 | 70.90 | 67.61 | 65.16 | 65.25 | 63.56 | 68.69 | 68.62 | 69.04 | |
| Welsh Blood Service | 79.78 | 78.27 | 77.93 | 77.52 | 82.19 | 83.06 | 83.73 | 0.00 | 78.44 | 78.16 | 79.26 | 77.53 | |
| Velindre Organisations | 73.28 | 73.58 | 73.67 | 71.69 | 72.11 | 70.83 | 69.21 | 69.75 | 66.86 | 69.24 | 69.81 | 69.29 | |
| 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 | June Figure | Hotspot Areas | % | Comment |
|---|---|---|---|---|---|
| **PADR Compliance (85%)** | **70.45%** ↑ | 69.29% | **Welsh Blood Service (76.90%)** | | |
| | | | Directors | 25.00 | No change from last month |
| | | | Quality Assurance | 55.81 | Decrease on last month of 64.29% |
| | | | General Section | 62.96 | Increase on last month 74.07% |
| | | | **Velindre Cancer Centre (71.30%)** | | |
| | | | Cancer Services Management Officer | 26.92 | Decrease on previous month 30.77% |
| | | | Medical Staffing | 60.94 | Increase from previous 54.84% |
| | | | Outpatients | 50.00 | Decrease from previous month 61.11% |
| | | | Psychology | 40.00 | New hotspot |
| | | | **Corporate Areas (58.37%)** | | |
| | | | Finance – Management Accounting | 28 | Decrease from previous month 33.46% |
| | | | Fundraising | 0.00 | Same as previous month<br>PADR conversations all complete and ESR team have supported management to being the inputting of these conversations into ESR. |
| | | | Corporate Management Section | 40 | Decrease on previous month 42.86% |
| | | | Clinical Governance Section | 14.29 | New Hotspot |

**Action/reasons/initiatives:**

**<u>Velindre University NHS Trust</u>**

Senior Business Partners continue to support the leadership teams in improving PADR targets across the Trust however the growth is slow given the complex operational priorities ongoing currently. WOD Department are in the process of developing an effective people management training framework that will be available to all managers and which will include the importance of PADR's and how to undertake a successful PADR.

The NHS Wales Pay Progression Policy will come into effect in October 2022, Comms will be send to all staff in September 2022 and a targeted training approach based on those impacted soonest will take place by the ESR tea,

**Welsh Blood Service**

PADR compliance continues to steadily grow month on month in WBS, although still reporting below target, managers are working around operational pressures to progress these conversations.

**VCC**

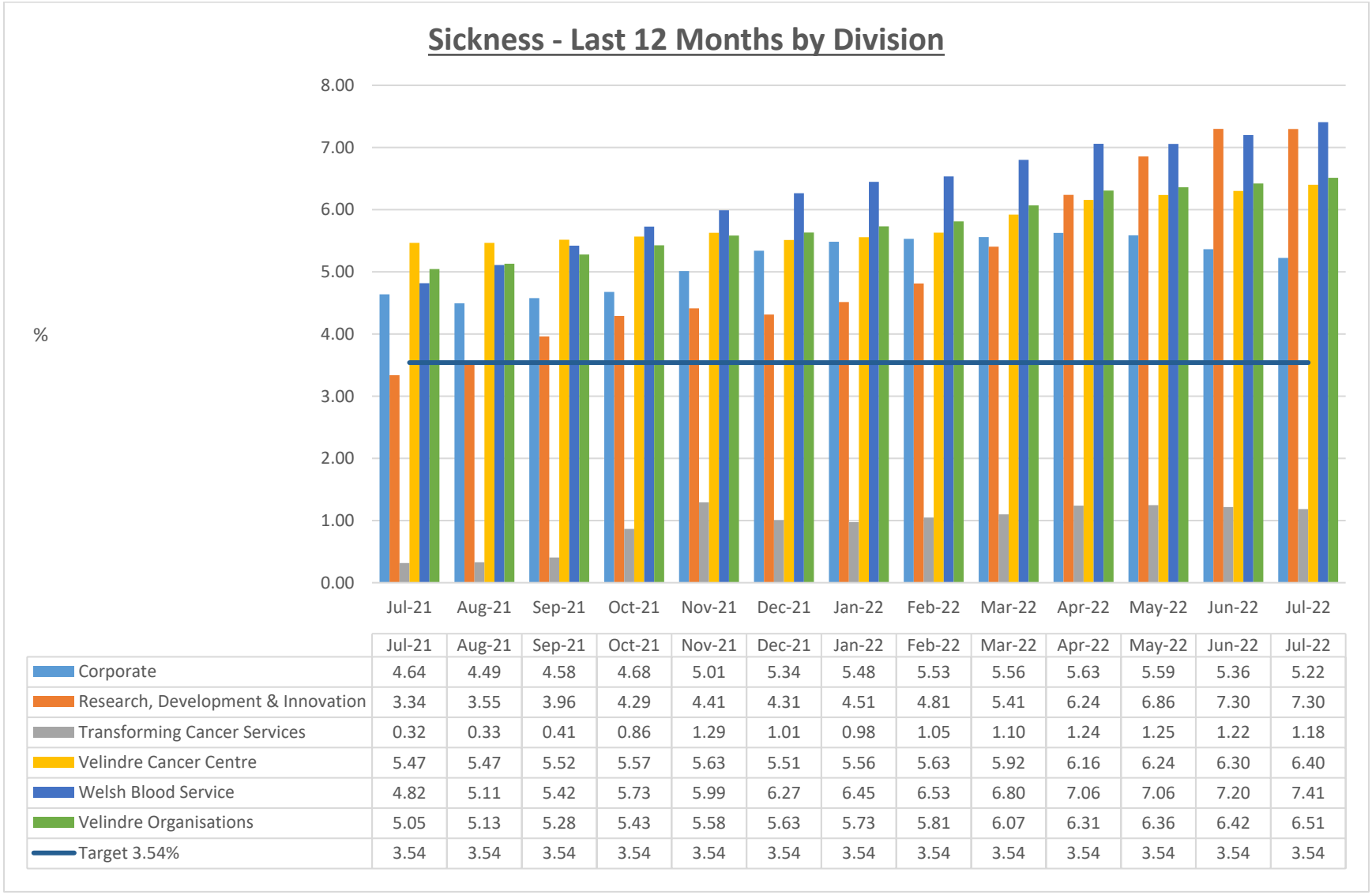
Workforce People and Relationship Team continue to highlight PADR compliance in regular meetings with managers.

PADR compliance is discussed monthly at SLT performance meetings, and compliance has improved slightly this month in comparison to June 2022.

**Corporate Areas (including RD&T, HTW & TCS)**

An increase of 4.19% compliance in one month following targeted interventions from the People and Relationship Team in June to support managers in improving compliance. This support will continue through August and September.

## Sickness Data – The Figures



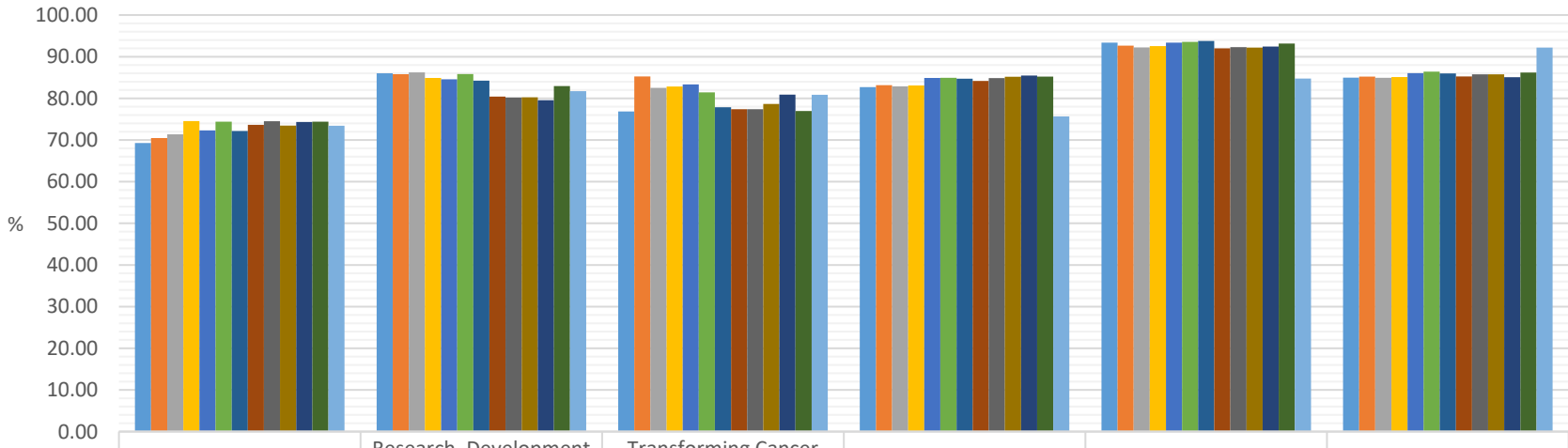

| | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 4.64 | 4.49 | 4.58 | 4.68 | 5.01 | 5.34 | 5.48 | 5.53 | 5.56 | 5.63 | 5.59 | 5.36 | 5.22 |
| Research, Development & Innovation | 3.34 | 3.55 | 3.96 | 4.29 | 4.41 | 4.31 | 4.51 | 4.81 | 5.41 | 6.24 | 6.86 | 7.30 | 7.30 |
| Transforming Cancer Services | 0.32 | 0.33 | 0.41 | 0.86 | 1.29 | 1.01 | 0.98 | 1.05 | 1.10 | 1.24 | 1.25 | 1.22 | 1.18 |
| Velindre Cancer Centre | 5.47 | 5.47 | 5.52 | 5.57 | 5.63 | 5.51 | 5.56 | 5.63 | 5.92 | 6.16 | 6.24 | 6.30 | 6.40 |
| Welsh Blood Service | 4.82 | 5.11 | 5.42 | 5.73 | 5.99 | 6.27 | 6.45 | 6.53 | 6.80 | 7.06 | 7.06 | 7.20 | 7.41 |
| Velindre Organisations | 5.05 | 5.13 | 5.28 | 5.43 | 5.58 | 5.63 | 5.73 | 5.81 | 6.07 | 6.31 | 6.36 | 6.42 | 6.51 |
| 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

<table>
<tr><th>Performance Indicator</th><th>RAG/ Change from previous month</th><th>June Figure</th><th>Hotspot</th><th>%</th><th>Comment</th></tr>
<tr><td rowspan="11">Sickness absence (3.42%)</td><td rowspan="11">6.51%<br>↑</td><td rowspan="11">6.34%</td><td colspan="3">Welsh Blood Service (7.41%)</td></tr>
<tr><td>Collections Section</td><td>13.00</td><td>Increase on last month 9.86%</td></tr>
<tr><td>Laboratory Section</td><td>8.02</td><td>Increase on last month 7.62%</td></tr>
<tr><td>Quality Assurance</td><td>4.76</td><td>Improvements continue to decline month on month. Remove as hotspot</td></tr>
<tr><td colspan="3">Velindre Cancer Centre (6.40%)</td></tr>
<tr><td colspan="3">Significant number of departments are showing as a concern and significantly over the target for absence this month. Only 6 areas in VCC are showing sickness of less than 6% areas over 6% are:<br><br>• Clinical Audit – 8.63%<br>• Information Services – 11.23%<br>• Nuclear Medicine – 24.89%<br>• Nursing – 7.89%<br>• Operational Services – 6.07%<br>• Outpatients – 11.99%<br>• Pharmacy – 8.71%<br>• Psychology – 6.14%<br>• Radiotherapy – 9.06%<br>• Therapies – 7.86%<br><br>This change of in month absence in all figures is not representative in the rolling absence yet but it needs to be noted that this will grow significantly given the developing absence rates month on month in almost all areas.</td></tr>
<tr><td colspan="3">Corporate Areas (4.57%)</td></tr>
<tr><td>Clinical Governance</td><td>14.8</td><td>Same as previous month</td></tr>
<tr><td>Estates</td><td>0.00</td><td>Decrease on previous month 14.29%. Consider removing form hotspot due to significant improvement in absence figures.</td></tr>
</table>

| | | | | | |
|---|---|---|---|---|---|
| | | | RD&I CTU Research (late phase0 | 11.06 | Decrease on previous month 11.89% |
| | | | | | |

## Statutory and Mandatory Figures – The Figures




| | Corporate | Research, Development & Innovation | Transforming Cancer Services | Velindre Cancer Centre | Welsh Blood Service | Velindre Organisations |
|---|---|---|---|---|---|---|
| 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 |
| Mar-22 | 74.51 | 80.21 | 77.39 | 84.88 | 92.30 | 85.77 |
| Apr-22 | 73.48 | 80.23 | 78.64 | 85.17 | 92.19 | 85.76 |
| May-22 | 74.31 | 79.56 | 80.91 | 85.46 | 92.44 | 85.08 |
| Jun-22 | 74.41 | 82.95 | 76.96 | 85.22 | 93.17 | 86.20 |
| Jul-22 | 73.42 | 81.74 | 80.87 | 75.65 | 84.75 | 92.18 |

## Statutory and Mandatory Figures – The Narrative

| Performance Indicator | RAG/ Change from previous month | June Figure | Hotspot | % | Comment to include reasons for change / rates high or low |
|---|---|---|---|---|---|
| **Stat & Mand Training (85%)** | **92.18%** ↑ | 86.20% | **Welsh Blood Service (84.75%)** | | |
| | | | Directors | 72.50 | New Hotspot |
| | | | **Velindre Cancer Centre (75.65%)** | | |
| | | | Cancer Services Management Officer | 78.21 | New Hotspot |
| | | | Medical Staffing | 52.46 | Decrease on previous month 52.99% |
| | | | Palliative/Chronic Pain | 64.50 | Decrease on previous month 65.71% |
| | | | **Corporate Areas (78.68%)** | | |
| | | | Fundraising | 55.0 | Decrease on previous month 56.25% |
| | | | Corporate Management Section | 51.18 | Decrease on previous month 52.5% |
| | | | TCS Programme Management Office | 50.00 | Same as previous month |

**Action/ initiatives:**

**<u>Velindre University NHS Trust</u>**

Statutory and Mandatory compliance has reported over target for 10 months within the last year for the Trust. Face to face training has now fully resumed and the digital VAR training project continues. The Education and Training Team have also been through a procurement exercise to bring in a temporary trainer for inanimate load training while the in-house recruitment is ongoing.

**<u>WBS</u>**

WBS is reporting below target for the first time in over 12 months, Interventions will be undertaken with SMT to understand this change and support on brining compliance back to target.

**VCC**

This month has seen a significant decline in statutory and mandatory figured from 85.22% in June to 75.65% in July. Intervention will be undertaken with SLT to understand this huge dip in figures.

**Corporate Areas (including RD&T, HTW & TCS)**

Slight improvement made on June's performance but work is still required to improve compliance.

## Job Planning

Work is currently ongoing with the Medical Directorate to ensure compliance with Job Plans and significant work has been undertaken to represent the data without those employees on long-term sickness, maternity leave or appointed within the last 12 months.

No data available for July 2022 at time for publishing report.

## Work In Confidence (WIC)

No new concerns have been raised via the Work in Confidence platform in relation to behaviour of colleagues.

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.

# TRUST BOARD

# FINANCE REPORT FOR THE PERIOD ENDED 31 AUGUST 2022 (M5)

| | |
|---|---|
| **DATE OF MEETING** | 29/09/2022 |

| | |
|---|---|
| **PUBLIC OR PRIVATE REPORT** | Public |

| | |
|---|---|
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |

| | |
|---|---|
| **PREPARED BY** | Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance |
| **PRESENTED BY** | Matthew Bunce, Executive Director of Finance |
| **EXECUTIVE SPONSOR APPROVED** | Matthew Bunce, Executive Director of Finance |

| | |
|---|---|
| **REPORT PURPOSE** | FOR NOTING |

| **COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING** | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| EMB RUN (OUT OF BOARD) | 21.09.2022 | NOTED |

| **ACRONYMS** | |
|---|---|
| IMTP | Integrated Medium Term Plan |
| WBS | Welsh Blood Service |
| WTAIL | Welsh Transplantation and Immunogenetics Laboratory |
| WG | Welsh Government |
| VCC | Velindre Cancer Centre |
| MMR | Monthly Monitoring Returns |
| HTW | Health Technology Wales |

## 1. SITUATION/BACKGROUND

**1.1** The attached report outlines the financial position and performance for the period to the end of August 2022.

**1.2** This financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as they are directly accountable to WG for their financial performance. Only the balance sheet (SoFP) and cash flow provides the full Trust position as this is reported in line with the WG monthly monitoring returns (MMR).

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

### 2.1 Performance against Key Financial Targets:

| | Unit | Current Month £m | Year to date £m | Year End Forecast £m |
|---|---|---|---|---|
| **Revenue** | Variance | (0.002) | 0.005 | 0.000 |
| **Capital** (To ensure that costs do not exceed the Capital Expenditure limit) | Actual Spend | 0.615 | 4.615 | 23.063 |
| **Public Sector Payment Performance** (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid). | % | 96.5% | 95.5% | 95.0% |

### 2.2 Revenue Budget

At this stage of the financial year the overall revenue budget (excl Covid and the exceptional cost pressures) remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of August 22 is an underspend of **£0.005m**, with an underachievement against income offset by an underspend within both Pay and Non Pay.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid, for which the Trust is expecting to receive

WG funding to cover during the first 6 months of the year, with strategic plans being put in place to mitigate the risk exposure during the latter part of the year.

It is expected that potential cost pressures are managed by budget holders to ensure the delegated expenditure control limits are not exceeded in line with budgetary control procedures.

Two saving schemes relating to service redesign and supportive structures currently remain RAG rated amber and therefore it is important that those schemes that have not yet gone live are reviewed at divisional level with a view to either turn green or find replacement schemes.

***The Trust is reporting a year end forecast breakeven position; however, this assumes that all additional Covid-19 costs along with the Exceptional National cost pressures will be fully reimbursed by both WG and the Trust Commissioners, that all other planned additional income is received, and the savings targets are achieved.***

## 2.3 PSPP Performance

PSSP performance for the whole Trust (inc. NWSSP) is currently 95.82% against a target of 95%, with the performance against the Core Trust (exc. NWSSP) being 95.69%

Measures have recently been put in place to target key areas which have been causing 'bottlenecks' in the PSPP process which has been reflected recent performance figures.

## 2.4 Covid Expenditure

| Covid-19 Funding 2022/23 | | | |
|---|---|---|---|
| | WG £m | Commissioners £m | Total £m |
| Mass Vaccination | 0.222 | | 0.222 |
| PPE | 0.219 | | 0.219 |
| Cleaning | 0.420 | | 0.420 |
| Other Covid Response | 0.255 | | 0.255 |
| Covid Recovery - Internal Capacity | | 3.645 | 3.645 |
| Covid Recovery - Outreach | | 0.261 | 0.261 |
| | **1.116** | **3.906** | **5.022** |

The overall gross funding requirement related to Covid has reduced further and currently stands at £5.022m, with £1.116m being recognised although not confirmed for funding from WG, and the balance of £3.906m being sought from our Commissioners.

The £5.022m represents a significant reduction in outsourcing costs from the Trust IMTP plan as of 31st March, largely due to the liquidation of the Rutherford Cancer Centre (RCC).

Other funding / cost reduction reflects control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

## 2.5 Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

**At this stage only unavoidable costs pressures are being considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that all Covid related expenditure and Exceptional National cost pressures will be funded by WG and / or Commissioners.**

## 2.6 Financial Risks

### Covid

The Trust continues to be in dialogue with Commissioners with regards to the costs of additional capacity required to meet the demands placed on our Planned Care services. To date, the full requirement of £3.906m, which has been invested in securing additional capacity, has not been agreed by Commissioners.

The Trust has received signed Long Term Agreements (LTA's) from our Commissioners. However, the funding for Planned care & Covid backlog capacity remains a risk as the marginal income that the Trust is forecast to receive will not cover the additional costs being incurred.

The expectation at this stage is that Covid response costs will be funded from WG, however the Trust has not yet received formal confirmation.

**Savings**

Due to the ongoing pandemic and the potential inability to enact two of the Trust savings schemes there is a risk that some of the savings that are RAG rated amber may not be fully achieved. Those schemes with risk of delivery are being reviewed at divisional level with a view to ensure delivery, or to find replacement schemes as the year progresses.

**TCS**

A non-recurrent revenue funding request of £0.104m has been made by the TCS Programme relating to shortfalls in funding on the PMO and nVCC project. This was presented to EMB Run on 1st July and agreed. Latest forecast requirement currently stands at £0.133m which reflects additional Judicial fees of £0.029m (total to date £0.043m).

The revenue financial information provided within the main body of the report and the TCS Programme Board paper differ slighlty which is due to both a timing difference, and the authorisation of budget virements from the Core Trust to the TCS Programme.

**Other Exceptional National Cost Pressures**

The Trust is anticipating full funding for the Employers NI increase (£0.550m) and the incremental increase in Energy prices (£3.016m). The anticipated funding for the Energy price increase reflects the latest forecast provided by NWSSP during September, which indicates once again another significant rise from the £2.235m included in the prior month forecast.

All other financial risks are expected to be mitigated at divisional level, however there is a risk that operational cost pressures may materialise during the year which is beyond divisional control or the ability to be managed through the overall Trust funding envelope.

## 2.7 Capital

### a) All Wales Programme

Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget.

Other Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, WBS Hemoflows, Scalp Coolers, VCC Outpatients & Ventilation and Plasma Fractionation.

**b) Discretionary Programme**

The Trust discretionary capital allocation for 2022/23 is £1.454m. This represents a 24% reduction in capital allocation compared to £1.911m in 2021/22 and is reflective of the reduced overall NHS capital budget position.

The Trust Discretionary Programme for 2022/23 was approved by EMB in August.

## 3. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | There are no specific quality and safety implications related to the activity outined in this report. |
| | |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies please list below: |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | There are no specific legal implications related to the activity outlined in this report. |
| | |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | The Trust financial position at the end of August 2022 is an underspend of £0.005m with a year-end forecast break-even position in accordance with the approved IMTP |

## 4. RECOMMENDATION

Trust Board is asked to **NOTE**

**4.1** the contents of the August 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs.

**4.2** the TCS Programme financial report for August 2022 attached as **Appendix 1**.

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 AUGUST 2022/23

**TRUST BOARD**
**29/09/2022**

## 1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2022-23.

## 2. Background / Context

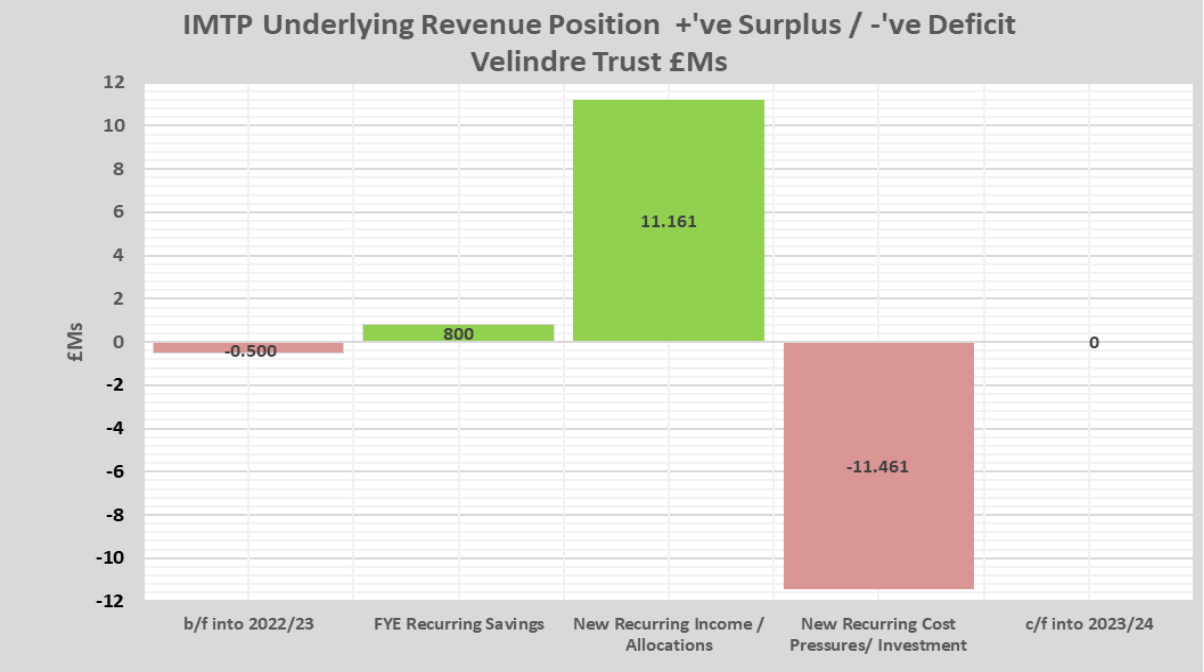
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2022-23 to 2024-25 to Welsh Government on the 31 March 2022.

- For 2022-23 the Plan (excl Covid) included;
  - an underlying **deficit of -£0.5m** brought forward from 2021-22,
  - FYE **of new cost pressures / Investment** of **-£11.461m,**
  - offset by **new recurring Income** of **£11.161m,**
  - and Recurring FYE **savings schemes** of **£0.8m,**
  - Allowing **a balanced position** to be carried into 2023-24.

- The underlying deficit is expected to be eliminated during 2022/23 through the discretionary uplift in funding, enabling a balanced position to be carried into 2023/24.

- **To eliminate the brought forward underlying deficit, the savings target set for 2022-23 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**




| Underlying Position +Deficit/(-Surplus) £Ms | b/f into 2022/23 | Recurring Savings | New Recurring Income / Allocations | FYE New Cost Pressures/ Investment | c/f into 2023/24 |
|---|---|---|---|---|---|
| Velindre NHS Trust | -0.500 | 0.800 | 11.161 | -11.461 | 0 |

## 3. Executive Summary

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

*(Figures in parenthesis signify an adverse variance against plan)*

**Table 1 - Key Targets**

| | Unit | Current Month £m | Year to date £m | Year End Forecast £m |
|---|---|---|---|---|
| **Revenue** | Variance | (0.002) | 0.005 | 0.000 |
| **Capital** (To ensure that costs do not exceed the Capital Expenditure limit) | Actual Spend | 0.615 | 4.615 | 23.063 |
| **Public Sector Payment Performance** (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid). | % | 96.5% | 95.5% | 95.0% |

### Performance against Planned Savings Target

| | | | | |
|---|---|---|---|---|
| Efficiency / Savings | Variance | (44) | (44) | 0 |

**Revenue**

The Trust has reported a £(0.002)m overspend for August '22, with a cumulative position of £0.005m underspent, and an outturn forecast position of **Breakeven**.

**Capital**

The approved Capital Expenditure Limit (CEL) as at August 2022 is **£23.063m**. This represents all Wales Capital funding of **£21.069m**, and Discretionary funding of **£1.454m.** The Trust reported Capital spend to August'22 of £4.615m and is forecasting to remain within its CEL of £23.603m.

The Trust's CEL is broken down as follows:

| | £m Opening | £m Movement | £m August 2022 |
|---|---|---|---|
| **Discretionary Capital** | 1.454 | 0.000 | 1.454 |
| **All Wales Capital:** | | | |
| Fire Safety | 0.500 | 0.000 | 0.500 |
| CANISC Cancer Project | 0.000 | 0.579 | 0.579 |
| TCS Programme | 23.902 | -3.372 | 20.530 |
| **Total CEL** | **25.856** | **-2.793** | **23.063** |

With WG agreement slippage on the TCS Programme has led to £3.372m Capital funding being pushed back to 2023/24 financial year, reducing the WG Capital allocation to £20.530m this financial year.

**PSPP**

During August '22 the Trust (core) achieved a compliance level of **96.31%** (July 22: 95.61%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.69%** as at the end of month 5, and a Trust position (including hosted) of **95.82%** compared to the target of 95%.

PSPP has been significantly impacted by the ongoing pandemic and reduced levels of receipting on orders which is due to the high levels of sickness being experienced in the Trust over the past year. The finance team has been working with NWSSP colleagues with a view to help improve performance, which has included a full review the approval hierarchy which has been reflected in recent performance figures.

### Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2022-23, with contingency plans being put in place to support any potential under delivery on amber rated schemes.

## Revenue Position

| Cumulative | | | | Forecast | | |
|---|---|---|---|---|---|---|
| £0.005m Underspent | | | | Breakeven | | |
| Type | YTD Budget (£m) | YTD Actual (£m) | YTD Variance (£m) | Full Year Budget (£m) | Full Year Forecast (£m) | Forecast Variance (£m) |
| Income | (70.524) | (70.184) | (0.340) | (177.649) | (177.148) | (0.500) |
| Pay | 30.199 | 30.124 | 0.075 | 71.452 | 71.384 | 0.068 |
| Non Pay | 40.325 | 40.056 | 0.269 | 106.196 | 105.764 | 0.433 |
| **Total** | **(0.000)** | **(0.005)** | **0.005** | **0.000** | **(0.000)** | **0.000** |

The overall position against the profiled revenue budget to the end of August 2022 is an underspend of **£0.005m**, with a Pay and Non Pay underspend offsetting an Income under achievement.

***The Trust is reporting a year end forecast breakeven position, however this assumes that all additional Covid-19 costs, along with the exceptional national cost pressures will be fully reimbursed by both WG and the Trust commissioners, that all other planned additional income is received, and the planned savings targets are achieved during 2022-23.***

### 4.1 Revenue Position Key Issues

### Income Key Issues

Income underachievement to August and is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS, with plans being put in place to support recovery in the latter part of the year.

### Pay Key Issues

The total Trust vacancies as at August 2022 is 134wte, VCC (72wte), WBS (33wte), Corporate (6wte), R&D (17wte), TCS (0wte) and HTW (6wte).

The pay award to be paid in September is based on the pay circular that was shared on the 27th July (corrected version 4th August). Early indications based on an approximate calculation is that the cost to the Trust during 2022-23 will be circa £3.4m. The Trust is currently working on the assumption that this will be fully funded by WG.

Increase in Employers NI rates (1.25%) is currently being offset by divisional reserves, however funding requirement of circa £0.550m is currently expected to be secured from WG through the recognition of exceptional national cost pressures but remains a risk.

Vacancies throughout the Trust remain high however several posts in both VCC and WBS have been appointed at risk in response to Covid activity backlog and additional capacity required for forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. In addition, work is underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Both VCC and WBS hold a £0.450m vacancy factor target, which will need to be achieved during 2022/23 in order to balance the overall Trust financial position.

**Non Pay Key Issues**

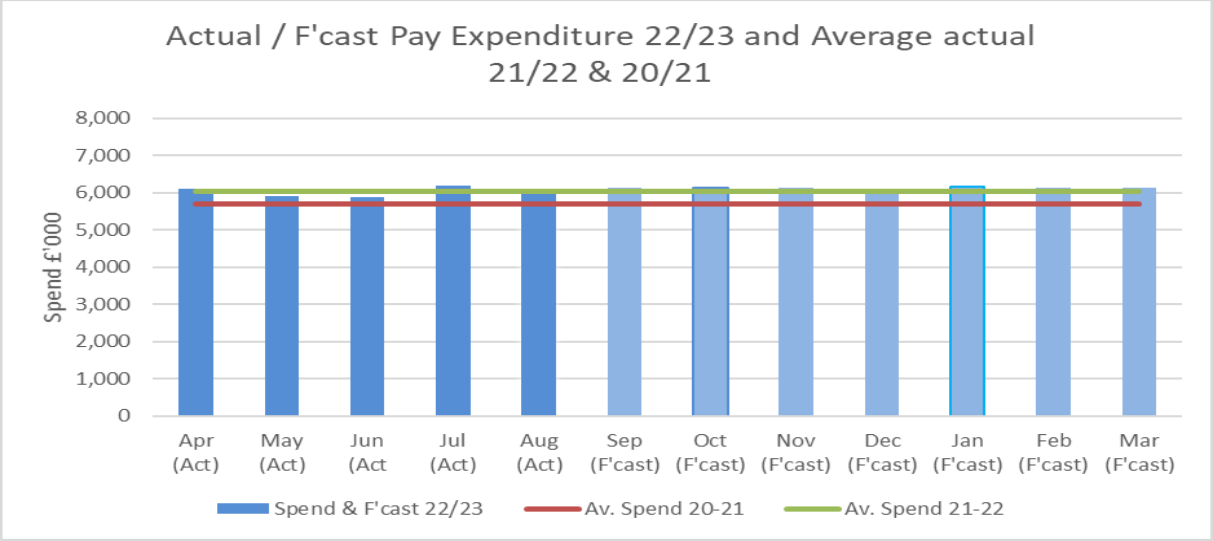
The expected increase in energy prices circa (£3.016m) July (£2.235m), has been recognised as an exceptional national cost pressures by WG with the Trust expectation that these costs will be fully funded during 2022/23, although this is yet to be confirmed.

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The savings target for each division was set as VCC £0.700m, WBS £0.500m and Corporate £0.100m as part of the IMTP for 2022/23.

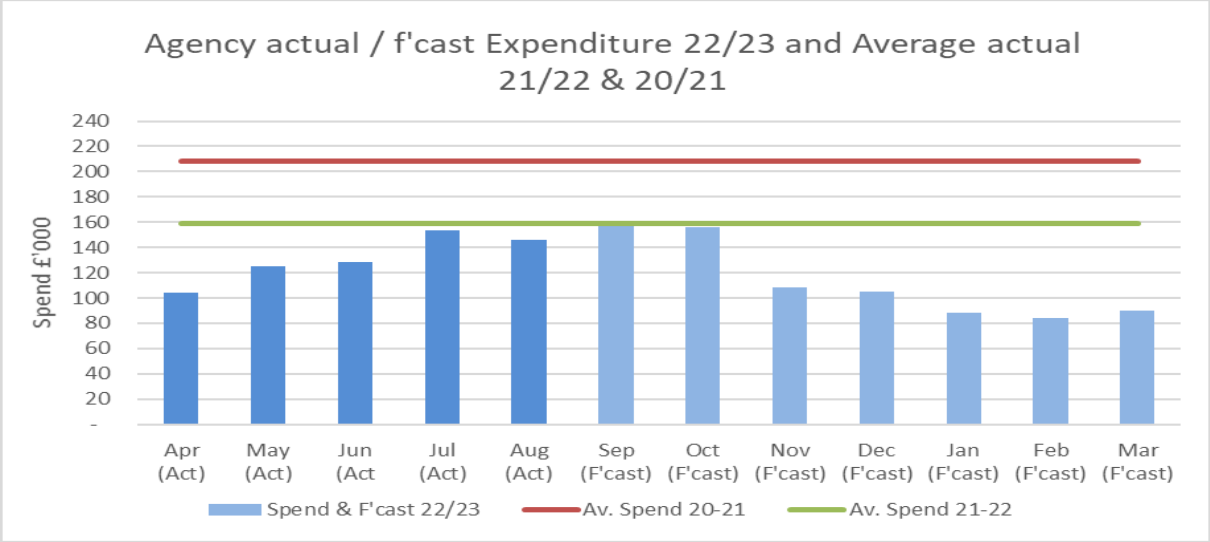
The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

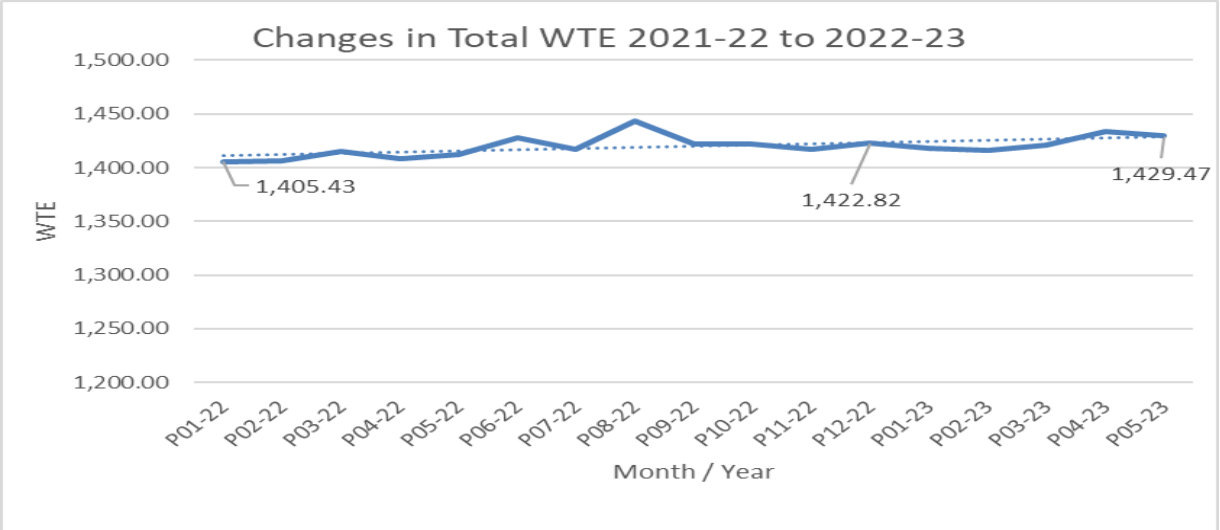
**4.2 Pay Spend Trends (Run Rate)**

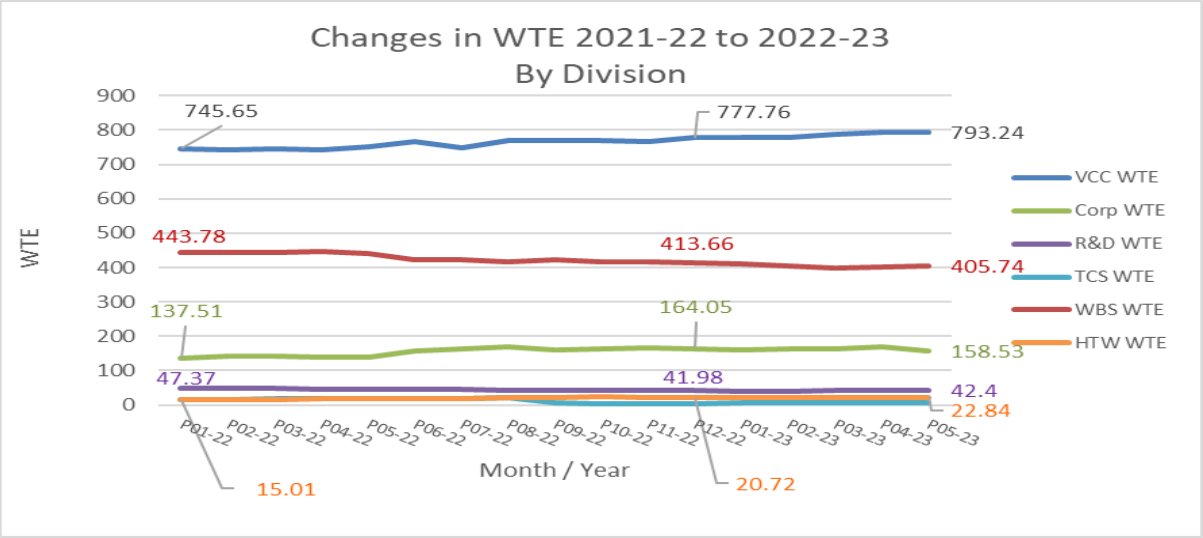
The pay award for 2022/23 is not currently included with the graphs with expectation that this will be paid in September and be fully funded. It is hopeful that agency costs will decrease during 2022/23 largely from the reduction of agency staff that has been used over the past year in response to Covid and through the recruitment into filling vacancies.




The spend on agency for August 22 was £0.146m (July £0.154m), which gives a cumulative year to date spend of **£0.658m** and a current forecast outturn spend of circa **£1.449m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of August is £0.156m and forecast spend is circa £0.346m (£0.826m 2021/22).

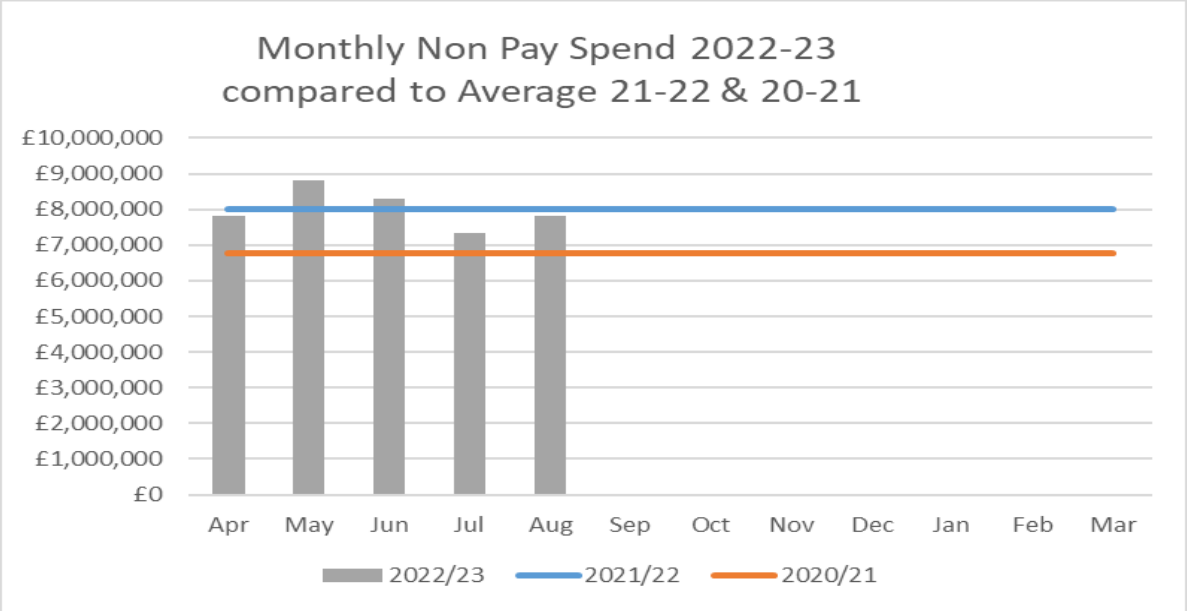





### 4.3 Non Pay

Non-pay 21/22 (c£96m) av. monthly spend of £8m was £1.2m higher than the reported monthly average spend for 20/21 (£6.8m). Most of the monthly average increase (circa £0.9m) related to the growth in NICE / High Cost drug usage following the recovery and associated surge related to Covid and increase in WBS wholesaling (circa £0.3m). The average monthly spend for 22-23 is currently £8m which is currently in line with 21/22 expenditure.




### 4.4 Covid-19

The latest forecast funding requirement as at 31st August in relation to Covid for 2022-23 has been further revised down to £5.022m (July £5.134m) which is a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £5.022m total Covid requirement £1.116m (IMTP plans £2.104m) is being requested directly from WG, and the balance of £3.906m (IMTP plans £10.206m) being sought from our commissioners.

| **Covid-19 Funding 2022/23** |
|---|

| | WG £m | Commissioners £m | Total £m |
|---|---|---|---|
| Mass Vaccination | 0.222 | | 0.222 |
| PPE | 0.219 | | 0.219 |
| Cleaning | 0.420 | | 0.420 |
| Other Covid Response | 0.255 | | 0.255 |
| Covid Recovery - Internal Capacity | | 3.645 | 3.645 |
| Covid Recovery - Outreach | | 0.261 | 0.261 |
| | **1.116** | **3.906** | **5.022** |

The latest forecast spend and funding requirement from WG has reduced by a further £0.112m from £1.228m reported in June to £1.116m. which is due to further de-escalation of security on the WBS sites for storage of vaccines and Velindre no longer contributing to the autumn vaccination programme with our staff being invited via their respective health boards.

WG funding has been assumed for programme related Covid costs of £0.441m (Mass Vaccination and PPE), along with other Covid response funding of £0.675m in relation to ongoing cleaning, increase in workforce costs, and other support costs per letter received from Judith Paget dated 14th March 2022. The Trust has to date invoiced for QTR 1 costs relation to Mass Vaccination and PPE.

| Covid-19 Revenue Spend/ Funding | | |
|---|---|---|
| | YTD Actual £m | Forecast Spend 2022/23 £m |
| Mass Covid Vaccination | 0.123 | 0.222 |
| PPE | 0.079 | 0.219 |
| Cleaning Standards | 0.149 | 0.420 |
| WG Other Covid Response | 0.120 | 0.255 |
| Covid Recovery | 1.698 | 3.906 |
| **Total Covid Spend /Funding Requirement 2022/23** | **2.169** | **5.022** |
| WG Funding | | 1.116 |
| Commissioner Funding | | 3.906 |
| **Balance of Funding Requirement** | **0.000** | **5.022** |

The Trust Covid expenditure is based on activity demand forecast modelling which commenced in 2021/22 and has been updated regularly since. The Trust has already invested £2.943m in additional capacity. Following news that The Rutherford has gone into liquidation, the funding previously required for outsourcing has significantly reduced (by the full £4.150m). In response the Trust is looking to establish additional outreach Capacity at Prince Charles Hospital for SACT with forecast additional cost above that already invested in Covid capacity of circa £0.261m and is currently developing plans for Radiotherapy capacity internally looking to weekend working which will require WLI and enhanced pay rates. The cost of this additional capacity is currently still being worked up. These additional investments in capacity to meet the activity demand from Health Boards will not be fully covered through LTA marginal income leading to an additional financial risk to the Trust

Other cost reduction from IMTP plans reflects financial control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

## 4. Savings

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as actual saving schemes and £0.550m being income generation.

The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

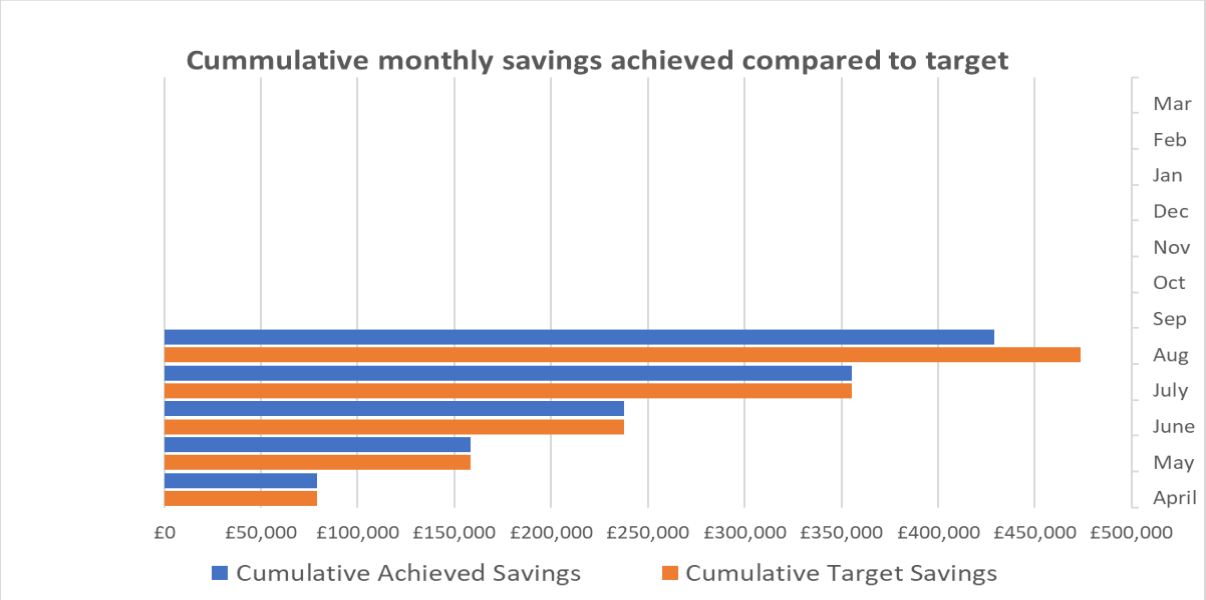
Currently two of the schemes relating to service redesign and supportive structures are still RAG rated amber which are those that continue to be impacted by Covid during 2022-23 and have underachieved by £0.044m year to date.

Service redesign and supportive structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. These plans are aligned to a number of the Trust VBHC bids that sought funding for new posts to support medical workforce redesign but were unsuccessful. Due to the pandemic the savings scheme start date has been pushed back further to October, with work ongoing but proving to be difficult under the current workforce situation, particularly with the high number of vacancies and the high level of sickness currently being experienced throughout the core Trust.

Contingency measures are being put in place should the savings schemes not achieve however **It is extremely important that divisions review their current savings schemes, and where delivery may not be achieved alternative schemes are implemented to ensure that the Savings target is met for 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** | **700** | **224** | **179** | **(44)** | **700** | **0** |
| | | | **80%** | | **100%** | |
| **WBS TOTAL SAVINGS** | **500** | **208** | **208** | **0** | **500** | **0** |
| | | | **100%** | | **100%** | |
| **CORPORATE TOTAL SAVINGS** | **100** | **42** | **42** | **0** | **100** | **0** |
| | | | **100%** | | **100%** | |
| **TRUST TOTAL SAVINGS IDENTIFIED** | **1,300** | **474** | **429** | **(44)** | **1,300** | **0** |
| | | | **91%** | | **100%** | |

| Scheme Type | RAG RATING | TOTAL £000 | Planned YTD £000 | Actual YTD £000 | Variance YTD £000 | F'cast Full Year £000 | Variance Full Year £000 |
|---|---|---|---|---|---|---|---|
| **Savings Schemes** | | | | | | | |
| Establishment Control (Corporate) | Green | 100 | 42 | 42 | 0 | 100 | 0 |
| Laboratory & Collection Model (WBS) | Green | 50 | 21 | 21 | 0 | 50 | 0 |
| Laboratory & Collection Model (WBS) | Green | 50 | 21 | 21 | 0 | 50 | 0 |
| Stock Management (WBS) | Green | 100 | 42 | 42 | 0 | 100 | 0 |
| Stock Management (WBS) | Green | 150 | 63 | 63 | 0 | 150 | 0 |
| Procurement - Supply Chain (WBS) | Amber | 50 | 21 | 21 | 0 | 50 | 0 |
| Service Redesign (VCC) | Amber | 100 | 22 | 0 | (22) | 100 | 0 |
| Supportive Stuctures (VCC) | Amber | 100 | 22 | 0 | (22) | 100 | 0 |
| Procurement - Supply Chain (VCC) | Amber | 50 | 4 | 4 | 0 | 50 | 0 |
| **Total Saving Schemes** | | **750** | 257 | 213 | (44) | 750 | 0 |
| **Income Generation** | | | | | | | |
| Maximinsing Income Opportunities - Income Attraction (WBS) | Green | 50 | 21 | 21 | 0 | 50 | 0 |
| Maximinsing Income Opportunities - Income Attraction (WBS) | Green | 50 | 21 | 21 | 0 | 50 | 0 |
| Maximinsing Income Opportunities - Private Patients (VCC) | Amber | 150 | 33 | 33 | 0 | 150 | 0 |
| Maximinsing Income Opportunities - Private Patients (VCC) | Green | 100 | 42 | 42 | 0 | 100 | 0 |
| Maximinsing Income Opportunities - Income Attraction (VCC) | Green | 200 | 83 | 83 | 0 | 200 | 0 |
| **Total Income Generation** | | **550** | 200 | 200 | 0 | 550 | 0 |
| **TRUST TOTAL SAVINGS** | | **1,300** | **457** | **413** | **(44)** | **1,300** | **0** |
| | | | | **90%** | | **100%** | |




## 5. Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

| Summary of Total Recurrent Reserves Remaining Available in 2022/23 | £m |
|---|---|
| Recurrent Reserves Available for investment | 1.241 |
| Previously Committed Reserves Bfwd 2021-22 | (0.137) |
| Previously agreed Exec Investment | (0.973) |
| New Commitments | (0.131) |
| Emergence of Slippage against Recurrent Reserves Commitments | |
| **Remaining Balance** | **0** |

| Summary of Total Non-Recurrent Reserves Remaining Available in 2022/23 | £m |
|---|---|
| Non-Recurrent Reserves Available for investment | 1.471 |
| Previously Committed Reserves Bfwd 2021-22 | (0.102) |
| Previously Agreed Exec Investment | (1.302) |
| New Commitments | (0.067) |
| Emergence of Slippage against Non-Recurrent Commitments | |
| **Remaining Balance** | **0** |

**At this stage only unavoidable costs pressures should be considered for funding against the Trust reserves, with any new investment decisions being put on hold until the Trust receives confirmation that all Covid related expenditure will be funded**

## 6. End of Year Forecast / Risk Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are a number of risks which are being managed and closely monitored. The table below summarises the key financial risks & opportunities highlighted to Welsh Government.

Non-Delivery of Savings - *Risk £0.100m, Likelihood - Medium*

The Trust as part of the IMTP identified £1.300m of Savings and Income Generation to be achieved during 2022/23. Due to the ongoing pandemic and impact on sickness levels that remain significantly above pre Covid levels at this stage the Trust is unable to implement service redesign and changes to supportive structures, therefore there is a risk that the savings target against these schemes may not be fully achieved. The Trust will continue to review the savings schemes with a view of ensuring delivery, or to find replacement schemes as the year progresses.

The conclusion of the Microsoft 365 National Deal led to a £0.157m (incl. VAT) in-year cost pressure, which will be assigned as a Cost Improvement Programme to the Digital Services Team. This includes the standing down of legacy IT infrastructure which is not required due to the MS 365 deal.

Covid Funding via Commissioners – *Risk TBC, Likelihood - High*

The Trust continues to have discussions with its commissioners who recognise our Covid funding requirement, however they have not committed to providing the full funding ask of £3.906m. Commissioners have all stated that any funding required to cover additional Covid recovery costs will only flow through the LTA under the national funds flow mechanism. This mechanism whilst providing enhanced income protection over the normal LTA would not cover the additional costs of premium rates through outsourcing NHS Wales enhanced pay rates for WLI's or additional costs above marginal when establishing new capacity. The Trust has received signed LTA's back from our commissioners, however the funding for planned care & Covid backlog capacity will remain a risk for the Trust.

Other C-19 Response Costs – *Risk £1.116m, Likelihood - Medium*

Following further Covid de-escalation related activity and a review of operational costs in line with the updated guidance, the latest forecast spend and funding requirement from WG has reduced by a further £0.112m from £1.228m reported in July to £1.116m.

Other Exceptional National Cost Pressures – *Risk £3.566m - Medium*

The Trust is still anticipating full funding for the Employers NI increase (£0.550m) and the incremental increase in Energy prices (£3.016m). The anticipated funding for the Energy price increase reflects the latest forecast provided by NWSSP during August, which indicates another significant rise from the £2.235m included in the prior month forecast .

Management of Operational Cost Pressures – *Risk £0.250m, Likelihood - Low*

Cost pressures that have / will surface through the year are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a small risk that pressures may materialise beyond divisional control or be able to be managed through the overall Trust funding envelope.

## 7. CAPITAL EXPENDITURE

*Administrative Target*

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

| | Approved CEL £m | YTD Spend £m | Committed Orders Outstanding £m | Budget Remaining @ M5 £m | Full Year Actual Spend £m | Year End Variance £m |
|---|---|---|---|---|---|---|
| **All Wales Capital Programme** | | | | | | |
| nVCC - project costs | 2.089 | 1.602 | 0.000 | 0.487 | 2.892 | -0.803 |
| nVCC - Enabling Works | 18.441 | 2.310 | 0.000 | 16.131 | 17.638 | 0.803 |
| Canisc Cancer Project | 0.579 | 0.330 | 0.000 | 0.249 | 0.579 | 0.000 |
| Fire Safety | 0.500 | 0.043 | 0.000 | 0.457 | 0.500 | 0.000 |
| **Total All Wales Capital Programme** | 21.609 | 4.285 | 0.000 | 17.324 | 21.609 | 0.000 |
| **Discretionary Capital** | 1.454 | 0.330 | 0.000 | 1.124 | 1.454 | 0.000 |
| **Total** | 23.063 | 4.615 | 0.000 | 18.448 | 23.063 | 0.000 |

The approved 2022/23 Capital Expenditure Limit (CEL) as at August 2022 was £23.063m. This includes All Wales Capital funding of £21.609m, and discretionary funding of £1.454m. The approved CEL has been reduced by £3.372m to reflect the latest forecast requirement on the nVCC Enabling works project for 2022/23. Following agreement with WG the £3.372m will be re-provided to the programme during 2023/24.

In addition, WG colleagues have been notified of an additional request to move £0.803m (previously £0.450m) from the nVCC enabling works to support the additional costs associated with the nVCC project fees and advisory activities.

In January 2022 WG informed the Trust that the discretionary allocation with be significantly reduced during 2022/23 (previously £1.911m), which is reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme was approved by EMB Shape on the 27th August.

The discretionary allocation has ringfenced £0.434m to support the Integrated Radiotherapy Solution (IRS). Discussions are currently taking place with WG colleagues with the ambition that the Trust may be reimbursed for the costs incurred in supporting the procurement phase of the scheme.

The Trust is working collaboratively with Commissioners to progress the IRS FBC through the governance structures of each organisation in order to secure the funding requirements to deliver the solution. The Trust is in the final stages of negotiating the contract with the solution provider, which is due to commence in October 2022. There is a risk that the Trust may need to place an order with the provider ahead of contract signature in order for the provider to secure the available resource within its supply chain.

Whilst there is a reduction in availability of Capital funding this year, WG colleagues have indicated that they are keen for organisation to continue to develop capital proposals should additional funding become available later in the financial year.

Whilst the financial position is challenging it is expected that capital requirements will be managed through the Trust discretionary allocation during 2022/23 or additional funding will be agreed and secured from WG.

**Performance to date**

The actual cumulative expenditure to August 2022 on the All-Wales Capital Programme schemes was £4.285m, this is broken down between spend on the nVCC enabling works £2.310m, nVCC project costs of £1.602m, Canisc Cancer Project £0.330m, and fire safety £0.043m.

Spend to date on Discretionary Capital is currently £0.330m leaving a remaining balance of £1.124m as at the 31st August.

**Year-end Forecast Spend**

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

**Major Schemes in Development**

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

Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include:

| | Scheme | Scheme Total | Stage ( i.e. OBC development, FBC development, scoping etc.) | 22/23 £m | 23/24 £m | 24/25 £m | 25/26 £m | 26/27 £m | 27/28 £m | 28/29 £M |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | WBS HQ | 34.125* | FBC being developed | 1.016 | 12.808 | 9.996 | 4.434 | 5.215 | 0.608 | 0.048 |
| 2 | IRS | 46.921* | OBC & PBC approved by WG, FBC under development | 7.453 | 9.533 | 22.832 | 7.103 | 0.000 | 0.000 | 0.000 |
| 3 | Hemoflows | 0.224 | SBAR being Completed | 0.224 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 |
| 4 | Scalp Coolers | 0.250 | SBAR being Completed | 0.250 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 | 0.000 |

*Cash flow of these schemes is still under review alongside WG.

Other Major schemes which are under discussion internally and WG are sighted on include VCC outpatients, ventilation, and plasma fractionation.

## 8. BALANCE SHEET (Including Hosted Organisations)

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

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

| | Opening Balance Beginning of Apr 22 | Closing Balance End of Aug-22 | Movement from 1st April Aug-22 | Forecast Closing Balance End of Mar 23 |
|---|---|---|---|---|
| **Non-Current Assets** | **£'m** | **£'m** | **£'m** | **£'m** |
| Property, plant and equipment | 143.136 | 148.880 | 5.74 | 139.375 |
| Intangible assets | 8.667 | 7.803 | (0.864) | 5.869 |
| Trade and other receivables | 1,092.008 | 1,317.656 | 225.65 | 1,317.656 |
| Other financial assets | 0.000 | 0.000 | 0.00 | 0.000 |
| Non-Current Assets sub total | 1,243.811 | 1,474.339 | 230.528 | 1,462.900 |
| **Current Assets** | | | | |
| Inventories | 65.207 | 54.770 | (10.437) | 54.770 |
| Trade and other receivables | 540.227 | 244.447 | (295.780) | 275.556 |
| Other financial assets | 0.000 | 0.000 | 0.00 | 0.000 |
| Cash and cash equivalents | 30.404 | 38.170 | 7.77 | 18.500 |
| Non-current assets classified as held for sale | 0.000 | 0.000 | 0.00 | 0.000 |
| Current Assets sub total | 635.838 | 337.387 | (298.451) | 348.826 |
| | | | | |
| TOTAL ASSETS | 1,879.649 | 1,811.726 | (67.923) | 1,811.726 |
| **Current Liabilities** | | | | |
| Trade and other payables | (277.601) | (205.789) | 71.81 | (205.789) |
| Borrowings | 0.00 | 0.00 | 0.00 | 0.00 |
| Other financial liabilities | 0.00 | 0.00 | 0.00 | 0.00 |
| Provisions | (341.123) | (339.079) | 2.04 | (339.079) |
| Current Liabilities sub total | (618.724) | (544.868) | 73.86 | (544.868) |
| | | | | |
| NET ASSETS LESS CURRENT LIABILITIES | 1,260.93 | 1,266.86 | 5.93 | 1,266.86 |
| **Non-Current Liabilities** | | | | |
| Trade and other payables | (7.336) | (7.336) | 0.00 | (7.336) |
| Borrowings | 0.00 | 0.00 | 0.00 | 0.00 |
| Other financial liabilities | 0.00 | 0.00 | 0.00 | 0.00 |
| Provisions | (1,094.206) | (1,094.206) | 0.00 | (1,094.206) |
| Non-Current Liabilities sub total | -1,101.542 | -1,101.542 | 0.00 | -1,101.542 |
| | | | | |
| TOTAL ASSETS EMPLOYED | 159.383 | 165.316 | 5.93 | 165.316 |
| **FINANCED BY:** **Taxpayers' Equity** | | | | |
| General Fund | 0.000 | 0.000 | 0.00 | 0.000 |
| Revaluation reserve | 30.935 | 30.934 | (0.001) | 30.934 |
| PDC | 112.982 | 118.911 | 5.93 | 118.911 |
| Retained earnings | 15.466 | 15.471 | 0.01 | 15.471 |
| Other reserve | 0.000 | 0.000 | 0.00 | 0.000 |
| Total Taxpayers' Equity | 159.383 | 165.316 | 5.933 | 165.316 |

## 9. CASH FLOW (Includes Hosted Organisations)

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

As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

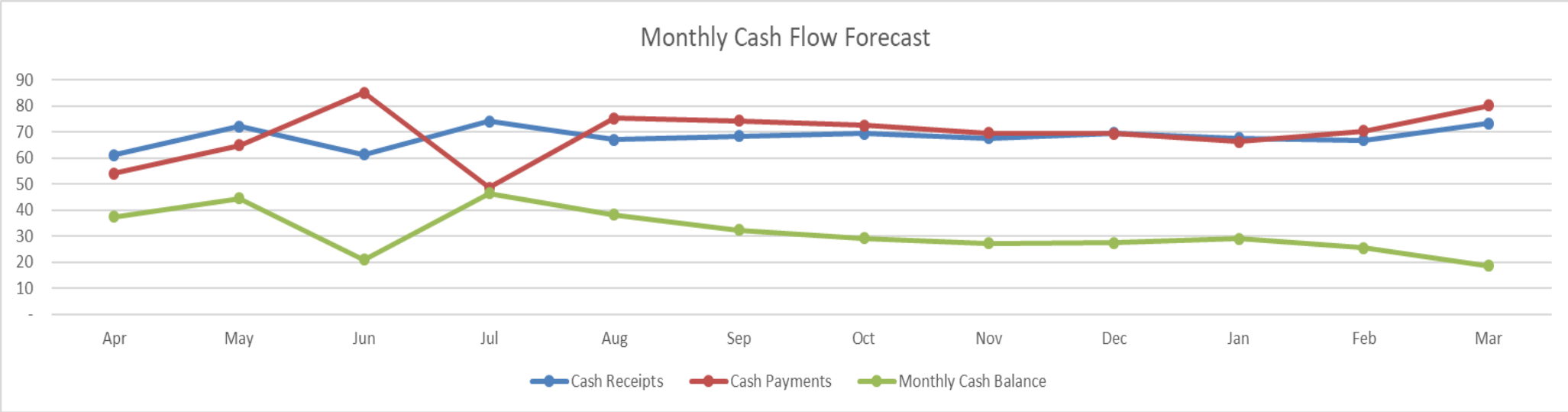
To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP are continuing to liaise with WG regarding the level of Brexit stock to maintain but it is anticipated that the repayment of the additional cash will take place later this year but will be dependent on the stock being released.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual, however this year expectation is that cash balances should return to pre-Covid levels.

Following a request from WG the Trust transferred £5.9m of cash into the Escrow holding account during May for the nVCC programme. These funds were consequently drawn down in July from WG to reimburse the Trust ensuring that there was no cash risk to the organisation.

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

| | | Apr £'m | May £'m | Jun £'m | Jul £'m | Aug £'m | Sep £'m | Oct £'m | Nov £'m | Dec £'m | Jan £'m | Feb £'m | Mar £'m | Totals £'m |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ***RECEIPTS*** | | | | | | | | | | | | | |
| 1 | LHB / WHSSC income | 33.135 | 40.208 | 40.042 | 37.491 | 47.836 | 39.377 | 41.602 | 40.388 | 40.100 | 40.000 | 39.725 | 35.218 | 475.122 |
| 2 | WG Income | 20.937 | 24.551 | 17.010 | 24.552 | 15.002 | 24.145 | 24.620 | 24.155 | 24.188 | 24.158 | 24.037 | 24.182 | 271.536 |
| 3 | Short Term Loans | | | | | | | | | | | | | 0.000 |
| 4 | PDC | | | | 5.928 | | | | | | | | 8.494 | 14.422 |
| 5 | Interest Receivable | 0.019 | 0.027 | 0.030 | 0.025 | 0.037 | 0.010 | 0.010 | 0.010 | 0.010 | 0.010 | 0.010 | 0.010 | 0.208 |
| 6 | Sale of Assets | | | | | | | | | | | | | 0.000 |
| 7 | Other | 7.106 | 7.289 | 4.321 | 6.094 | 4.246 | 4.948 | 3.223 | 3.190 | 5.271 | 3.520 | 3.183 | 5.447 | 57.839 |
| 8 | TOTAL RECEIPTS | **61.197** | **72.074** | **61.403** | **74.090** | **67.121** | **68.480** | **69.455** | **67.743** | **69.569** | **67.688** | **66.955** | **73.351** | **819.126** |
| | ***PAYMENTS*** | | | | | | | | | | | | | |
| 9 | Salaries and Wages | 21.735 | 29.243 | 29.483 | 29.705 | 29.549 | 37.654 | 32.235 | 32.240 | 32.237 | 32.281 | 32.274 | 32.785 | 371.423 |
| 10 | Non pay items | 30.543 | 33.079 | 54.139 | 17.703 | 44.384 | 36.050 | 38.270 | 35.525 | 34.738 | 30.760 | 36.496 | 38.322 | 430.009 |
| 11 | Short Term Loan Repayment | | | | | | | | | | | | 7.000 | 7.000 |
| 12 | PDC Repayment | | | | | | | | | | | | | 0.000 |
| 14 | Capital Payment | 1.926 | 2.567 | 1.420 | 1.215 | 1.428 | 0.583 | 2.107 | 1.886 | 2.450 | 3.162 | 1.726 | 2.128 | 22.598 |
| 15 | Other items | | | | | | | | | | | | | 0.000 |
| 16 | TOTAL PAYMENTS | **54.205** | **64.889** | **85.042** | **48.623** | **75.361** | **74.288** | **72.613** | **69.651** | **69.425** | **66.203** | **70.496** | **80.235** | **831.030** |
| | | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 | |
| 17 | Net cash inflow/outflow | 6.993 | 7.185 | -23.639 | 25.467 | -8.240 | -5.808 | -3.158 | -1.908 | 0.144 | 1.485 | -3.541 | -6.884 | |
| 18 | Balance b/f | 30.404 | 37.397 | 44.582 | 20.943 | 46.410 | 38.170 | 32.362 | 29.204 | 27.296 | 27.440 | 28.925 | 25.384 | |
| 19 | Balance c/f | 37.397 | 44.582 | 20.943 | 46.410 | 38.170 | 32.362 | 29.204 | 27.296 | 27.440 | 28.925 | 25.384 | 18.500 | |



# DIVISIONAL ANALYSIS

*(Figures in parenthesis signify an adverse variance against plan)*

## Core Trust

| | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Budget £m | Full Year Forecast £m | Year End Projected Variance £m |
|---|---|---|---|---|---|---|
| VCC | (14.922) | (14.922) | 0.000 | (36.415) | (36.415) | 0.000 |
| RD&I | (0.153) | (0.153) | (0.000) | 0.365 | 0.365 | 0.000 |
| WBS | (8.043) | (8.043) | 0.000 | (19.882) | (19.882) | 0.000 |
| **Sub-Total Divisions** | **(23.118)** | **(23.118)** | **0.000** | **(55.932)** | **(55.932)** | **0.000** |
| Corporate Services Directorates | **(4.193)** | **(4.187)** | **(0.006)** | **(10.143)** | **(10.143)** | **0.000** |
| **Delegated Budget Position** | **(27.310)** | **(27.305)** | **(0.006)** | **(66.075)** | **(66.075)** | **0.000** |
| TCS | (0.230) | (0.230) | 0.000 | (0.551) | (0.551) | 0.000 |
| Health Technology Wales | (0.012) | (0.011) | (0.000) | (0.028) | (0.028) | 0.000 |
| Trust Income / Reserves | 27.552 | 27.550 | 0.002 | 66.654 | 66.654 | 0.000 |
| **Trust Position** | 0.000 | 0.005 | (0.005) | 0.000 | 0.000 | 0.000 |

## VCC

| | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Budget £m | Full Year Forecast £m | Year End Projected Variance £m |
|---|---|---|---|---|---|---|
| **Income** | **27.229** | **27.367** | **0.138** | **72.104** | **72.104** | **0.000** |
| Expenditure | | | | | | |
| Staff | **17.928** | **17.933** | **(0.005)** | **42.745** | **42.745** | **0.000** |
| Non Staff | **24.223** | **24.356** | **(0.133)** | **65.774** | **65.774** | **0.000** |
| **Sub Total** | **42.151** | **42.289** | **(0.138)** | **108.519** | **108.519** | **0.000** |
| **Total** | **(14.922)** | **(14.922)** | 0.000 | **(36.415)** | **(36.415)** | **0.000** |

## VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of August 2022 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 5 represents an overachievement of **£0.138m**. This is largely from an increase in activity from providing SACT Homecare and the additional VAT savings, an over achievement on private patient income due to drug performance which is above general private patient performance and a one off drug rebate. This is offsetting the divisional income savings target and

the loss of income from the now permanent closure of gift shop, which was initially closed due to Covid, and is now be transformed to make additional clinical space at the Cancer Centre.

VCC have reported a year to date overspend of **£(0.005)m** against staff. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly within Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting the cost of agency (£0.469m to end of June) although £0.140m is directly related to Covid. Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures, however with social distancing measures reducing a review of service model is being undertaken which considers both recruitment requirement, but also additional ambulatory care to help reduce inpatient flow.

Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. Additionally, enhanced out of hours service, for advanced life support which will be nursing led is currently still being covered by Jnr Dr's with expectation that the transition to nursing starts to take place from august.

Early recruitment to the delayed Integrated Radiotherapy Solution (IRS) has led to year to date committed cost of £0.207m.

Non-Staff Expenditure at Month 3 was **£(0.133)m** overspent. The overspend largely relates to the maintenance and repairs of the Linacs, transport SLA overspend, and unexpected prior year invoices being received from Virgin Media which is being partly offset by an underspend on general drugs. The affect from the increase in price for utilities is included as an exceptional national costs pressure with the expectation that the costs will be funded by WG.

## WBS

| | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Budget £m | Full Year Forecast £m | Year End Projected Variance £m |
|---|---|---|---|---|---|---|
| **Income** | **10.889** | **10.478** | **(0.412)** | **23.352** | **22.750** | **(0.602)** |
| Expenditure | | | | | | |
| Staff | **6.780** | **6.853** | **(0.074)** | **15.489** | **15.710** | **(0.221)** |
| Non Staff | **12.153** | **11.668** | **0.485** | **27.745** | **26.922** | **0.823** |
| **Sub Total** | **18.933** | **18.521** | **0.412** | **43.233** | **42.631** | **0.602** |
| **Total** | **(8.043)** | **(8.043)** | 0.000 | **(19.882)** | **(19.881)** | **0.000** |

## WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of August 2022 was **breakeven** with an outturn forecast position of **breakeven** currently expected.

Income underachievement to date is **£(0.412)m**, where activity is lower than planned on Bone Marrow and Plasma Sales. Plasma sales recovery is still being impacted and expected to continue in the short term, with the pan to award a new contract in September, however volume of product

to sell is extremely low linked to stock pressures. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in activity being considerably lower than target. Covid funding will be utilised during the first 6 months to offset reduce activity impacted by the pandemic, with the division developing a strategy to increase the panel to help mitigate the risk during the latter part of the year.

Staff reported a year-to-date overspend of **£(0.074)m** to August. Overspend from posts supported without identified funding source which includes advanced recruitment and service developments have been incurred as a divisional cost pressure particularly in relation to Plasma Fractionation where no WHSSC funding has been secured.

Work is still underway to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff underspend of **£0.485m** is largely due to reduced costs from suppressed activity underspends on Laboratory Services, WTAIL, and General Services which is primarily timing of proactive and reactive building maintenance.

## Corporate

| | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Budget £m | Full Year Forecast £m | Year End Projected £m |
|---|---|---|---|---|---|---|
| **Income** | **0.319** | **0.457** | **0.138** | **0.757** | **0.995** | **0.238** |
| Expenditure | | | | | | |
| Staff | **3.581** | **3.580** | **0.001** | **8.591** | **8.483** | **0.108** |
| Non Staff | **0.931** | **1.064** | **(0.133)** | **2.310** | **2.655** | **(0.345)** |
| **Sub Total** | **4.512** | **4.644** | **(0.132)** | **10.901** | **11.138** | **(0.237)** |
| **Total** | **(4.193)** | **(4.187)** | 0.006 | **(10.143)** | **(10.143)** | **0.000** |

### Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of August 2022 was an underspend of **£0.006m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust is currently benefiting from receiving greater returns on cash being held in the bank due to the rise in interest rates which is being reflected in the overachievement on income within the Corporate Division.

Staff expectation is that vacancies within the division, will help offset use of agency and achieve the £0.100m divisional savings target.

Non pay overspend is **£(0.133)m** as at month 4 largely relates to the divisional savings target £(0.065)m as at end of August which is expected to be met in year via staff vacancies and the additional income being received in response to the increase in interest rates. Other pressure include the increased running costs for the hospital estate with work ongoing to understand the total pressure for 2022-23.

## RD&I

| | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Budget £m | Full Year Forecast £m | Year End Projected Variance £m |
|---|---|---|---|---|---|---|
| **Income** | **0.984** | **0.919** | **(0.064)** | **3.169** | **3.033** | **(0.136)** |
| Expenditure | | | | | | |
| Staff | **1.073** | **1.001** | **0.073** | **2.621** | **2.440** | **0.181** |
| Non Staff | **0.063** | **0.071** | **(0.008)** | **0.183** | **0.183** | **(0.045)** |
| **Sub Total** | **1.136** | **1.072** | **0.065** | **2.804** | **2.623** | **0.136** |
| **Total** | **(0.153)** | **(0.153)** | (0.000) | **0.365** | **0.410** | **0.000** |

### RD&I Key Issues

The reported financial position for the RD&I Division at the end of August 2022 was **breakeven** with a current forecast outturn position of **breakeven**.

staff vacancies are offsetting the innovation income target with the stretched target for this year currently proving to be difficult to meet.

## TCS – (Revenue)

| | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Budget £m | Full Year Forecast £m | Year End Projected Variance £m |
|---|---|---|---|---|---|---|
| **Income** | **0.000** | **0.000** | **0.000** | **0.000** | **0.000** | **0.000** |
| Expenditure | | | | | | |
| Staff | **0.230** | **0.230** | **0.000** | **0.551** | **0.551** | **0.000** |
| Non Staff | **0.000** | **0.000** | **0.000** | **0.000** | **0.000** | **0.000** |
| **Sub Total** | **0.230** | **0.230** | **0.000** | **0.551** | **0.551** | **0.000** |
| **Total** | **(0.230)** | **(0.230)** | 0.000 | **(0.551)** | **(0.551)** | **0.000** |

### TCS Key Issues

The reported financial position for the TCS Programme at the end of August 2022 is **Breakeven** with a forecasted outturn position of **Breakeven.**

TCS will achieve breakeven on the assumption that the Trust reserves again supports the forecasted non-pay costs of £0.030m, along with associated costs of the judicial review which is currently expected to be £0.043m.

The TCS report assumes budget for the above Trust reserves allocation which is pending formal approval along with previously approved funding

## HTW (Hosted Other)

| | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Budget £m | Full Year Forecast £m | Year End Projected Variance £m |
|---|---|---|---|---|---|---|
| **Income** | **0.416** | **0.338** | **(0.078)** | **1.664** | **1.664** | **0.000** |
| Expenditure | | | | | | |
| Staff | **0.364** | **0.299** | **0.065** | **1.456** | **1.456** | **0.000** |
| Non Staff | **0.059** | **0.046** | **0.013** | **0.235** | **0.235** | **0.000** |
| **Sub Total** | **0.423** | **0.344** | **0.079** | **1.692** | **1.692** | **0.000** |
| **Total** | **(0.007)** | **(0.007)** | (0.000) | **(0.028)** | **(0.028)** | **0.000** |

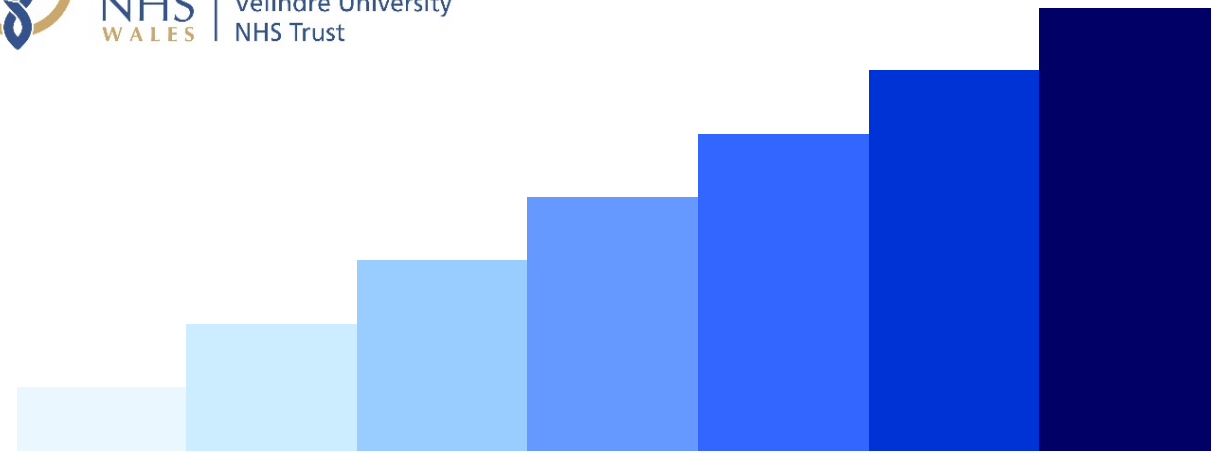
## HTW Key Issues

The reported financial position for Health Technology Wales at the end of June 2022 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage will be handed back to WG.

## Appendix 1 – TCS Programme Board Finance Report

TCS Programme Board Finance Repo

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



# TCS PROGRAMME FINANCE REPORT 2022/23

## Period Ending August 2022

**Presented to the**
**TCS Programme Delivery Board on**
**15th September 2022**

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# 1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2022/23, outlining spend to date against budget as at Month 05 and the current forecast.

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

# 2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2022/23 as at 31st August 2022 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

| Expenditure Type | Year to Date Spend | 2022/23 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Capital | £4.047m | £20.964m | £20.962m | £0.002m |
| Revenue | £0.259m | £0.684m | £0.684m | £0m |
| **Total** | **£4.306m** | **£21.648m** | **£21.646m** | **£0.002m** |

2.2 The Programme is currently forecasting an overall underspend of £0.002m for capital and revenue expenditure for the financial year 2022/23.Following a review in August 2022, WG have agreed a further virement of £1.472m of the Enabling Works Project capital funding from 2022/23 into 2023/24. This reduces the overall capital funding for 2022/23 to £21.648m. The Project will make an assessment to 'slip' funding into 2023-24 as per agreement with WG. To date the EW Project has undertaken the following adjustments into 2023-24:

- Adjustment of £1.9m in May 22 – delay in EW Project
- Adjustment of £1.472m in August 22 – delay in the Asda works

2.3 The previously reported risks for the Programme of an Enabling Works underspend due to delays and increased New Velindre Cancer Centre (nVCC) advisory fees have been mitigated. There are currently no financial risks for the TCS Programme.

# 3. BACKGROUND

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

3.2 By 31st March 2022, the Welsh Government (WG) had provided a total of £25.904m funding (£23.283m capital, £2,261m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.111m from non-recurrent revenue funding.

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

3.4 Following a review in August 2022, the current funding provided to support the TCS Programme in 2022/23 is £20.964m capital and £0.684m revenue, as outlined in Appendix 2.

## 4. CAPITAL POSITION

4.1 There is a revised Capital Expenditure Limit (CEL) from WG of £18.441m for the Enabling Works Project and £2.089m to support the nVCC Project in 2022/23.

4.2 WG funding for the Integrated Radiotherapy Solution Procurement (IRS) Project was utilised in previous years, therefore no CEL has been issued for this Project. The capital funding requirement of £0.434m will be provided from the Trust's discretionary capital allocation.

4.3 The capital position as at 31st August 2022 is outlined below, with a forecast outturn of £20.962m for 2022/23 against an overall budget of £20.964m.

| Capital Expenditure | Year to Date Spend | 2022/23 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Enabling Works Project | £2.354m | £18.441m | £17.636m | £0.805m |
| nVCC Project | £1.563m | £2.089m | £2.892m | -£0.803m |
| IRS Project | £0.130m | £0.434m | £0.434m | £0m |
| **Total** | **£4.047m** | **£20.964m** | **£20.962m** | **£0.002m** |

4.4 The forecast overspend of £0.803m for the nVCC Project will be supported by the Enabling Works Project underspend of £0.805m.

## 5. REVENUE POSITION

5.1 Revenue funding for the Programme Management Office (PMO) and the Service Development & Transformation (SDT) Project continues to be provided by the Trust and the NHS Commissioners.

5.2 To date, the Trust has ring-fenced £0.073m revenue funding for the nVCC Project, as no revenue funding has been provided by WG this year. Formal delegation of this budget is pending.

5.3 The revenue position as at 31st August 2022 is outlined below, with a forecast breakeven outturn for 2022/23 against a budget of the £0.684m.

| Revenue Expenditure | Year to Date Spend | 2022/23 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| PMO | £0.091m | £0.300m | £0.300m | £0m |
| nVCC Project | £0.047m | £0.073m | £0.073m | £0m |
| SDT Project | £0.121m | £0.311m | £0.311m | £0m |
| **Total** | **£0.259m** | **£0.684m** | **£0.684m** | **£0m** |

## 6. CASH FLOW

6.1 This update is currently being developed.

## 7. PROJECT FINANCE UPDATES

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

### Programme Management Office

7.2 In November 2021, the Trust EMB approved phased funding of £0.250m for the Strategic Transformation Programme from 2021/22 to 2023/24. £0.060m has been provided to the TCS Programme in 2022/23 as part of the transition between Programmes. This additional funding was agreed in May 2022, increasing the total revenue funding from £0.240m (Commissioners' funding) to £0.300m for 2022/23.

7.3 There is no capital funding requirement for the PMO in 2022/23.

7.4 The revenue position for the PMO as at 31st August 2022 is shown below.

| PMO Expenditure | Year to Date Spend | 2022/23 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £0.090m | £0.283m | £0.283m | £0m |
| Non Pay | £0.002m | £0.017m | £0.017m | £0m |
| **Total** | **£0.091m** | **£0.300m** | **£0.300m** | **£0m** |

7.5 There are currently no financial risks relating to the PMO.

### Enabling Works Project

7.6 In February 2022, the Minister for Health and Social Services approved the Enabling Works FBC, along with a total capital funding of £28.089m. £21.813m of this funding was allocated in the financial year 2022/23. In May 2022, WG approved a funding reduction of £1.900m due to a delay in the Project. A further reduction of £1.472m due to a delay in the Asda works to was approved in August 2022. There will be a virement of this overall reduction in funding of £3.372m into 2023/24. The revised CEL for the Enabling Works Project for 2022/23 is £18.441m

7.7 The Enabling Works financial position for 31st August 2022 is shown below, with a further breakdown provided in Appendix 3. The forecast position reflects an

underspend of £0.805m due to a delay in key activities, which will be used to support the nVCC Project as agreed by WG.

| Enabling Works Expenditure | Year to Date Spend | 2022/23 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £0.090m | £0.220m | £0.218m | £0.002m |
| Non Pay | £2.264m | £18.221m | £17.419m | £0.802m |
| **Total** | **£2.354m** | **£18.441m** | **£17.636m** | **£0.805m** |

7.8 The previously reported financial risk relating to a significant underspend as a result of the delay in key project activities has been mitigated by the provision of support to the nVCC Project and the aforementioned virement to the 2023/24 financial year. There are no other financial risks for the Enabling Works Project.

## New Velindre Cancer Centre Project

### *Capital*

7.9 In March 2021, the Minister for Health and Social Services approved the nVCC OBC. This has provided capital funding of £5.550m in total, with a CEL of £2.089m in 2022/23.

7.10 The capital financial position for the nVCC Project for 31st August 2022 is shown below, with a further breakdown provided in Appendix 4. The forecast position reflects an overspend of £0.803m, which will be supported from the Enabling Works Project as agreed by WG.

| nVCC Capital Expenditure | Year to Date Spend | 2022/23 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £0.538m | £1.413m | £1.337m | £0.076m |
| Non Pay | £1.026m | £0.676m | £1.555m | -£0.879m |
| **Total** | **£1.563m** | **£2.089m** | **£2.892m** | **-£0.803m** |

7.11 The increased from £0.450m to £0.803m is due to financial pressures not funded within the nVCC OBC, which include:

- Technical Advisory support for Section 73 Application;
- Additional legal support; and
- Staff resources to provide Digital and Estates Support.

7.12 Additional financial support is available from the Enabling Works Project due to an increased underspend. The support provided will be included in the nVCC FBC to pay back to the Enabling Works Project in 2023/24.

7.13 The financial risk relating to increased advisory fees now been mitigate as outlined above. There are no other financial risks for the nVCC Project, however the Project's financial position will be monitored closely over the remaining months of the financial year as no further support will be available from the Enabling Works Project.

### *Revenue*

7.14 No revenue funding has been provided for nVCC Project by WG, therefore the Trust has ring-fenced a revenue budget of £0.030m for nVCC Project Delivery, and a further £0.043m for the Judicial Review Matter. Formal delegation for both budgets is pending.

7.15 The revenue financial position for the nVCC Project for 31st August 2022 is shown below, reflecting a forecast breakeven spend against a budget of £0.073m.

| nVCC Revenue Expenditure | Year to Date Spend | 2022/23 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Project Delivery | £0.014m | £0.030m | £0.030m | £0m |
| Judicial Review | £0.033m | £0.043m | £0.043m | £0m |
| **Total** | **£0.047m** | **£0.073m** | **£0.073m** | **£0m** |

7.16 Following the closure of the Judicial Review matter, the budget and forecast spend for this matter will be reviewed once of any outstanding and final fees have been presented to the Project.

7.17 There are currently no financial risks relating to the nVCC revenue expenditure.

## Integrated Radiotherapy Solution Procurement Project

7.18 Due to a delay in the procurement process, the IRS Project has been extended to September 2022. This has resulted in an additional capital requirement of £0.434m in 2022/23, which has been ring-fenced by the Trust from its 2022/23 discretionary capital allocation.

7.19 There is no revenue funding requirement for the Project in 2022/23.

7.20 The capital position for the IRS Project for 31st August 2022 is outlined below, with a breakeven position forecast for the year.

| IRS Expenditure | Year to Date Spend | 2022/23 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £0.065m | £0.072m | £0.080m | -£0.008m |
| Non Pay | £0.065m | £0.362m | £0.354m | £0.008m |
| **Total** | **£0.130m** | **£0.434m** | **£0.434m** | **£0m** |

7.21 There are currently no financial risks relating to the IRS Procurement Project.

## Service Delivery and Transformation Project

7.22 The SDT Project has received revenue funding of £0.131m from the Trust and £0.180m funding from the NHS Commissioners' contribution to support pay and non-pay costs in 2022/23.

7.23 There is no capital funding requirement for the Project in 2022/23.

7.24 The SDT Project revenue position as at 31st August 2022 is shown below.

| SDT Expenditure | Year to Date Spend | 2022/23 Full Year | | |
|---|---|---|---|---|
| | | Budget | Forecast | Variance |
| Pay | £0.121m | £0.288m | £0.288m | £0m |
| Non Pay | £0m | £0.023m | £0.023m | £0m |
| **Total** | **£0.121m** | **£0.311m** | **£0.311m** | **£0m** |

7.25 There are currently no financial risks relating to the SDT Project.

## 8. KEY RISKS AND MITIGATING ACTIONS

8.1 The previously reported financial risks due to a result of the delay of key activities within the Enabling Works Project, and increased advisory fees within the nVCC Project have been mitigated as outlined in Section 7.

8.2 There are currently no other financial risks for the TCS Programme.

## 9. TCS SPEND REPORT SUMMARY

9.1 This update is currently being developed.

# APPENDIX 1: TCS Programme Budget and Spend 2022/23 as at 31st August 2022

| CAPITAL | Year to Date | | | Financial Year | | |
|---|---|---|---|---|---|---|
| | Budget Aug-22 | Spend Aug-22 | Variance Aug-22 | Annual Budget | Annual Forecast | Annual Variance |
| | £ | £ | £ | £ | £ | £ |
| **PAY** | | | | | | |
| Project Leadership | 86,990 | 88,808 | -1,818 | 208,776 | 212,701 | -3,925 |
| Project 1b - Enabling Works FBC | 91,560 | 89,643 | 1,917 | 219,744 | 217,507 | 2,237 |
| Project 2a - New Velindre Cancer Centre OBC | 524,307 | 448,783 | 75,525 | 1,203,913 | 1,123,845 | 80,067 |
| Project 3a - Radiotherapy Procurement Solution | 64,202 | 64,720 | -518 | 72,101 | 79,773 | -7,672 |
| **Capital Pay Total** | **767,059** | **691,954** | **75,105** | **1,704,534** | **1,633,826** | **70,708** |
| **NON-PAY** | | | | | | |
| nVCC Project Delivery | 34,405 | 32,932 | 1,473 | 84,000 | 84,947 | -947 |
| Project 1b - Enabling Works FBC | 2,588,032 | 2,263,881 | 324,151 | 18,221,033 | 17,418,646 | 802,387 |
| Project 2a - New Velindre Cancer Centre OBC | 592,311 | 992,634 | -400,323 | 592,311 | 1,470,134 | -877,823 |
| Project 3a - Radiotherapy Procurement Solution | 162,500 | 65,283 | 97,217 | 361,899 | 354,227 | 7,672 |
| **Capital Non-Pay Total** | **3,377,248** | **3,354,730** | **22,518** | **19,259,243** | **19,327,954** | **-68,711** |
| **CAPITAL TOTAL** | **4,144,307** | **4,046,684** | **97,623** | **20,963,777** | **20,961,780** | **1,996** |

| REVENUE | Year to Date | | | Financial Year | | |
|---|---|---|---|---|---|---|
| | Budget Aug-22 | Spend Aug-22 | Variance Aug-22 | Annual Budget | Annual Forecast | Annual Variance |
| | £ | £ | £ | £ | £ | £ |
| **PAY** | | | | | | |
| Programme Management Office | 88,446 | 89,734 | -1,289 | 282,993 | 282,993 | 0 |
| Project 6 - Service Change Team | 120,163 | 121,228 | -1,066 | 288,390 | 288,390 | 0 |
| **Revenue Pay total** | **208,609** | **210,963** | **-2,354** | **571,383** | **571,383** | **0** |
| **NON-PAY** | | | | | | |
| nVCC Project Delivery | 12,562 | 13,643 | -1,081 | 30,000 | 30,000 | 0 |
| nVCC Judicial Review | 32,956 | 32,956 | 0 | 43,417 | 43,417 | 0 |
| Programme Management Office | 2,500 | 1,626 | 874 | 17,007 | 17,007 | 0 |
| Project 6 - Service Change Team | 5,697 | 111 | 5,586 | 22,610 | 22,610 | 0 |
| **Revenue Non-Pay Total** | **53,716** | **48,337** | **5,379** | **113,034** | **113,034** | **0** |
| **REVENUE TOTAL** | **262,324** | **259,300** | **3,025** | **684,417** | **684,417** | **0** |

## APPENDIX 2: TCS Programme Funding for 2022/23

| Description | Funding Type | |
|---|---|---|
| | Capital | Revenue |
| **Programme Management Office** | **£0m** | **£0.300m** |
| Commissioner's funding (April 2022) | | £0.240m |
| Year 1 Trust revenue funding for Strategic Transformation (April 2022) | | £0.060m |
| **Enabling Works OBC** | **£18.441m** | **£0m** |
| 2022/23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022 | £21.813m | |
| Virement of funds from 2022/23 to 2023/24 financial year (May 2022) | -£1.900m | |
| Virement of funds from 2022/23 to 2023/24 financial year (August 2022) | -£1.472m | |
| **New Velindre Cancer Centre OBC** | **£2.089m** | **£0.073m** |
| 2022/23 CEL from Welsh Government funding for nVCC OBC (March 2021) | £2.089m | |
| Trust revenue funding for nVCC Project Delivery (May 2022) | | £0.030m |
| Trust revenue funding for Judicial Review matter (May 2022) | | £0.014m |
| Additional Trust revenue funding for Judicial Review matter (June 2022) | | £0.029m |
| **Integrated Radiotherapy Procurement Solution** | **£0.434m** | **£0m** |
| Trust Discretionary Capital Allocation (June 2022) | £0.434m | |
| **Radiotherapy Satellite Centre** | **£0m** | **£0m** |
| No funding requested or provided for this project to date | | |
| **SACT and Outreach** | **£0m** | **£0m** |
| No funding requested or provided for this project to date | | |
| **Service Delivery, Transformation and Transition** | **£0m** | **£0.311m** |
| Commissioner's funding (April 2022) | | £0.180m |
| Trust Funding (April 2022) | | £0.131m |
| **VCC Decommissioning** | **£0m** | **£0m** |

| Description | Funding Type | |
|---|---|---|
| | Capital | Revenue |
| No funding requested or provided for this project to date | | |
| **Total** | **£20.964m** | **£0.684m** |

# APPENDIX 3: Enabling Works Project Budget and Spend 2022/23 as at 31st August 2022

| Description | | Year to Date Budget Aug-22 £ | Year to Date Spend Aug-22 £ | Year to Date Variance Aug-22 £ | Financial Year Annual Budget £ | Financial Year Annual Forecast £ | Financial Year Annual Variance £ |
|---|---|---|---|---|---|---|---|
| **PAY** | | | | | | | |
| Project 1b - Enabling Works FBC | | 91,560 | 89,643 | 1,917 | 219,744 | 217,507 | 2,237 |
| **Pay Capital Total** | | **91,560** | **89,643** | **1,917** | **219,744** | **217,507** | **2,237** |
| **NON-PAY - PROJECTS** | | | | | | | |
| EF01 | Construction Costs | 0 | 51,662 | -51,662 | 0 | 51,662 | -51,662 |
| EF02 | Utility Costs | 0 | 0 | 0 | 1,850,895 | 1,850,895 | 0 |
| EF03 | Supply Chain Fees | 242,213 | 242,213 | 0 | 596,047 | 596,380 | -333 |
| EF04 | Non Works Costs | 44,483 | 44,483 | 0 | 495,847 | 516,847 | -21,000 |
| EF05 | ASDA Works | 249,872 | 220,078 | 29,795 | 4,570,654 | 4,570,654 | 0 |
| EF06 | Walters D&B | 1,540,778 | 1,540,778 | 0 | 8,735,418 | 8,735,418 | 0 |
| EF07 | Other (Decant Works, Surveys & Investigations, IM&T etc.) | 0 | 0 | 0 | 174,000 | 153,000 | 21,000 |
| EFQR | Quantified Risk | 510,686 | 164,668 | 346,018 | 1,351,828 | 534,711 | 817,117 |
| EFQS | QRA - SCP | 0 | 0 | 0 | 454,080 | 454,080 | 0 |
| EFRS | Enabling Works FBC Reserves | 0 | 0 | 0 | -7,736 | -45,000 | 37,264 |
| **Enabling Works Project Capital Total** | | **2,588,032** | **2,263,881** | **324,151** | **18,221,033** | **17,418,646** | **802,387** |
| **TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE** | | **2,679,592** | **2,353,524** | **326,067** | **18,440,777** | **17,636,153** | **804,624** |

# APPENDIX 4: nVCC Project Budget and Spend 2022/23 as at 31st August 2022

| Description | Year to Date Budget Aug-22 £ | Year to Date Spend Aug-22 £ | Year to Date Variance Aug-22 £ | Financial Year Annual Budget £ | Financial Year Annual Forecast £ | Financial Year Annual Variance £ |
|---|---|---|---|---|---|---|
| **PAY** | | | | | | |
| Project Leadership | 86,990 | 88,808 | -1,818 | 208,776 | 212,701 | -3,925 |
| Project 2a - New Velindre Cancer Centre OBC | 524,307 | 448,783 | 75,525 | 1,203,913 | 1,123,845 | 80,067 |
| **Pay Capital Total** | **611,297** | **537,591** | **73,707** | **1,412,689** | **1,336,546** | **76,143** |
| **NON-PAY** | | | | | | |
| **nVCC Project Delivery** | **34,405** | **32,932** | **1,473** | **84,000** | **84,947** | **-947** |
| **Work Packages** | | | | | | |
| VC08 Competitive Dialogue - Dialogue & SP to FC | 592,311 | 950,058 | -357,747 | 592,311 | 1,427,558 | -835,247 |
| VC10 Legal Advice | 0 | 2,460 | -2,460 | 0 | 2,460 | -2,460 |
| VC11 S73 Planning | 0 | 99,206 | -99,206 | 0 | 99,206 | -99,206 |
| VCRS nVCC Reserves | 0 | -59,090 | 59,090 | 0 | -59,090 | 59,090 |
| **nVCC Project Capital Total** | **592,311** | **992,634** | **-400,323** | **592,311** | **1,470,134** | **-877,823** |
| **TOTAL nVCC fbc CAPITAL EXPENDITURE** | **1,238,013** | **1,563,157** | **-325,144** | **2,089,000** | **2,891,627** | **-802,627** |

# TRUST BOARD

# TRUST RISK REGISTER

| | |
|---|---|
| **DATE OF MEETING** | 29.09.2022 |

| | |
|---|---|
| **PUBLIC OR PRIVATE REPORT** | Public |

| | |
|---|---|
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |

| | |
|---|---|
| **PREPARED BY** | MEL FINDLAY, BUSINESS SUPPORT OFFICER |
| **PRESENTED BY** | Lauren Fear, Director of Corporate Governance and Chief of Staff |
| **EXECUTIVE SPONSOR APPROVED** | Lauren Fear, Director of Corporate Governance and Chief of Staff |

| | |
|---|---|
| **REPORT PURPOSE** | FOR APPROVAL |

| **COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING** | | |
|---|---|---|
| **COMMITTEE OR GROUP** | **DATE** | **OUTCOME** |
| Executive Management Board | 01.09.2022 | NOTED |
| Quality, Safety and Performance Committee | 15.09.2022 | DISCUSSED and NOTED |

## Acronyms

| | | | |
|---|---|---|---|
| VCC | Velindre Cancer Centre | SLT | Senior Leadership Team |
| WBS | Welsh Blood Service | SMT | Senior Management Team |
| TCS | Transforming Cancer Services | EMB | Executive Management Board |

## 1. BACKGROUND

The purpose of this report is to:

Share the current extract of risk registers to allow the Trust Board to have effective oversight and assurance of the way in which risks are currently being managed across the Trust.

- Summarise the feedback, and progress against that to date, on the process from the previous cycle of Committees and Trust Board.
- Summarise the final phase in implementing the Risk Framework.
- Outline approach to risk appetite review for autumn 2022.
- Approve the new Trust Risk Management Policy.

## 2. ASSESSMENT OF MATTERS FOR CONSIDERATION

2.1 Key points for the Trust Board:

- There has been extensive review of the Velindre Cancer Services risks, which are reflected in the profile of risks over 15 recorded in this report. There is a focus on risk in Velindre Cancer Services Senior Leadership Team continuing in the next reporting period, where all actions (shown as blank in this report if not yet completed) will be completed.
- Migration onto Datix 14 complete for WBS for all new risks and Board level reporting risks. Remainder now being migrated.
- The Risk Management Policy has been endorsed by the Audit Committee for Trust Board approval and is attached in Appendix 2.

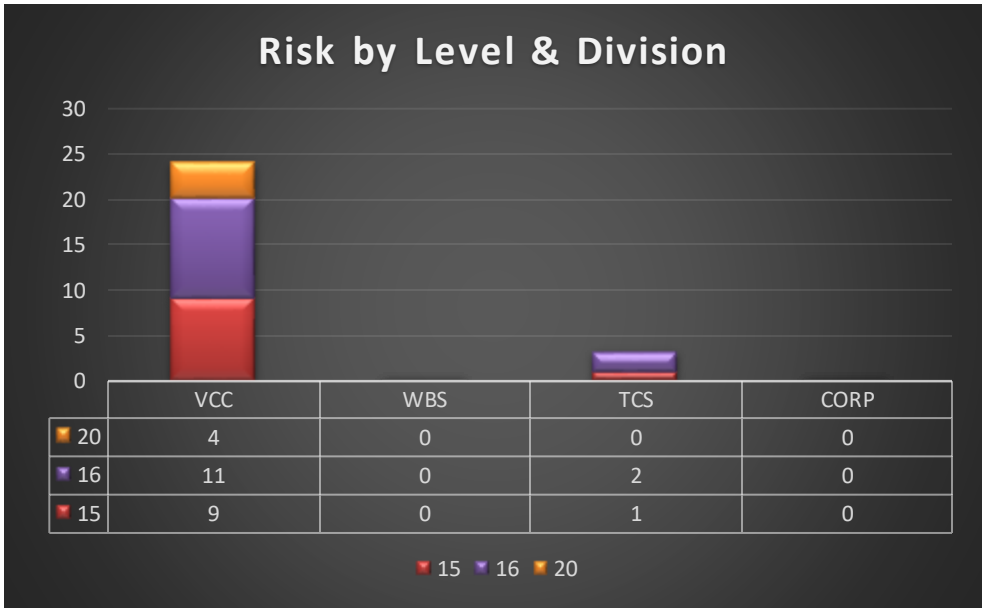
### 2.4 Trust Risk register.

#### 2.4.1 Total Risks

There are a total of 33 risks with a current risk level over 15 recorded on Datix 14. The extract is appended in full in Appendix 1.

#### 2.4.2 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.


### 2.4.3 **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 (to note, the data extract is at end August)- and title of the risk.

**Risks level 20**

The table below provides a breakdown of level 20 risks**.**

| ID | Title | Division | Risk (in brief) | Rating (current) | Rating (Target) | Review date | Action Summary |
|---|---|---|---|---|---|---|---|
| 2644 | Digital Health & Care Record DH&CR080(R) - SACT Treatment Summary PDF displaying 'Authorised' status | Velindre Cancer Centre | An issue has been identified whereby the SACT Treatment Summary PDF is displaying an 'Authorised' status for a cycle where all the drugs within the cycle have been marked as Given or Not Given. The Chemocare application has inbuilt logic to derive the 'Completed' status when the cycle has been Authorised + drugs marked as Given/Not Given. The SACT TS PDF is misleading and could cause the reader to interpret that the treatment was not given to the patient. | 20 | 1 | 30/09/2022 | |
| 2630 | Digital Health & Care Record DHCR062(R) - Dual Running timeline - risk of patients in Canisc with not finished treatment | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period.<br><br>Following decision to run dual entry up to 12 weeks, there will be a resource requirements, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales. | 20 | 15 | 05/09/2022 | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2579 | Palliative Care Training posts | Velindre Cancer Centre | Wales been unsuccessful in appointing to any of the pall care registrar posts at the recent round of UK wide recruitment, this appears to be reflected across the UK with posts in all regions unfilled.In addition one of our trainees has been successful in gaining an Inter Deanery Transfer to Severn Deanery which will mean she will leave our training programme in October 2022 and return directly from maternity leave to Severn.2 new palliative care StR training posts have had their funding frozen - which means it isn't lost (this year at least), goes back to Welsh Government, but at present we are told that we cannot access the funding for these 2 posts to appoint locum replacement specialty or LAS doctors. Added to this a further trainee is likely going for an Intradeanery transfer to London, and if final approval is granted which is likely, will be there for Oct 2022. This leaves us with approximately 4 middle grade doctors on the 1:6 on call rota. There will need to be locum provision into these vacant on call spots, unless we are able to fill the vacant posts with specialty doctors. | 20 | 4 | 30/09/2022 | |
| 2200 | Radiotherapy Capacity | Velindre Cancer Centre | Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes.2/7/19 updateHazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ).This will be linked to Risk 22455/11/2021 - UpdateCurrently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix.23/11/2021 - UpdateCurrently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet.Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service13/6/2022 - UpdateCurrently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet.Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service31/8/2022 - | 20 | 6 | 31/10/2022 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | UPDATERisk reviewed and no change to risk rating due to no change in capacity or outsourcing possibilities. | | | | |

**Risks level 16**

The work undertaken to further review risks have also resulted in a change in the number of level 16 risks.

| ID | Title | Risk Type | Division | Risk (in brief) | Rating (current) | Rating (Target) | Review date |
|---|---|---|---|---|---|---|---|
| 2650 | Digital Health & Care Record DH&CR094(R) - Non-delivery of interface that pulls clinical annotations from WCP OMN to VCC DMS | Performance and Service Sustainability | Velindre Cancer Centre | A risk has been raised regarding the non-delivery of the interface that pulls clinical annotations from the WCP Outpatient Medical Note (OMN) to the VCC Document Management System (DMS). This is an existing interface that pulls clinical annotations recorded against the outpatient appointment in Canisc into DMS at the point of letter creation. | 16 | 4 | 05/09/2022 |
| 2211 | Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working | Performance and Service Sustainability | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>DHCR004(R) - Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays.<br><br>There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming. | 16 | 12 | 05/09/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2221 | Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS | Performance and Service Sustainability | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.DHCR019(R) - Clinical coding require a 'Copy Coding Functionality' within WPAS. Currently within Canisc VCC Clinical Coding staff are able to choose an option to 'copy exact coding to all linked Radiotherapy (RT) Regular Day Admissions (in same sequence of admissions)'.This means that if a patient has received 10 episodes of radiotherapy the coder can code the first episode and then click the copy function to copy to the other 9 episodes. This saves the coder time and ensures the accuracy of the coding.This functionality is not available within WPAS; therefore it is requested that the functionality be developed.There is a risk that NWIS are unable to deliver an exact replica of the functionality within the timescales - there is also a prerequisite on the Radiotherapy Admissions work completing and the eIRMER development. This could affect the implementation timescales.DHCW confirmed that they can replicate the copy coding functionality but that it could take up to 12 months. They have confirmed a temporary manual copy coding function that will be used in the interim. This will require 2 staff (or equivalent overtime) for up to 12 months.Without the ability to copy the RT Regular Day Admissions (in same sequence of admissions) will have a resource and financial impact.Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards. At present, 2 coders code 60,000 episodes of RT Regular Day Admissions. Without the function to copy the coding team would need additional resource to maintain deadlines. A full time coders would generally code approx. 6,000 episodes per year. Therefore an additional 8 full time coders would be required to maintain current levels of productivity. Financials can be calculated if necessary.Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards. | 16 | 12 | 05/09/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2326 | Digital Health & Care Record DHCR030(R) - Service unable to significantly reduce the capacity of clinics over the Go-Live period | Performance and Service Sustainability | Velindre Cancer Centre | There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care Record go-live.<br><br>A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system. | 16 | 9 | 05/09/2022 |
| 2329 | Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics | Performance and Service Sustainability | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required.Documentation and performance data will not be accurate. Protracted administrative process causing stress to clinical teams whose primary focus is clinical care. | 16 | 16 | 12/09/2022 |
| 2440 | Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics | Performance and Service Sustainability | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>DHCR046(R) - SACT & MM service are unable to significantly reduce the capacity of SACT daycase clinics and concern re: reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients<br><br>Minimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity. | 16 | 6 | 05/09/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2499 | Digital Health & Care Record DHCR051(R) - There is a risk that not all interfaces will be delivered timely for sufficient testin | Performance and Service Sustainability | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>DHCRO51(R) - There is a risk that not interfaces will be delivered in a timely manner for sufficient testing.<br><br>* Clinical information will not be available in WCP/WPAS.<br>* VCC runs a clinical safety risk if data is not available for decision support.<br>*Not enough time will be available to provide adequate assurance. | 16 | 8 | 05/09/2022 |
| 2465 | Number of emails medics are receiving, especially those related to clinical tasks. | Safety | Velindre Cancer Centre | The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on. | 16 | 4 | 30/11/2022 |
| 2407 | Risk of overlapping timeframes and interdependencies between RSC & IRS Projects | Performance and Service Sustainability | Transforming Cancer Services | There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependencies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk. | 16 | 4 | 20/10/2022 |
| 2513 | There are a lack of staff holding a practitioners licence for prostate Brachytherapy | Performance and Service Sustainability | Velindre Cancer Centre | 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 | 16 | 10 | 31/07/2022 |
| 2428 | There is a risk of increased infection transmission due to poor ventilation. | Compliance | Velindre Cancer Centre | Concerns have been raised around the poor ventilation and seasonal extremes of temperature that exist within inpatient areas at VCC impacting both staff and patients, this risk assessment relates to First Floor (FF) ward. Patients receiving care in the inpatient ward at VCC are often immunocompromised and/or neutropenic and therefore would benefit from improved air quality which can only be guaranteed through a compliant mechanical ventilation system. See document for full description | 16 | 9 | 02/09/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 2554 | There is a risk that Patients may not be informed in a timely manner | GDPR | Velindre Cancer Centre | There is a risk that Patients may not be informed in a timely manner as to the loss/damage to their Medical Records caused by the capacity of the Medical Records Department to identify and categorise lost/damaged records. The impact will be a material breach of the Data Protection Act 2018 in that patients who suffer a loss or damage to records may not be informed in line with the requirements of the Act | 16 | 4 | 30/09/2022 |
| 2528 | There is a risk that Programme Master Plan objectives & outcomes are delayed and/or not met | Performance and Service Sustainability | Transforming Cancer Services | There is a risk that Projects remain 'On Hold' and / or incur delays impacting on the key interdependencies with other projects resulting in Programme Master Plan objectives & outcomes being delayed / not being met | 16 | 6 | 30/06/2022 |

**Risks level 15**

Summary of level 15 risks are detailed in the table below.

| ID | Title | Risk Type | Division | Risk (in brief) | Rating (current) | Rating (Target) | Review date |
|---|---|---|---|---|---|---|---|
| 2187 | Radiotherapy Physics Staffing | Safety | Velindre Cancer Centre | There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing.<br><br>This staff group is key in ensuring quality and safety of radiotherapy treatments.<br><br>This may result in<br>- patient treatment delay<br>- Radiotherapy treatment errors.<br>- key projects not keeping to time e.g. commissioning of essential systems<br>- suboptimal treatment - either due to lack of planning time or lack of developmental time<br><br>Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include<br><br>i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice<br>ii. Inability to provide engineering cover during weekend quality control activities<br>iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice<br>iv. Development of workflow processes to increase efficiency<br>v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN)<br>vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C)<br>vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC.<br><br>Background<br>The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance.<br><br>The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly | 15 | 5 | 31/10/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced.<br><br>Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties. | | | |
| 2612 | Acute Oncology Service (AOS) Workforce Gaps | Workforce and OD | Velindre Cancer Centre | There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced.<br><br>As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service.<br><br>This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered. | 15 | 6 | 28/10/2022 |
| 2253 | Availability of CANISC System | Performance and Service Sustainability | Velindre Cancer Centre | There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc. | 15 | 5 | 01/12/2022 |
| 2205 | CANISC failure | Performance and Service Sustainability | Velindre Cancer Centre | Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no "fall-back" method for the above tasks. | 15 | 9 | 01/12/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling.<br><br>IRMER-lite form in WPAS will go live in November 2023 | | | |
| 2638 | Digital Health & Care Record DH&CR065(R) - Provision of a DPIA - as WPAS is a national system for the WPAS System. | Compliance | Velindre Cancer Centre | The VCC IG Manager discussed with DHCW IG colleagues about providing a copy of the data protection impact assessment (DPIA - as WPAS is a national system) for the WPAS System. From a DHCW perspective WPAS predates current assurance processes and was introduced before GDPR and the requirement for Data Protection Impact. The NIIAS integration is documented but It is believe there is no formal DPIA for WPAS. The WPAS Applications Manager has stated that the WPAS system has a sophisticated role-based security model and further success controls. When WCP was implemented into VCC a DPIA was provided which provide assurance from an information governance perspective on access controls, role based structure and permission levels etc. The impact is on the DPIA being requested by VCC not being available in the same format as the WCP DPIA with access controls etc. being documented. Currently no IG Manager on post at VCC | 15 | 4 | 05/09/2022 |
| 2649 | Digital Health & Care Record DH&CR093(R) - Lack of Administrative Support and associated processing errors using WPAS | Performance and Service Sustainability | Velindre Cancer Centre | Specific Risk raised by Therapies Team regarding the lack of Administrative support for processing their planned and drop in clinics. At present there are 32 members of clinical staff and 0.4 wte of administrative support. The clinical staff process all of their clinics on Canisc themselves. The incoming process with the WPAS system is far more intricate and less forgiving - as it has strict booking and outcoming rules which require skilled and knowledgeable processing. The potential for error is increased - and for clinical staff to be responsible for this will further increase the potential for error. The assistants and Therapies Technician's will have to be removed from their clinical roles, to manage the administrative work.1) They will no longer be working at the top of their banding/liscence2) Patients may not be seen in a timely fashion by therapies teams, impacting their quality of care and potentially their outcomes.3) Increase potential errors by staff who are not employed to do the role they are doing. | 15 | 4 | 05/09/2022 |
| 2512 | Digital Health & Care Record DHCR022(R) - Business Continuity Risk following Implementation | Performance and Service Sustainability | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board. DHCR022 - A potential business continuity risk following implementation. Currently the WCP is used to access case note summaries for patients in | 15 | 12 | 05/09/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | order to provide business continuity when Canisc is unavailable.<br><br>The impact in this risk would be felt after go-live but could impact on service delivery.<br><br>This is potentially a service risk but will be considered and summarised for the project risk register and discussed further at the next Project Board Meeting | | | |
| 2515 | There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service | Performance and Service Sustainability | Velindre Cancer Centre | "Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day."<br>"There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment.<br>Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff" | 15 | 5 | 27/05/2022 |
| 2604 | There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution. | Workforce and OD | Transforming Cancer Services | There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution. | 15 | 4 | 30/09/2022 |
| 2609 | There is a risk to safety as a result of hot weather leading to harm to staff in non clinical areas | Safety | Velindre Cancer Centre | The Met Office have issued an Amber Weather warning for the 17th, 18th and 19th July for extreme heat with temperatures potentially reaching in excess of 360C. It may possibly be hotter in the VCC buildings due to their age, construction, equipment and lack of mechanical ventilation.<br><br>The Met Office identifies population wide adverse health effects are identified and substantial changes to working practices are likely to be required.<br><br>VCC is a flat roofed building which does not have air conditioning throughout the building. In addition some air conditioning has been turned off due to NWSSP guidance on control of risks of Covid transmission. Some offices do not have windows that open.<br><br>Currently following IP&C and NWSSP advice to the Trust Ventilation Group fans are not allowed in both clinical and non clinical areas.<br><br>Working conditions for staff in non clinical areas are going to be extremely hot over the period of the Amber Weather warning this may have an impact both on health, stress and wellbeing and on the ability of our staff | 15 | 8 | 01/09/2022 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | to deliver services.<br><br>Control measures are already in place but given the extreme nature of the forecast heat event these may not be sufficient in all areas of the buildings and further cooling/air movement may be beneficial which could involve the use of fans during this period. | | | |

## 3. Development of Risk Framework

**3.1** Three key steps remain for the development of risk framework:

3.1.1 Approval of the Risk Management Policy by Trust Board approval in September.

The Audit Committee considered the Risk Management Policy and asked to have a view of the other framework documents to provide a fuller context:

- Trust Assurance Framework – as approved in Trust Board September 2021
- Risk Appetite Strategy – due for renewal in November Trust Board (following the Board Development risk and assurance session in early November)
- Risk Management Procedure – at Executive Management Board level for approval

3.1.2 Three levels of training to be delivered:

- All staff Level - training covering: why is risk management important, what is my role, first form of Datix 14, which is the simple input form which all staff in organisation have access to in order to raise a risk. This training will be delivered via online learning on ESR. This training is in the later stages of the process with Shared Service.
- 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. Level 2 training has been completed at the Welsh Blood Service, is currently underway for Corporate division, which will be completed by the end of September. Velindre Cancer Centre training will be delivered primarily via their away day but additional sessions will be run.
- Leadership level – covering the Policy and oversight roles - Divisional Leadership Teams, Executive Management Board and Trust Board.

Training has been completed for Board members and Executive Management Board members, including Divisional leadership.

3.1.3 The transition to version 14 of Datix for The Welsh Blood Service is complete.

3.1.4 Oversight of the development of the risk framework is via the Audit Committee. This includes specific action tracking following Internal Audit's report on the Risk Framework at the end of 2021.

3.1.5 The review of risk appetite will be discussed with the Board in development session in early November.

## 4. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Yes (Please see detail below) |
| | Is considered to have an impact on quality, safety and patient experience |
| **RELATED HEALTHCARE STANDARD** | Safe Care |
| | If more than one Healthcare Standard applies please list below. |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| **LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Risks open for extended periods of time without indication that work is being undertaken could expose the Trust that may have legal implications. |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |

| | |
|---|---|
| | If risks aren't managed / mitigated it could have financial implications. |

## 4. RECOMMENDATIONS

Trust Board is asked to:

- **NOTE** the risks level 20, 16 and 15 reported in the Trust Risk Register and highlighted in this paper.
- **NOTE** the on-going developments of the Trust's risk framework.
- **APPROVE** the Trust Risk Management Policy in Appendix 2.

| ID | Title | Division | Risk (in brief) | Rating (initial) | Rating (current) | Rating (Target) | Review date | Action Summary |
|---|---|---|---|---|---|---|---|---|
| 2187 | Radiotherapy Physics Staffing | Velindre Cancer Centre | There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing.<br><br>This staff group is key in ensuring quality and safety of radiotherapy treatments.<br><br>This may result in<br>- patient treatment delay<br>- Radiotherapy treatment errors.<br>- key projects not keeping to time e.g. commissioning of essential systems<br>- suboptimal treatment - either due to lack of planning time or lack of developmental time<br><br>Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include<br><br>i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice<br>ii. Inability to provide engineering cover during weekend quality control activities<br>iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice<br>iv. Development of workflow processes to increase efficiency<br>v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN)<br>vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C)<br>vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC.<br><br>Background<br>The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance.<br><br>The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced.<br><br>Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties. | 25 | 15 | 5 | 31/10/2022 | |
| 2612 | Acute Oncology Service (AOS) Workforce Gaps | Velindre Cancer Centre | There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced.<br><br>As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service.<br><br>This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered. | 15 | 15 | 6 | 28/10/2022 | |

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| 2253 | Availability of CANISC System | Velindre Cancer Centre | There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff.<br><br>In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc. | 15 | 15 | 5 | 01/12/2022 | |
| 2205 | CANISC failure | Velindre Cancer Centre | Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies.<br>It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations.<br>If CANISC is unavailable, there is no “fall-back” method for the above tasks.<br>Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling.<br><br>IRMER-lite form in WPAS will go live in November 2023 | 25 | 15 | 9 | 01/12/2022 | Risk to be reviewed following Canisc change |
| 2638 | Digital Health & Care Record DH&CR065(R) - Provision of a DPIA - as WPAS is a national system for the WPAS System. | Velindre Cancer Centre | The VCC IG Manager discussed with DHCW IG colleagues about providing a copy of the data protection impact assessment (DPIA - as WPAS is a national system) for the WPAS System.<br>From a DHCW perspective WPAS predates current assurance processes and was introduced before GDPR and the requirement for Data Protection Impact. The NIIAS integration is documented but It is believe there is no formal DPIA for WPAS.<br>The WPAS Applications Manager has stated that the WPAS system has a sophisticated role-based security model and further success controls.<br>When WCP was implemented into VCC a DPIA was provided which provide assurance from an information governance perspective on access controls, role based structure and permission levels etc. The impact is on the DPIA being requested by VCC not being available in the same format as the WCP DPIA with access controls etc. being documented.<br>Currently no IG Manager on post at VCC | 15 | 15 | 4 | 27/09/2022 | |

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| 2644 | Digital Health & Care Record DH&CR080(R) - SACT Treatment Summary PDF displaying 'Authorised' status | Velindre Cancer Centre | An issue has been identified whereby the SACT Treatment Summary PDF is displaying an 'Authorised' status for a cycle where all the drugs within the cycle have been marked as Given or Not Given.<br>The Chemocare application has inbuilt logic to derive the 'Completed' status when the cycle has been Authorised + drugs marked as Given/Not Given. The SACT TS PDF is misleading and could cause the reader to interpret that the treatment was not given to the patient. | 20 | 20 | 1 | 30/09/2022 | |
| 2649 | Digital Health & Care Record DH&CR093(R) - Lack of Administrative Support and associated processing errors using WPAS | Velindre Cancer Centre | Specific Risk raised by Therapies Team regarding the lack of Administrative support for processing their planned and drop in clinics. At present there are 32 members of clinical staff and 0.4 wte of administrative support. The clinical staff process all of their clinics on Canisc themselves. The incoming process with the WPAS system is far more intricate and less forgiving - as it has strict booking and outcoming rules which require skilled and knowledgeable processing. The potential for error is increased - and for clinical staff to be responsible for this will further increase the potential for error. The assistants and Therapies Technician's will have to be removed from their clinical roles, to manage the administrative work.<br>1) They will no longer be working at the top of their banding/liscence<br>2) Patients may not be seen in a timely fashion by therapies teams, impacting their quality of care and potentially their outcomes.<br>3) Increase potential errors by staff who are not employed to do the role they are doing. | 15 | 15 | 4 | 27/09/2022 | need for review in light of risk read wider than DHCR issue |
| 2650 | Digital Health & Care Record DH&CR094(R) - Non-delivery of interface that pulls clinical annotations from WCP OMN to VCC DMS | Velindre Cancer Centre | A risk has been raised regarding the non-delivery of the interface that pulls clinical annotations from the WCP Outpatient Medical Note (OMN) to the VCC Document Management System (DMS).<br>This is an existing interface that pulls clinical annotations recorded against the outpatient appointment in Canisc into DMS at the point of letter creation. | 16 | 16 | 4 | 27/09/2022 | |
| 2211 | Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>DHCR004(R) - Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays.<br><br>There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming. | 16 | 16 | 12 | 27/09/2022 | Risk to be reviewed - rating reviewed and amendments made |

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| 2221 | Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>DHCR019(R) - Clinical coding require a 'Copy Coding Functionality' within WPAS. Currently within Canisc VCC Clinical Coding staff are able to choose an option to 'copy exact coding to all linked Radiotherapy (RT) Regular Day Admissions (in same sequence of admissions)'.<br><br>This means that if a patient has received 10 episodes of radiotherapy the coder can code the first episode and then click the copy function to copy to the other 9 episodes. This saves the coder time and ensures the accuracy of the coding.<br>This functionality is not available within WPAS; therefore it is requested that the functionality be developed.<br><br>There is a risk that NWIS are unable to deliver an exact replica of the functionality within the timescales - there is also a prerequisite on the Radiotherapy Admissions work completing and the eIRMER development. This could affect the implementation timescales.<br><br>DHCW confirmed that they can replicate the copy coding functionality but that it could take up to 12 months. They have confirmed a temporary manual copy coding function that will be used in the interim. This will require 2 staff (or equivalent overtime) for up to 12 months.<br><br>Without the ability to copy the RT Regular Day Admissions (in same sequence of admissions) will have a resource and financial impact.<br><br>Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards.<br><br>At present, 2 coders code 60,000 episodes of RT Regular Day Admissions. Without the function to copy the coding team would need additional resource to maintain deadlines. A full time coders would generally code approx. 6,000 episodes per year. Therefore an additional 8 full time coders would be required to maintain current levels of productivity. Financials can be calculated if necessary.<br><br>Without the use of a copy coding function coding quality could be compromised as there would be great chance of human error. It could also compromise VCC achieving their current coding levels/standards. | 16 | 16 | 12 | 27/09/2022 | |
| 2512 | Digital Health & Care Record DHCR022(R) - Business Continuity Risk following Implementation | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br>DHCR022 - A potential business continuity risk following implementation. Currently the WCP is used to access case note summaries for patients in order to provide business continuity when Canisc is unavailable.<br><br>The impact in this risk would be felt after go-live but could impact on service delivery.<br><br>This is potentially a service risk but will be considered and summarised for the project risk register and discussed further at the next Project Board Meeting | 15 | 15 | 12 | 05/09/2022 | |
| 2326 | Digital Health & Care Record DHCR030(R) - Service unable to significantly reduce the capacity of clinics over the Go-Live period | Velindre Cancer Centre | There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care Record go-live.<br><br>A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system. | 16 | 16 | 9 | 27/09/2022 | |
| 2329 | Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required.<br><br>Documentation and performance data will not be accurate. Protracted administrative process causing stress to clinical teams whose primary focus is clinical care. | 16 | 16 | 16 | 27/09/2022 | Query re risk rating |

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| 2440 | Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>DHCR046(R) - SACT & MM service are unable to significantly reduce the capacity of SACT daycase clinics and concern re: reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients<br><br>Mimimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity. | 16 | 16 | 6 | 27/09/2022 | Query re risk rating |
| 2499 | Digital Health & Care Record DHCR051(R) - There is a risk that not all interfaces will be delivered timely for sufficient testin | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>DHCRO51(R) - There is a risk that not interfaces will be delivered in a timely manner for sufficient testing.<br><br>* Clinical information will not be available in WCP/WPAS.<br>* VCC runs a clinical safety risk if data is not available for decision support.<br>*Not enough time will be available to provide adequate assurance. | 20 | 16 | 8 | 27/09/2022 | |
| 2630 | Digital Health & Care Record DHCR062(R) - Dual Running timeline - risk of patients in Canisc with not finished treatment | Velindre Cancer Centre | Please note this risk has been raised as part of the Digital Health & Care Record (DH&CR - Canisc Replacement) programme and is ratified and managed via the DH&CR Project Board.<br><br>Dual running initially estimated to be 6-8 weeks post go-live, in meeting 20/06/22 it was established it's now likely to be 12 weeks minimum - 6 weeks + 6 weeks of fractions - finish W/c 6th Feb - finish Friday 10th. Risk is that there are still patients in Canisc who haven't finished treatment at the end of dual running period.<br><br>Following decision to run dual entry up to 12 weeks, there will be a resource requirements, which is planned for and now in place, but there are further specialist resource interdependencies beyond 12 weeks for which there is currently no mitigation, which will impact on other project timescales. | 20 | 20 | 15 | 27/09/2022 | |
| 2465 | Number of emails medics are receiving, especially those related to clinical tasks. | Velindre Cancer Centre | The volume of emails received by medical staff is unmanageable. There is a risk of missing critical emails especially critical clinical questions. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks.<br>There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on. | 16 | 16 | 4 | 30/11/2022 | |
| 2579 | Palliative Care Training posts | Velindre Cancer Centre | Wales been unsuccessful in appointing to any of the pall care registrar posts at the recent round of UK wide recruitment, this appears to be reflected across the UK with posts in all regions unfilled.<br>In addition one of our trainees has been successful in gaining an Inter Deanery Transfer to Severn Deanery, the trainee will leave our training programme in October 2022 and return directly from maternity leave to Severn.<br>2 new palliative care StR training posts have had their funding frozen - which means it isn't lost (this year at least), goes back to Welsh Government, but at present we are told that we cannot access the funding for these 2 posts to appoint locum replacement specialty or LAS doctors.<br>Added to this a further trainee is likely going for an Intradeanery transfer to London, and if final approval is granted which is likely, will be there for Oct 2022. This leaves us with approximately 4 middle grade doctors on the 1:6 on call rota. There will need to be locum provision into these vacant on call spots, unless we are able to fill the vacant posts with specialty doctors. | 20 | 20 | 4 | 30/09/2022 | |

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| 2200 | Radiotherapy Capacity | Velindre Cancer Centre | Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes.<br><br>2/7/19 update<br>Hazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ).<br>This will be linked to Risk 2245<br><br>5/11/2021 - Update<br>Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix.<br><br>23/11/2021 - Update<br>Currently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet.<br>Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service<br><br>13/6/2022 - Update<br>Currently we have insufficient capacity to meet demand. The number of hours available is restricted to a maximum due to safe staffing, skills mix, and the age and configuration of the fleet.<br>Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service<br><br>31/8/2022 - UPDATE<br>Risk reviewed and no change to risk rating due to no change in capacity or outsourcing possibilities. | 20 | 20 | 6 | 31/10/2022 | |
| 2407 | Risk of overlapping timeframes and interdependancies between RSC & IRS Projects | Transforming Cancer Services | There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependancies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk. | 16 | 16 | 4 | 20/10/2022 | |
| 2513 | There are a lack of staff holding a practitioners licence for prostate Brachytherapy | Velindre Cancer Centre | 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 | 20 | 16 | 10 | 31/07/2022 | |

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| 2428 | There is a risk of increased infection transmission due to poor ventilation. | Velindre Cancer Centre | Concerns have been raised around the poor ventilation and seasonal extremes of temperature that exist within inpatient areas at VCC impacting both staff and patients, this risk assessment relates to First Floor (FF) ward. Patients receiving care in the inpatient ward at VCC are often immunocompromised and/or neutropenic and therefore would benefit from improved air quality which can only be guaranteed through a compliant mechanical ventilation system. See document for full description | 16 | 16 | 9 | 02/09/2022 | |
| 2554 | There is a risk that Patients may not be informed in a timely manner | Velindre Cancer Centre | There is a risk that Patients may not be informed in a timely manner as to the loss/damage to their Medical Records caused by the capacity of the Medical Records Department to identify and categorise lost/damaged records. The impact will be a material breach of the Data Protection Act 2018 in that patients who suffer a loss or damage to records may not be informed in line with the requirements of the Act | 20 | 16 | 4 | 30/09/2022 | |
| 2528 | There is a risk that Programme Master Plan objectives & outcomes are delayed and/or not met | Transforming Cancer Services | There is a risk that Projects remain 'On Hold' and / or incur delays impacting on the key interdependencies with other projects resulting in Programme Master Plan objectives & outcomes being delayed / not being met | 16 | 16 | 6 | 30/06/2022 | |

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| 2515 | There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service | Velindre Cancer Centre | "Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required.<br>There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day."<br>"There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment.<br>Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff" | 15 | 15 | 5 | 27/05/2022 | |
| 2604 | There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution. | Transforming Cancer Services | There is a risk that the Trust may not be able to recruit sufficient resource to implement the Solution. | 15 | 15 | 4 | 30/09/2022 | |
| 2609 | There is a risk to safety as a result of hot weather leading to harm to staff in non clinical areas | Velindre Cancer Centre | The Met Office have issued an Amber Weather warning for the 17th, 18th and 19th July for extreme heat with temperatures potentially reaching in excess of 360C. It may possibly be hotter in the VCC buildings due to their age, construction, equipment and lack of mechanical ventilation.<br><br>The Met Office identifies population wide adverse health effects are identified and substantial changes to working practices are likely to be required.<br><br>VCC is a flat roofed building which does not have air conditioning throughout the building. In addition some air conditioning has been turned off due to NWSSP guidance on control of risks of Covid transmission. Some offices do not have windows that open.<br><br>Currently following IP&C and NWSSP advice to the Trust Ventilation Group fans are not allowed in both clinical and non clinical areas.<br><br>Working conditions for staff in non clinical areas are going to be extremely hot over the period of the Amber Weather warning this may have an impact both on health, stress and wellbeing and on the ability of our staff to deliver services.<br><br>Control measures are already in place but given the extreme nature of the forecast heat event these may not be sufficient in all areas of the buildings and further cooling/air movement may be beneficial which could involve the use of fans during this period. | 15 | 15 | 8 | 01/09/2022 | |

# Velindre University NHS Trust
# Risk Management Policy

v. Draft for Trust Board approval

## Contents

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# 1. Purpose of this Policy

This Policy provides an overarching and strategic level document for the framework of managing risk in Velindre University NHS Trust.

The primary objective of the Policy is to support staff across the Trust to identify and manage the risks that may prevent the achievement of the Trust's objectives. This includes assessing risks to patient and donor safety, compliance across our legal and regulatory frameworks and risks attached to our key dependencies, core processes, stakeholder expectations and in so doing, the achievement of Trust Strategy. It is also important to emphasise that the Trust's commitment to quality and safety is the 'golden thread' throughout the organisation and recognise the key role that a strong risk management culture has in that. As with everything the Trust does, this is achieved by putting our patients and donors at the centre of everything we do, working towards optimum quality, safety and experience and continual learning and improving.

The Policy aims to deliver a pragmatic and effective multidisciplinary approach to risk management which is underpinned by a clear accountability structure through the organisation. It recognises the need for robust systems and processes to support the continuous and ever-changing nature of risk. The Policy requires individuals throughout the Trust to embed risk management in their day to day activities and support better decision making through a deeper understanding and insight into risks and their potential impact.

# 2. Scope

VUNHST's Risk Management Policy represents compulsory minimum standards. Activities and functions in and out of scope are outlined below:

## In scope

**All members of staff**

This Policy represents compulsory minimum standards in risk management. It applies organisation wide to all members of staff, those seconded to work in the organisation, and contractors engaged by us in every aspect of their work including all programmes and projects.

**All activities, services and new initiatives (projects) across VUNHST's managed Departments and Divisions, including the Velindre University NHS Trust Charity**

All activities of the Trust are in scope of the Policy. This includes assessing risks to patient and donor safety, compliance across our legal and regulatory frameworks and risks attached to our key dependencies, core processes, stakeholder expectations and in so doing, the achievement of Trust Strategy. The 10 year Trust Strategy was approved by the Trust Board in January 2022:

**Our Purpose**: To improve lives

**Our Vision**: Excellent care, Inspirational Learning, Healthier People

**Our Strategic goals** – by 2032 we will be recognised as:

**1:** Outstanding for quality, safety and experience;

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

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

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

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

### Hosted Units

Velindre University NHS Trust is 'Host' to a number of external organisations:

The Directors sign an annual Governance Compliance Statement to support the Trust Chief Executive in signing the Trust's Annual Governance Statement.

Each hosted organisation has its own risk register. Risks are only be escalated to the Trust risk register where matters directly affecting the Trust's statutory hosting role are apparent. Matters relating to service delivery and performance are a matter for the hosted organisation to receive, manage, and escalate as necessary to the relevant sponsor body.

This Risk Management Policy is applicable to hosted organisations. Supporting procedures and guidance for hosted organisations which align to this Policy are referenced in section 4.

### All domains/categories and levels of risk

A risk is "*an uncertain event or set of events that, should it occur will have an effect on the achievement of objectives*". The Trust faces numerous levels of risk in delivering on objectives; these can relate to strategic challenges, our tactics/programmes, clinical and operational matters, compliance with laws, statutory duties and reporting obligations.

The Trust categorises risks across eleven Domains: quality; safety; compliance; research and development; reputation; performance and service sustainability; financial sustainability; workforce; environment; information governance; and partnerships. All types of risk are in scope.



## Out of direct scope

### Issue management, Incident Reporting and Investigations

Issues are managed and reported on separately through various means, including concerns, performance, quality, incident and change management reporting.

For clarity a risk as an event that has not happened yet whereas an issue as something that already has happened.

Although these matters are out of the direct scope of this Policy, there are some key considerations regarding the importance of linking between these matters. For instance, risk assessment is an integral part of the overall incident management process and as a result of the risk assessment, there may be risks identified which then would fall into the scope of this Policy. For details of the incident reporting and investigation process, please refer

to the Trust's Incident Reporting and Investigation Policy (including Serious Incidents) and any supplementary guidance in this area.

# 3. Why do we manage risk?

It is also important to consider the importance of risk management in the context of the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Having a strong foundation of risk management across the organisation is crucial to improving the quality of health care services. These three core "whys" form an important part of the Trust's training of staff in risk and underpin the strong risk culture the Trust is continuing to develop.

1. **Duty of Quality – "First do no Harm"**
   - All staff in the Trust make risk-based decisions everyday.
   - Donor, patient and staff safety must come first.
   - The Trust has statutory duties for legal compliance, financial stewardship, environment and information governance.

2. **Evidence based decisions**
   - Allows a structured approach to support decisions at all levels.
   - Allows proportionate decisions to be made.

3. **System, process and product design and validation**
   - System and process controls should be used appropriately to prevent risks through mitigation or early detection.
   - Process validation should provide assurance that risks have been mitigated.

# 4. What this Policy does

The Policy is a key component in the Trust's risk management framework. As such it:

- promotes consistency and transparency by articulating an overarching framework for managing risk and establishing a common risk language across Trust;
- explains how the three lines of defence operates;
- explains how risk management is aligned to the governance structures across the organisation;
- defines risk management roles and responsibilities for individuals and teams within VUNHST;
- ensures that risk management processes support and align with the overarching strategy for the Trust, in which the golden thread is our commitment to quality and safety, ensuring that we put our patients and donors at the centre of everything we do;
- recognises that timely and accurate monitoring, review, communication and reporting of risk are critical to providing:
  - early warning mechanisms for the effective management of risk occurrences
  - assurance to our patients and donors
  - assurance through governance structures to the Trust Board and to our partners/stakeholders such as Regulators and Inspection bodies
  - a sound platform for organisational resilience
- supports decision-making through risk based information;
- and supports the continued development a culture where proactive risk management is integrated into all Trust business.

# 5. Components of the Risk Management Framework

| Risk management framework requirements | Description |
|---|---|
| A **risk management Policy** in place, approved by the Trust Board and communicated to all staff | This Policy provides an overarching and strategic level document for the framework of managing risk in the organisation. It is formally reviewed every two years, or upon significant change. Any changes require endorsement from the Audit Committee and approval from Trust Board.<br>*This Policy.* |
| Clear **roles, responsibilities and accountabilities for risk management** established | We have clear risk management roles, responsibilities and accountabilities across the organisation, both at individual role level and through governance arrangements.<br>*Outlined in this Policy and guidance to support in Trust Risk Management Procedure.* |
| Established **Risk governance** arrangements | Our organisational structure helps us manage risk effectively. A 'three lines of defence' model ensures clear accountability and expectation for risk management. This gives departments / divisions and hosted units autonomy for identifying, managing and reporting risk, as the first line of defence; with our central functions, for instance, governance, digital, workforce, quality & safety etc providing oversight, forming the second line of defence; and internal audit, Audit Wales, Regulators and other Inspectors providing independent assurance, as the third line of defence. The following is also in place:<br>• Governance structures and terms of references;<br>• internal risk reporting requirements, specifically the reporting and escalation of key risk information through the governance structure on a monthly basis;<br>• procedures for responding to urgent incidents and external events;<br>• external reporting, disclosures and certification.<br>*Outlined in this Policy and guidance to support in Trust Risk Management Procedure.* |

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|---|---|
| High level **risk appetite** statements and risk tolerance limits should be in place for principal risk categories/types. | The Trust has a clear approach to risk taking and innovation, outlined within the Risk Appetite Strategy:<br>• **Risk appetite statements** align with the organisation's strategic objectives, and this is structured according to risk domains;<br>• **Embedding risk appetite through the organisation**, including in decision making, delegation frameworks and risk reporting levels through governance levels.<br><br>*See Risk Appetite Strategy.* |
| A Trust level **risk management procedure** available to guide staff in identifying, assessing, treating, reporting and communicating risks | A Trust level risk management procedures is in place for use by all teams to outline the Trust level principles and processes in identifying, analysing, managing, monitoring and reporting on risks impacting on objectives. This includes guidance on using the risk quantification matrix, which assesses the impact if a risk is not well managed and the likelihood of the risk occurring. It also includes details of how reporting operates through the governance structures of the organisation.<br>*See Trust Risk Management Procedure.* |
| **Specific Divisional or Subject Matter procedures and guidance** | Where appropriate, and aligned to the Trust level risk management procedure referenced above, there are Standard Operating Procedures and guidance documents to support different parts or subjects within the Trust. Examples include: Welsh Blood Service Standard Operating Procedure for Risk Management; Health & Safety guidance for specific risk assessment requirements; Transforming Cancer Services programme guidance to support project teams; and Hosted Organisations procedural documents. A central register of these aligned procedures and forms will be maintained as an appendix to the Trust level risk management procedure, which will include document owners, review timeframes and version control.<br>*See Trust Risk Management Procedure.* |
| **Risk registers** recorded on Datix and managed through governance arrangements. | Our departments and divisions are each accountable for managing their risks and maintain a **record of these risks on Datix**. Major programmes and/or projects will also have risk registers where necessary again recorded on Datix.<br>Hosted organisations arrangements for recording of risks are set out in their procedural level documents.<br>*See Trust Risk Management Procedure for details.* |

| | |
|---|---|
| **Trust Assurance Framework (TAF)**: Regular evaluation of the nature and extent of strategic risks that the Trust is exposed to, the adequacy of key controls, sources of assurance and commentary against any gaps in control or assurance are provided | The Trust has also developed a Trust Assurance Framework, in order to identify the key strategic risks and track the insight gained from first, second and third Line of Defence assurance against these risks. The Framework also monitors and transparently records the progress in managing the design and operating effectiveness of the control framework for these strategic risks.<br>The Trust Assurance Framework is considered by relevant Committees and also by Trust Board.<br>*See Trust Assurance Framework.* |
| Opportunities for **training** and shared learning on risk management provided | A variety of risk training materials tailored to the various audiences within the Trust.<br>*See risk management training material, as outlined in Trust Risk Management Procedure.* |

# 6. Risk governance

### Risk governance and the internal control system

Velindre University NHS Trust recognise that risk governance is a fundamental part of its organisational governance and broader internal control system. Risk governance refers to the architecture within which risk management operates in our organisation and is fundamental to the day-to-day running of the Trust.

Good risk governance should therefore:

- put in place a structure of risk responsibility throughout the organisation so that everybody is aware of their own risk responsibilities and accountabilities and those of others with whom they work
- establish clear and effective lines of communication up and down the organisation and a culture in which good and bad news travel freely
- result in risk being accepted and managed within known and agreed risk appetites.

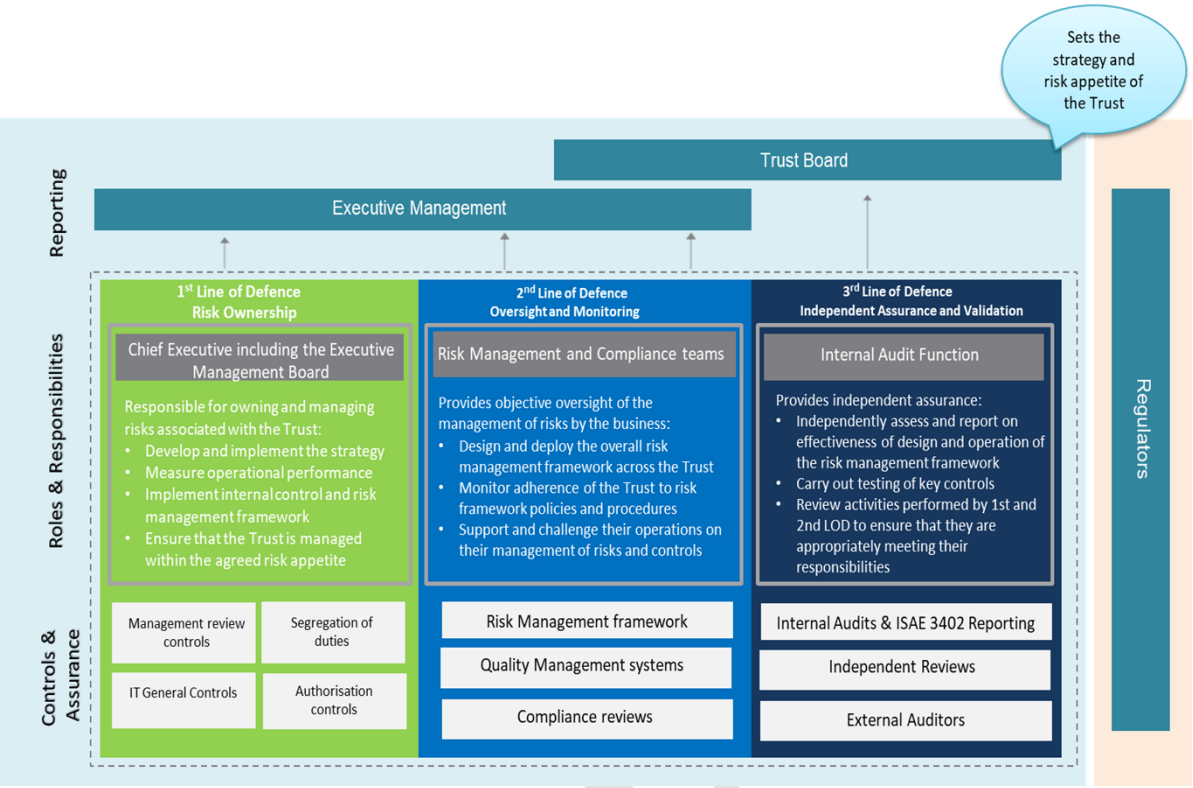


### Three lines of defence risk governance model

The Trust operates the three lines of defence model, which is a leading practice in risk governance, to help ensure segregation between direct accountability for risk decisions, oversight and assurance.

Figure 2 below illustrates the three lines of defence summarising reporting responsibilities and roles within the Trust.

Figure 2: VUNHST's three lines of defence model




## The first line of defence

The first line of defence relates to functions that own and manage risk. Staff and managers working in departments and divisions have direct ownership, responsibility and accountability for identifying, managing and controlling risks to their objectives. Assurance is provided through the monitoring and reporting of risk and control activities through senior leadership and management team meetings. This is ongoing.

## The second line of defence

The second line of defence relates to functions that oversee or specialise in risk management and compliance. They guide, support and challenge the first line by bringing expertise and subject matter knowledge to help ensure risks and controls are effectively managed and assured. The corporate governance team and other internal oversight teams such as divisional risk teams, digital, performance and business planning, finance and workforce and organisational development, among others, form the second line of defence and are responsible for co-ordinating, facilitating and overseeing the Trust's effectiveness and integrity.

**The third line of defence**

The third line of defence relates to functions that provide independent assurance. It provides assurance to senior management and the Board over both the first- and second-lines' efforts. It is independent of the design, implementation, control and operation of control activities and they are not permitted to perform management or operational functions. This is a crucial part of the model and helps protect objectivity and independence.

Internal audit and external scrutiny through Audit Wales provide independent assurance and challenge concerning the integrity and effectiveness of risk management and internal control. The independent audit team will, through a risk-based approach, provide assurance to the Boards and senior managers. This will include assurance on the effectiveness of the first and second lines of defence. Audit Wales will review and report on internal controls over financial reporting. Assurance is provided through monitoring and reporting of strategic/corporate risk and control activities through the Audit Committee. In addition the third line of defence includes assurance from regulators and inspectors.

# 7. Key accountabilities, roles and responsibilities

Risk management is a core responsibility, and staff at all levels are responsible for being risk aware and for implementing the framework. Key risk management roles, responsibilities and accountabilities are summarised as follows:

## Governance Roles

### Board

The Board has overall responsibility for risk management and will ensure our risk management approach is appropriate by considering whether the Trust Risk Register and Trust Assurance Framework identify principal areas of risk against objectives and that adequate risk mitigation strategies have been designed and implemented to manage all identified principal risks. The Trust Board is also responsible for reviewing the framework's effectiveness as assured by the Audit Committee. It sets the 'tone at the top' for risk management culture by setting risk appetite and explicitly considering risk when developing or updating the strategy, or when considering performance and/or major programmes of change.

### Audit Committee

The Audit Committee reviews the adequacy and effectiveness of the risk and assurance frameworks across the Trust. Through a programme of work, it will review internal and external audit plans and monitor the effectiveness of risk reporting.

Internal Audit will provide assurance to the Audit Committee on the effectiveness of the Trust's Risk Management Framework and its application across the business. It will also use the outputs from the risk management framework to drive its assurance plan going forward throughout the year.

### Quality, Safety & Performance Committee

The Quality, Safety & Performance Committee reviews the Trust Risk Register at each Committee. It provides: assurance to the Trust Board that the risk register appropriately reflects the most significant risks facing the organisation, through a Quality and Safety lens; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

### Strategic Development Committee

The Strategic Development Committee reviews the Trust Assurance Framework at each Committee. See Trust Assurance Framework Strategy and Process for further details.

### Other Board Committees

Other Board Committees provide assurance to the Trust Board, that the specific sections of the Trust Risk Register: appropriately reflects the most significant risks facing the organisation, in accordance to their scope; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

### Executive Management Board

The Executive Management Board is responsible for overseeing the implementation of the Trust's risk management framework, including defining, supporting, debating and challenging key risk and risk management activity across the Trust.

It reviews the Trust Risk Register each month and ensures that: the risk register appropriately reflects the most significant risks facing the organisation; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

### Divisional Senior Leadership and Management Teams and Programme Boards

Divisional Senior Leadership and Management Teams and major Programme and Project Boards are responsible for managing the risks which fall within their respective areas in accordance to this Policy, the Trust Risk Management Procedure and Divisional/ Local Standard Operating Procedures.



## Individual Roles

### Executive Management Board Directors

Directors will support and promote risk management. They must ensure that risk management is integrated into all activities, and should demonstrate leadership and commitment by ensuring:

- their portfolios (department/division) implement this Policy;
- risk is considered when setting their objectives/drafting their business plan and discussed alongside their performance and in any local management meetings;
- all risks, controls and risk management issues under their control are adequately co-ordinated, managed, monitored, reviewed and reported/escalated in accordance with the requirements of this framework;
- necessary resources are allocated to managing risk/that they identify individuals who have the accountability and authority to manage risk under their control (i.e. risk owners).

**Executive Lead for Risk Management Framework**

The Director of Corporate Governance will act as the Executive Lead for the risk framework of the Trust. The Executive Lead will own the risk management framework and associated Trust level risk management procedures and is accountable for the strategic development of organisational risk management. Including arrangements for:

- Maintaining and updating appropriate risk management Policies and Procedures;
- Ensuring the Trust has a comprehensive and dynamic Risk Register by working with executive and divisional management teams to ensure that they understand their accountability and responsibilities for managing risks in their areas;
- Ensuring that risk is reported though, and challenged appropriately, through the governance structures of the Trust.

**Risk Owner**

A risk owner is the person who will be accountable if the risk occurs. Risk owners need to ensure: that the risks in their ownership are defined appropriately; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

**All Managers and Staff**

All managers are responsible for the local implementation of this Policy and associated Procedures and Divisional/Local Standard Operating Procedure documents.

All managers have a 'first line' responsibility for identifying, assessing and managing risk within their own area of responsibility, for implementing agreed actions to manage risk and for reporting activities or circumstance that may give risk to new or changed risk.

All staff should:

- Follow the Trust's risk management arrangements;
- Take action to protect themselves and others from risks;
- Identify and report risks in Datix;
- Attend appropriate training.

# TRUST BOARD

# HEALTH AND SAFETY ANNUAL REPORT

| | |
|---|---|
| **DATE OF MEETING** | 29th September 2022 |

| | |
|---|---|
| **PUBLIC OR PRIVATE REPORT** | Public |

| | |
|---|---|
| **IF PRIVATE PLEASE INDICATE REASON** | N/A |

| | |
|---|---|
| **PREPARED BY** | Helen Jones, Health and Safety Manager |
| **PRESENTED BY** | Carl James, Director of Strategic Transformation, Planning and Digital |
| **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** |
| Trust Health Safety and Fire Board<br>Executive Management Board<br>Quality, safety & Performance Committee | 08/09/2022<br>01/09/2022<br>16/09/2022 | ENDORSED FOR APPROVAL |

| **ACRONYMS** | |
|---|---|
| | |

## 1. SITUATION

The paper is to provide the Trust Board with sight of the Health and Safety Annual Report for 2021/2022

## 2. BACKGROUND

As part of the governance of the Health and Safety management system a Health and Safety Report is produced each year.

## 3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Health and Safety report contains information on the following areas for the years 2021/2022.

- Health and Safety management
- Health and Safety Priority Improvement Plan
- Health and Safety related policies
- Staff incidents
- Reporting of Incidents, Diseases and Dangerous Occurrences Regulations
- Violence and Aggression
- Sharps incidents
- Recording of risks
- Health and Safety statutory and mandatory training compliance
- Manual handling training
- Progress against Health and Safety strategic goals
- Health and Safety related personal injury claims

## 4. IMPACT ASSESSMENT

| | |
|---|---|
| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Yes (Please see detail below) |
| | |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |

| | |
|---|---|
| **LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | Assurance of compliance with Health and Safety requirements |
| **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 Board is asked to **APPROVE** the Health and Safety Annual Report.

**HEALTH AND SAFETY ANNUAL REPORT 2021/2022**

## 1 Introduction

1.1 This Health and Safety annual report has been produced to provide an overview of the management of Health and Safety within Velindre University NHS Trust for the period 1st April 2021 – 31st March 2022.

## 2 Health and Safety Management

2.1 Health and Safety governance was strengthened during with the year by the establishment of a framework of Health, Safety and Fire meetings at both divisional and Trust level. The Trust meeting consists of senior managers and reports to the Executive Management Board. A divisional Health Safety and Fire meeting was established at Velindre Cancer Centre bringing together management level representatives from departments on that site to monitor and actively engage in health and safety planning and management. This meeting is supported by a monthly Health, Safety and Fire subgroup who provides operational support to the Health and Safety Lead for the division. Health and Safety was established as a standing agenda item at the monthly Estates and Facilities Management (Cynefin Group) meetings at the Welsh Blood Service.

2.2 In recognition of the synergy between Health and Safety and Fire Safety, and in order to run streamlined and effective management arrangements, a joint governance structure of Health, Safety and Fire meetings has been established.

2.3 There has been some initial disruption to the timetabling of meetings due to Covid-19 related pressures and the need to align the meetings to the wider cycle of business.

2.4 The Velindre Cancer Centre, Welsh Blood Service and Trust meetings for 2022/23 are scheduled quarterly and dates are in the diary.

Table 1 – Health and Safety governance – meeting schedule

| Health and Safety Governance | Chair | Agreed Frequency | Initial meeting | Number of meetings held 2021/22 |
|---|---|---|---|---|
| Trust Health, Safety and Fire Board | Director of Strategic Transformation, Planning & Digital, Corporate Services | Quarterly | 28/09/2021 | 2 |
| VCC Health and Management Group | Operations Manager | Quarterly | 21/10/2021 | 2 |
| WBS Estates and Facilities management Group. (Cynefin Group) | Interim General Services Manager | Monthly | Established meetings already in place | 8 |

2.5 The Cynefin Group in 2022/2023 will be held quarterly and will be chaired by the Operations Manager. This will continue the process of alignment of health and safety management across the divisions.

Table 2 – Health and Safety Groups providing specialist advice and governance

| Health and Safety Strategic Groups | Chair | Agreed Frequency | Actual |
|---|---|---|---|
| Electrical Safety Group | Head of Estates | 6 monthly | 2 |
| Water Safety Group | Head of Estates | 3 monthly | 4 |
| Ventilation Group | Assistant Director of Estates, Environment & Capital Development, Corporate Services | 3 monthly | 4 |

2.6 The Trust identified the need for additional Health and Safety resource at Velindre Cancer Centre to ensure equity of provision of health and safety advice across the divisions. To address this an additional Health and Safety Advisor was appointed in February 2022.

2.6 The Health and Safety Advisors for both Velindre Cancer Centre and Welsh Blood Service are currently studying for the NEBOSH Diploma in Health and Safety Management further developing and enhancing the professional expertise available to the Trust and reflecting the Trust's commitment to professional development.

Table 3 – Health and Safety resource

| | |
|---|---|
| Trust | Trust Health and Safety Manager |
| VCC | Health and Safety Advisor |
| WBS | Health Safety and Environment Manager |

## 3 Health and Safety Priority Improvement Plan

3.1 An independent Gap Analysis was undertaken by the Interim Trust Health and Safety Manager in March 2021 and this has been further refined and developed into a Priority Improvement Plan by the current Trust Health and Safety Manager.

3.2 There has been sustained progress with the development and implementation of the Plan. The Trust Health, Safety and Fire Board have been provided with updates on progress to enable monitoring. The Priority Improvement Plan will be reviewed and refreshed in Quarter 3 2022 to build on the work that has already been completed and submitted to the Trust Health Safety and Fire Board for approval.

## 4 Health and Safety Related Policies

4.1 All Trust Health and Safety policies are up-to-date and are published on the Trust website. The Health Safety and Wellbeing Policy has been redrafted and refreshed to reflect the developments in governance arrangements and to ensure clarity of responsibilities. The Policy has been approved through the Trust governance process.

## 5 Staff incidents

Table 4 – Number of incidents by division by month

| | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **VCC** | 12 | 8 | 12 | 10 | 5 | 12 | 17 | 7 | 11 | 4 | 7 | 5 | **110** |
| **WBS** | 7 | 6 | 10 | 12 | 5 | 5 | 5 | 11 | 8 | 7 | 4 | 10 | **90** |
| **Corporate Division** | 0 | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | **4** |
| **Total** | 0 | 14 | 22 | 24 | 10 | 17 | 22 | 18 | 19 | 11 | 12 | 15 | **203** |

5.1 Table 4 shows the number of incidents which occurred in each month and were recorded on the Datix system. Incidents are investigated, additional control measures are implemented when required and lessons learned are shared.

5.2 The new Once for Wales (OFW) Datix Cymru system was introduced in the Trust in May 2021. It replaced previous versions of Datix used by the Trust and provided an additional level of consistency across the NHS in Wales. The benefits of the system include:

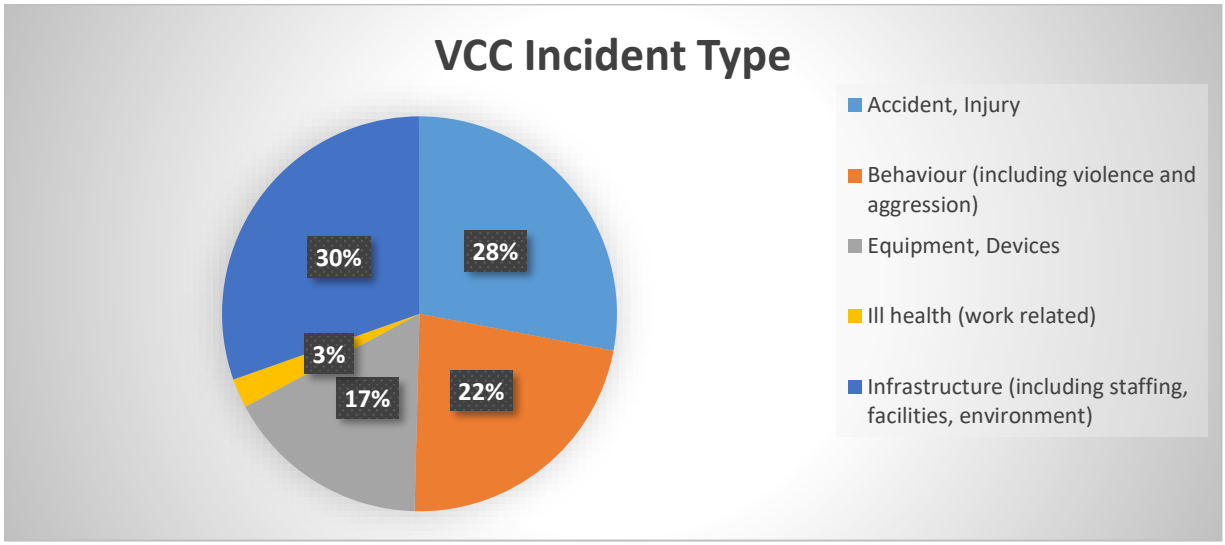
- Easier to log in - Nadex/Windows login can be used to access the system.
- Quicker process – The flow and layout of the incident form has been designed to make it more user friendly.
- Business Intelligence tool – simpler process to access reports from the system which will improve efficiency.

5.3 Incidents from 1st April 2021 to 16th May 2021 were transferred over to the new system so that all data for the reporting period 2021 – 2022 is on the new system.

5.4 Incidents are monitored by the Trust and divisional Health, Safety and Fire meetings and by the Estates Management Group. The manager responsible for the area/activity where the incident occurred is responsible for allocating a manager to investigate. Investigation training organised by Quality and Safety has been rolled out to a cohort of managers across the Trust to enhance the quality of incident investigations. Further support for incident investigation and recording on the Once for Wales Datix system is provided by the Health and Safety team.

5.5 Charts 1 shows the percentage of incidents by type in VCC. The Accident/Injury coding has the largest percentage of incidents and contains the highest number of subtypes related to health and safety.

Chart 1 – VCC incidents by type (%)




5.6 Chart 2 provides further details of the accident/incident coding. A further breakdown of sharps incidents and information about actions to address these incidents is contained in section 8.

Chart 2 – VCC accidents by subtype (%)

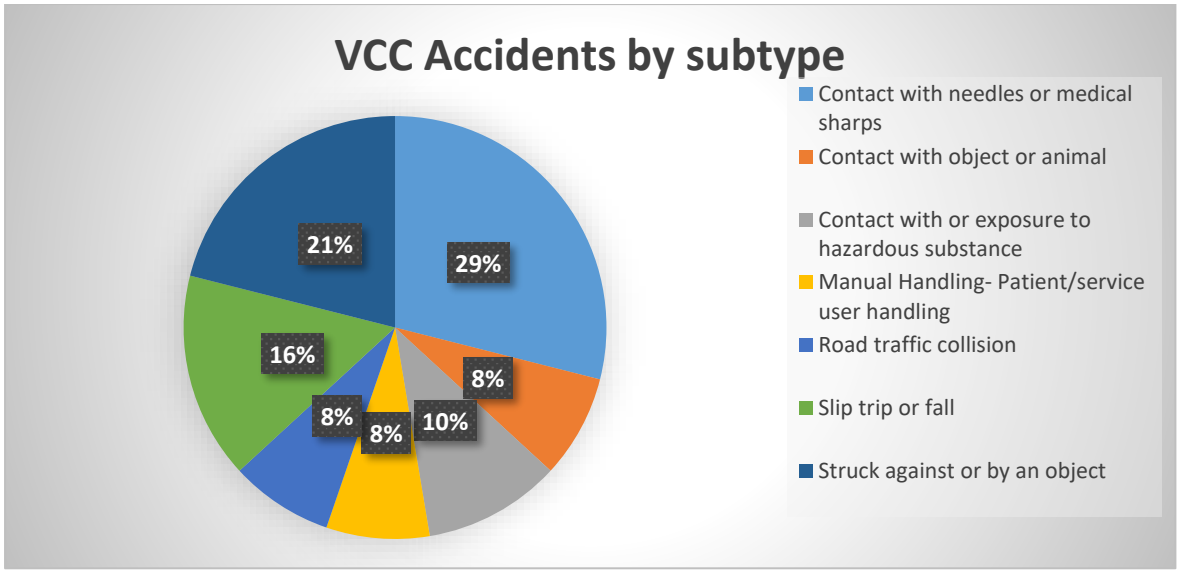
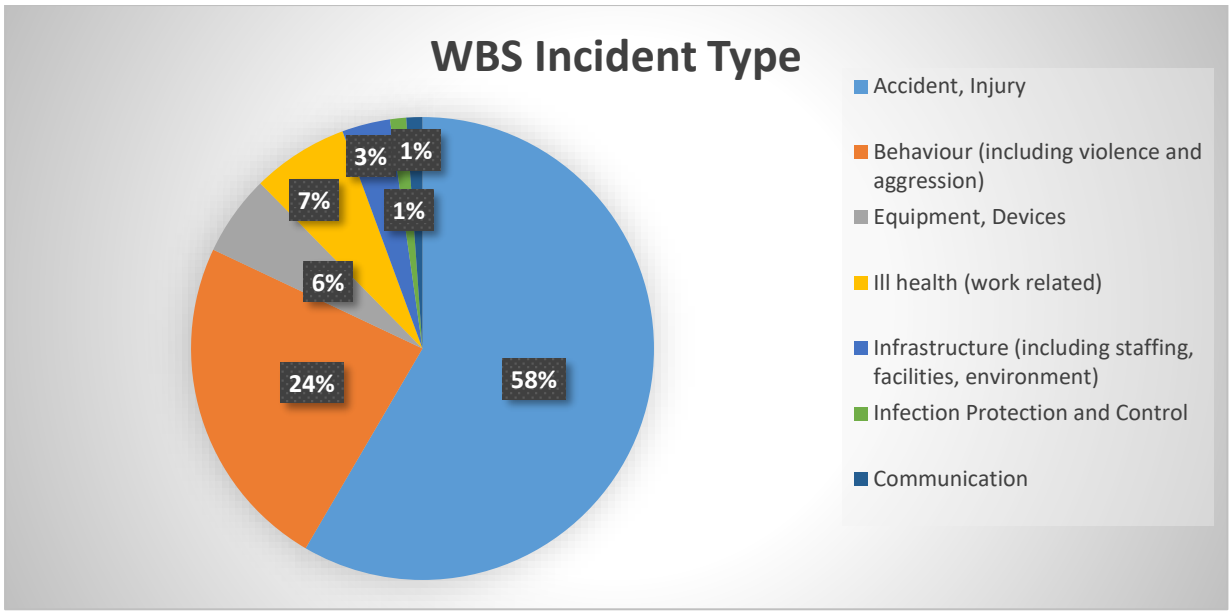


Chart 3 – WBS Incidents by type




5.7 At WBS Accident/injury is the highest incident type which reflects the pattern in previous years and the high number of incident subtypes contained within this Datix OFW code.

Chart 4 Accidents by subtype

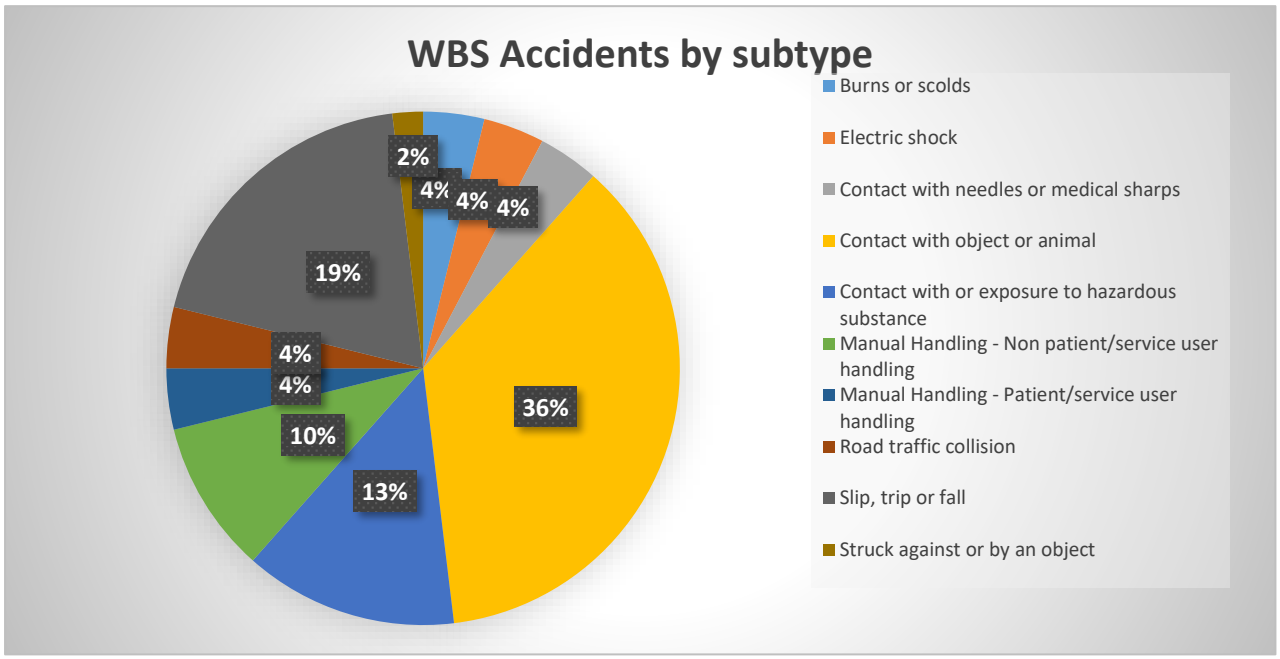
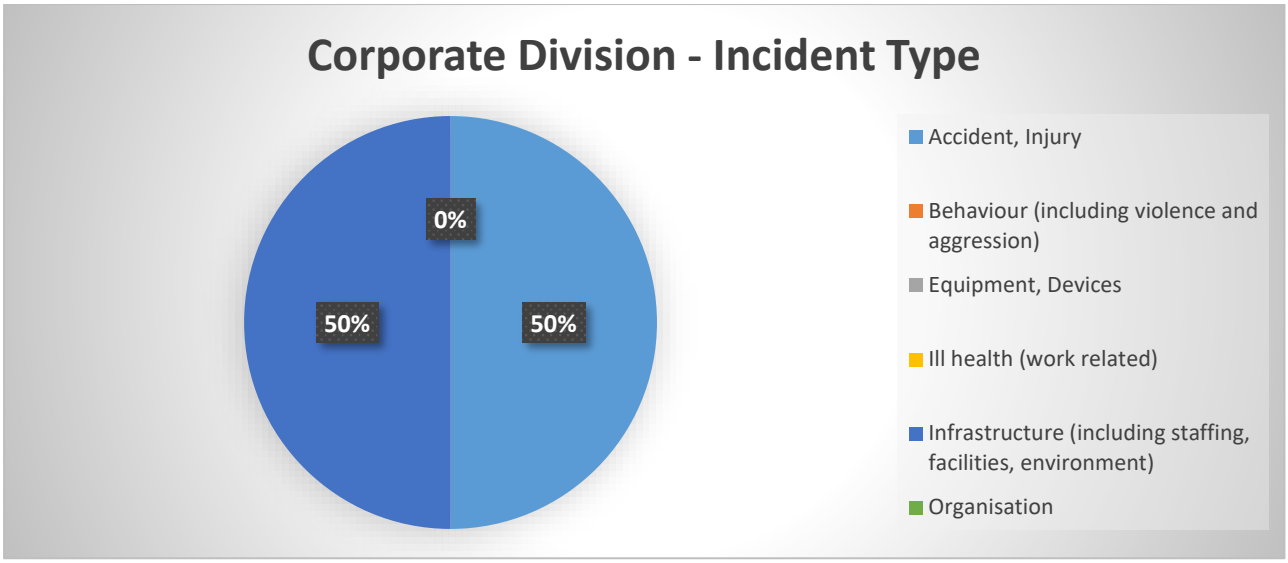


Chart 5 Corporate Division Incidents by type




5.8 There were only four incidents recorded in Corporate Division – thermal comfort, a road traffic incident, theft of earthing cables at Velindre Cancer Centre and one sharps incident.

## 6 Reporting of Incidents Diseases and Dangerous Occupancies Regulations 2012 (RIDDOR)

6.1 The Welsh Blood Service reported two incidents to the Health and Safety Executive during 2021-2022. The Health and Safety Executive took no further action on either occasion.

Table 5

| Date | Incident |
|---|---|
| 10/2021 | During a break time walk a member of staff slipped and fell on a path that runs along the boundary of the Welsh Blood Service site. The staff member attended A&E where a fractured wrist was confirmed. This is a reportable injury as defined by the Regulations. Signage warning staff of the hazards was in place at the time and works have since been completed on the path to remove moss. Further remedial work has been identified but has not been completed due to funding constraints. |
| 01/2022 | A member of the Welsh Blood Service Collection Team staff fell from a faulty chair belonging to a venue. The chair collapsed when he sat on it. An existing back injury was aggravated during the fall resulting in the staff member being off work for 9 days. As a result, an over 7-day injury was reported under RIDDOR. The member of the team returned to work and resumed normal duties with supervision by Team Supervisor |

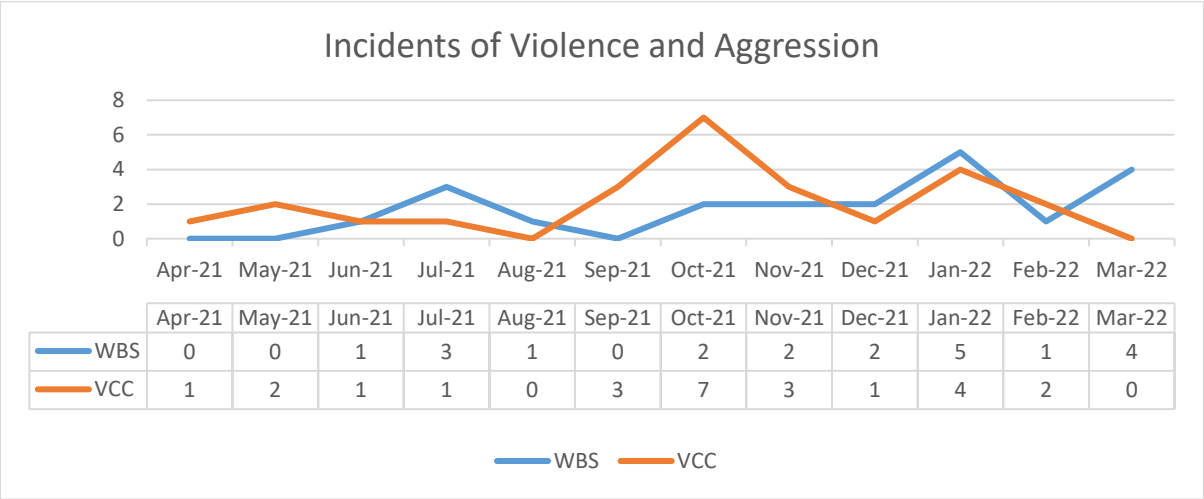
## 7 Violence and Aggression

7.1 Incidents of violence and aggression remain at relatively low levels across the Trust. The spike in recorded incidents from September to November 2021 represents a series of

incident involving an individual patient who was verbally aggressive to staff both other the telephone and when attending clinic. Case management support was provided by the Trust Health and Safety Manager and advice was taken from the Case Management team at Cardiff and Vale University Health Board. Action was escalated and a letter and Behaviour Agreement issued to the individual concerned. Continued Case Management support for Velindre Cancer Centre is provided by the Health and Safety Advisor and staff are actively encouraged to report incidents.

7.2 At Welsh Blood Services cases of verbal aggression by donors often relate to frustration around donation and Covid19 protocols. A revised SOP has been drafted and an escalation procedure is in place for repeated/serious incidents.

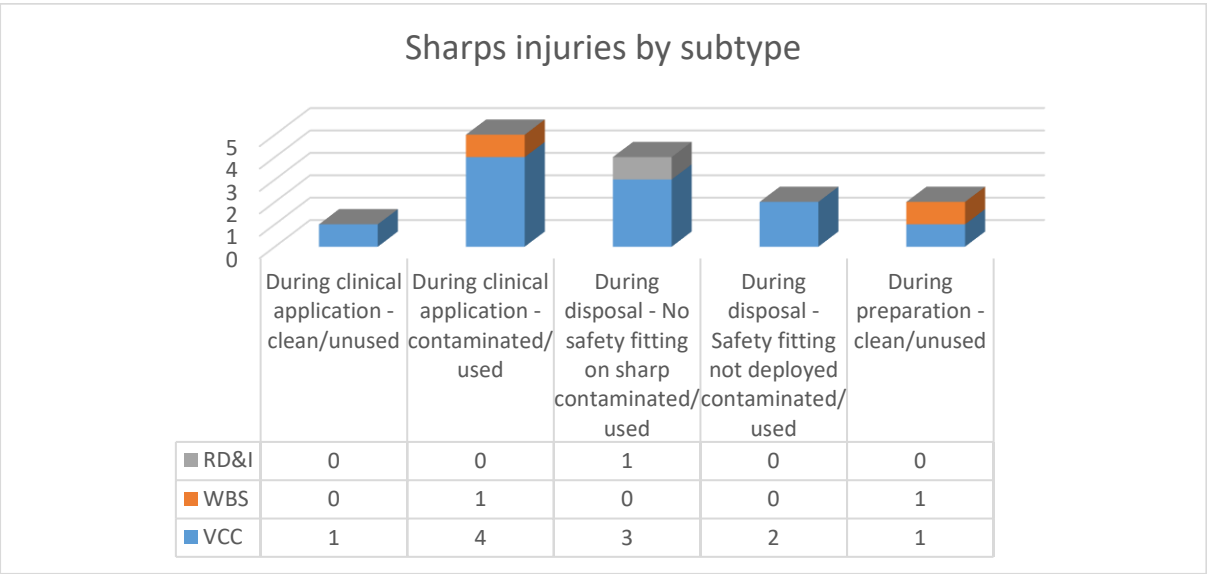
Chart 6 and Table 6 – Incidents of Violence and aggression at VCC and WBS by month




| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WBS | 0 | 0 | 1 | 3 | 1 | 0 | 2 | 2 | 2 | 5 | 1 | 4 |
| VCC | 1 | 2 | 1 | 1 | 0 | 3 | 7 | 3 | 1 | 4 | 2 | 0 |

## 8 Sharps injuries

Chart 7 and Table 7




| | During clinical application - clean/unused | During clinical application - contaminated/ used | During disposal - No safety fitting on sharp contaminated/ used | During disposal - Safety fitting not deployed contaminated/ used | During preparation - clean/unused |
|---|---|---|---|---|---|
| RD&I | 0 | 0 | 1 | 0 | 0 |
| WBS | 0 | 1 | 0 | 0 | 1 |
| VCC | 1 | 4 | 3 | 2 | 1 |

8.1 In all cases the referral process to Occupational Health has been followed. Infection Protection and Control are working with Health and Safety to review non-safety sharps risk assessments, and to review of areas ordering non safety to identify any gaps. Where

appropriate the 'Focused Review' function is used on Datix to enhance investigations and guidance is provided to departments to support investigations to ensure causes are identified and lessons learned.

## 9 Recording of risks

9.1 Velindre Cancer Centre and Corporate Division migrated to Datix v14 in May 2021. Welsh Blood Service continued to use Datix v12 whilst assurance around risk management processes where finalised. All Health and Safety risks rated above 12 were reported to divisional Health, Safety and Fire meetings and to the Trust Health Safety and Fire Board for scrutiny.

9.2 The adequacy of Health and Safety risk assessments is captured as part of the departmental HSG65 audits currently being scheduled and undertaken.

9.3 It is planned to roll out additional risk assessment training during 2022-2023.

## 10 Health and Safety Statutory and Mandatory Training Compliance

10.1 Health and safety training requirements are identified by training needs analysis. Table 8 shows the training compliance for individual courses for the Trust as a whole. The majority of courses are provided on-line through the ESR system with two moving and handling courses (inanimate loads and people handling) provided face to face in line with the requirements of the All-Wales Passport Scheme.

10.2 Compliance on most courses have risen steadily during the year but remains below the 85% target set by the Welsh Government. Multiple channels are used to communicate with managers and staff to enable increased compliance including monitoring at Trust and divisional health and safety meetings, escalation to senior management meetings, auditing of compliance during departmental HSG65 audits and contact with individual managers.

Table 8 – Trust wide compliance with Health and Safety statutory and mandatory training

| | Health Safety and Welfare | Moving & Handling module A | Moving & Handling Inanimate load | Moving &Handling People Handling | Display Screen Equipment | Violence and Aggression module A | Violence and Aggression module B | Trust Compliance |
|---|---|---|---|---|---|---|---|---|
| Apr-21 | 86% | 71% | 49% | 61% | 64% | 88% | 27% | 67% |
| May-21 | 87% | 58% | 50% | 61% | 65% | 89% | 28% | 67% |
| Jun-21 | 86% | 63% | 56% | 49% | 66% | 90% | 29% | 70% |
| Jul-21 | 85% | 68% | 64% | 82% | 67% | 90% | 44% | 74% |
| Aug-21 | 86% | 71% | 66% | 90% | 68% | 90% | 51% | 75% |
| Sep-21 | 84% | 74% | 71% | 90% | 67% | 90% | 55% | 77% |
| Oct-21 | 84% | 74% | 72% | 92% | 66% | 90% | 59% | 77% |
| Nov-21 | 85% | 75% | 70% | 95% | 68% | 91% | 65% | 79% |
| Dec-21 | 86% | 74% | 69% | 95% | 69% | 92% | 67% | 79% |
| Jan-22 | 86% | 73% | 66% | 95% | 69% | 82% | 72% | 79% |
| Feb-22 | 85% | 73% | 65% | 91% | 70% | 92% | 73% | 79% |
| Mar-22 | 83% | 75% | 64% | 87% | 70% | 93% | 75% | 79% |

Table 9 - Health and Safety statutory and mandatory training compliance by division

| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | 68% | 68% | 68% | 69% | 69% | 70% | 74% | 73% | 75% | 73% | 74% | 75% |
| RD&I | 75% | 78% | 83% | 82% | 84% | 84% | 86% | 86% | 85% | 82% | 81% | 81% |
| TCS | 72% | 72% | 74% | 75% | 81% | 77% | 77% | 77% | 75% | 74% | 76% | 74% |
| VCC | 63% | 64% | 65% | 68% | 70% | 72% | 72% | 74% | 75% | 76% | 77% | 78% |
| WBS | 70% | 71% | 77% | 83% | 85% | 86% | 86% | 86% | 86% | 85% | 83% | 83% |
| Trust | 67% | 67% | 70% | 74% | 75% | 77% | 77% | 79% | 79% | 79% | 79% | 79% |

## 11 Manual Handling Training

11.1 There are three levels of manual handling training provided to staff across the Trust, the syllabus for which is defined in the All-Wales Manual Handling Passport Scheme which is adopted by all NHS Trusts and Health Boards in Wales. The requirement for each course is identified by Training Needs Analysis

- Module A – available on-line
- Inanimate Load – face to face training
- Patient Handling – face to face training

11.2 The training compliance in some divisions is below the target level of 85% set by the Welsh Government.

11.3 Training compliance is monitored at divisional Health Safety and Fire meetings/ Cynefin Group, at the Joint Estates Management Group meeting and at the Trust Health, Safety and Fire Board. Health and Safety training compliance has also been escalated to Senior Management meetings within the divisions. Compliance is also discussed during the HSG65 Health and Safety Audit.

11.4 Module A – compliance is monitored and managers continue to be reminded to ensure that staff complete mandatory training. Arrangements are in place to enable access to IT to enable completion of the training.

11.5 Inanimate Load Training – Courses have been run in-house, further courses are planned using an external provider although in Velindre Cancer Centre/Corporate Division take up is not always to capacity due to operational staff pressures. In future, plans are in place to re-establish in-house provision.

11.6 Eight members of staff at Velindre Cancer Centre have been trained as Manual Handling Workplace Assessors through an initiative piloted by Cardiff and Vale University Health Board.

These staff are able to assess staff patient handling competence in the workplace on a three-year alternating cycle with classroom refresher training.

11.7 People Handling – the Service Level Agreement with Cardiff and Vale University Health Board remains in place and offers places on training course. Plans are also in hand to also be able to offer in-house training from September 2022 onwards. People handling training at WBS will continue to be delivered by the Clinical Training Team to the Collection Teams.

11.8 Further discussions are continuing with operational departments and support services to identify any / more flexible solutions that enable higher numbers of staff to attend the training courses available.

Table 10 – Manual Handling training compliance year end March 2022 (%)

| | Moving and Handling Module A | Moving and Handling Inanimate Load | Moving and Handling – People Handling |
|---|---|---|---|
| Corporate Division | 65.24% | 56.52% | |
| RD&I | 80.95% | 100% | 62.5% |
| TCS | 70.83% | 20% | |
| VCC | 69.57% | 58.72% | 58.48% |
| WBS | 89.21% | 63.33% | 86.4% |

## 12 Progress against Health and Safety Strategic Goals 2020 -2023

12.1 There has been good progress against the Health and Safety Strategic Goals with further action schedules until the end of the period (2023) for which these goals have been set.

Table 11 – Progress with Health and Safety Strategic Goals 2020-2023

| | Topic area | Strategic Goal | Progress | Timescale |
|---|---|---|---|---|
| 1 | Leadership | To demonstrate strong and effective health and safety leadership across the Trust | Introduction of Trust and divisional Health, Safety and Fire Management meetings. | Complete |
| 2 | Mangers | To develop Health and Safety training course for managers | Development and roll out of VUNHST specific course for managers. Flexible mode of delivery to account for covid19 pressures. Supported by managers information on staff intranet. | Q3, Q4 2022<br><br>Q1 2023 |

| | | | | |
|---|---|---|---|---|
| 3 | Management System | To ensure that the Trust has an effective health and safety management system across all divisions | Review and refresh of Health Safety and Welfare Policy. Appointment of H&S Advisor at VCC. Update of H&S procedures at VCC and ongoing review and rationalisation of procedures at WBS. | Q3, Q4 2022 |
| 4 | Monitoring | To ensure that health and safety performance is monitored and reported and that opportunities for continual improvement are actioned. | Continuation of audit programme in WBS. Scheduling and implementation of HSG65 audit in Corporate Division and VCC. Report provided to Trust Health, Safety and Fire Board | Q3, Q4 2022 Q1, Q2 2023 |

## 13 Health and Safety Related Personal Injury Claims


13.1 During the reporting period for 2021-2022, the main type of personal injury claims (excluding product liability) relate to:

| Data Protection Breach | Repetitive Strain | Poor Record Keeping | Defective Equipment | Slips, Trips and Falls |
|---|---|---|---|---|
| 1 | 1 | 1 | 3 | 2 |

# TRUST BOARD

# Welsh Language Annual Report 2021-22

| | |
|---|---|
| **DATE OF MEETING** | 29.09.2022 |

| | |
|---|---|
| **PUBLIC OR PRIVATE REPORT** | Public |

| | |
|---|---|
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |

| | |
|---|---|
| **PREPARED BY** | Jo Williams, Welsh language Manager |
| **PRESENTED BY** | Sarah Morley, Executive Director of Organisational Development & Workforce |
| **EXECUTIVE SPONSOR APPROVED** | Sarah Morley, Executive Director of 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 | 01/09/2022 | ENDORSED FOR APPROVAL |
| Quality, Safety and Performance Committee | 15/09/2022 | ENDORSED FOR APPROVAL |

| **ACRONYMS** | |
|---|---|
| | |

## 1. SITUATION/BACKGROUND

1.1 We are required to produce an annual report each year detailing the Trust's compliance against the Welsh Language Standards. The format of the report has been followed under the guidance set out by the Welsh Language Commissioner.

1.2 EMB have previously seen this report as part of the Trust's Annual Report 2021-22, accepted at the Annual General meeting earlier this year. It is an account of the previous year's activity relating to the compliance against the Welsh Language Standards.

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The ethos of the Welsh language cultural plan was agreed during year. Further work on this will continue running alongside the conversation around the Trust values and how Welsh language and Welsh culture can enhance the work that the Trust currently does to support patients and donors.

2.2 Welsh language training was increased during the year and again further support for successful learners continues.

2.3 The recruitment process was strengthened and embedded in how the Trust advertises and recruits for Welsh language skills within new posts. It provides the Trust with a more detailed view of when and why Welsh language skills are required, supporting our workforce planning needs.

## 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: |

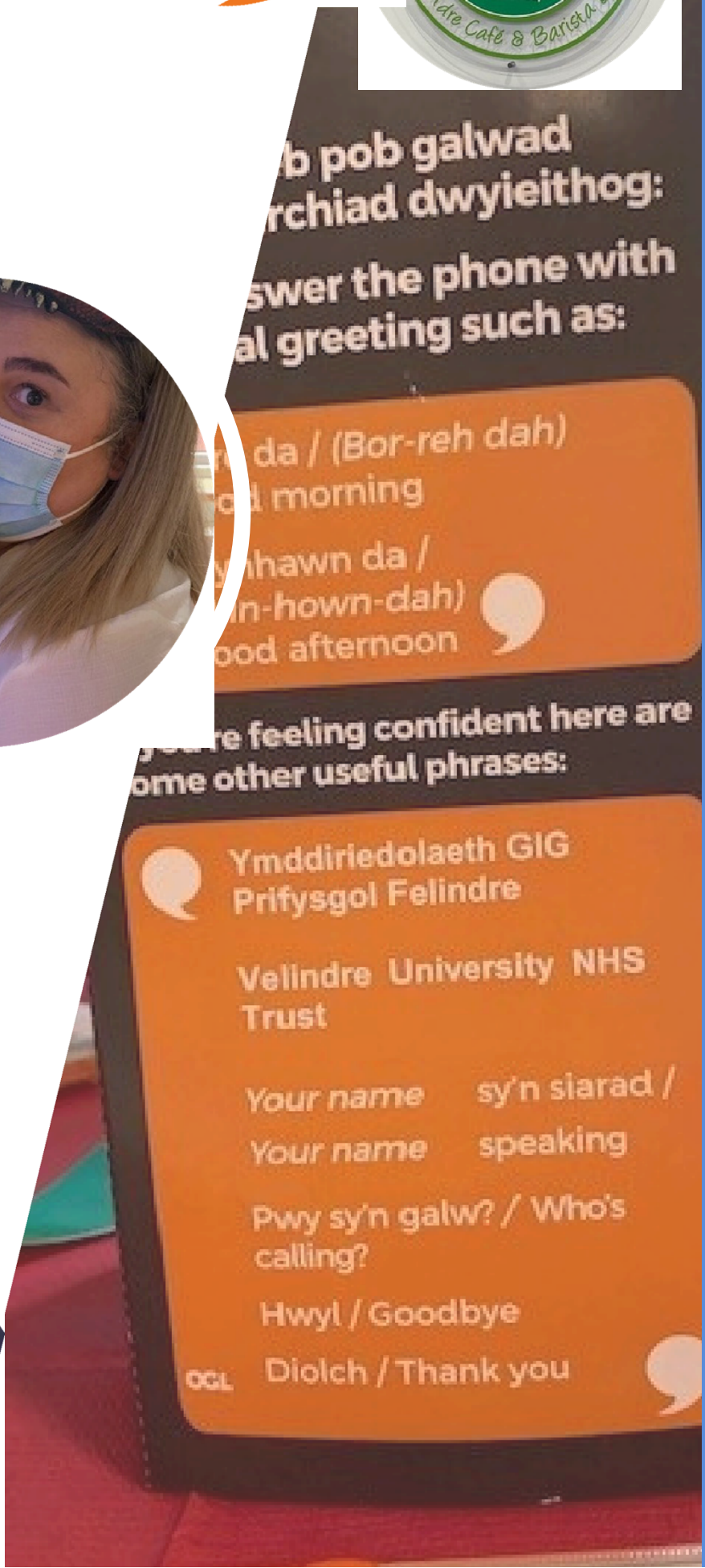
| | |
|---|---|
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| | |
| **LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | The non-production of a report could result in a £5,000 fine relating to non-compliance of the Welsh Language Policy Standards |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | As above |

## 4. RECOMMENDATION

4.1 The Trust Board is asked to **APPROVE** the Welsh Language Annual Report 2021-22

# ADRODDIAD BLYNYDDO GYMRAEG 20

Cymraeg

# RHEOLIADAU'R GYMRAEG A CHYDYMFFURFEDD

**Cyflwyniad:**

Bydd yr adroddiad hwn yn canolbwyntio ar y gwerth y mae'r Ymddiriedolaeth yn ei roi i wella'r ddarpariaeth ddwyieithog. Bydd yn dangos ymrwymiad i Safonau'r Gymraeg ond hefyd yn tynnu sylw at y gwaith rydym yn ei wneud ar hyn o bryd ar ein Cynllun Diwylliannol Cymraeg, sef ein llwyfan ar gyfer dathlu a chydnabod pwysigrwydd diwylliannol Cymru.

Rydym yn parhau i ddarparu cymorth ar gyfer anghenion ein cleifion a'n rhoddwyr dwyieithog. Rydym yn awyddus i sicrhau bod y gwasanaethau a ddarparwn hyd yn oed yn fwy gweladwy nag o'r blaen yn enwedig ar adeg lle mae'r pandemig wedi ei gwneud yn anodd cyfathrebu wyneb yn wyneb.

Rydym yn parhau i ymestyn y Llywodraethiant o amgylch y maes hwn ac yn cydnabod pwysigrwydd Safonau'r Gymraeg ond rydym hefyd yn awyddus i wneud mwy na'r hyn sy'n ofynnol gennym. Rydym wedi dechrau sgwrs ar draws yr Ymddiriedolaeth eleni ar ystyr Diwylliant ac wedi cydnabod bod angen i'n gwerthoedd efelychu'r hyn y mae'n ei olygu i'n staff ddarparu gwasanaeth dwyieithog o dan y pwysau parhaus y mae'r pandemig wedi'u dwyn i ni.

Rydym yn gwerthfawrogi gwaith ein staff ac ar adeg o newid parhaus rydym yn ceisio eu cefnogi gyda phopeth sydd ei angen arnynt i berthyn i sefydliad sydd â gwir werthoedd iaith a diwylliant Cymru. Cafodd ethos ein cynllun Diwylliannol newydd ei dderbyn gan y Bwrdd Gweithredol ac wrth symud ymlaen byddwn yn ymgorffori ei nodau a'i amcanion ac yn ceisio integreiddio ein cefnogaeth ymhellach i staff, cleifion a rhoddwyr sydd angen neu sy'n dewis defnyddio'r Gymraeg.

Steve Ham

Prif Weithredwr

**Dathlu Diwylliant Cymru:**

Mae'r Ymddiriedolaeth yn parhau i chwilio am ffyrdd o ennyn diddordeb ei staff yn niwylliant Cymru yn ogystal â'i hieithoedd. Rydym yn cydnabod yr angen i gydymffurfio â'i rwymedigaethau cyfreithiol ond ein nod yw gwneud mwy na'r hyn sydd ei angen gan fod hyn yn dathlu amrywiaeth ein staff a'n gwasanaethau.

Y flwyddyn adrodd hon rydym wedi drafftio Cynllun Diwylliannol sy'n anelu at gryfhau ein hymgysylltiad â staff ynghylch iaith a diwylliant Cymru a hyrwyddo gwerth cynhwysiant sy'n cwmpasu popeth a gredwn. Mae'r bwrdd rheoli gweithredol wedi ymgymryd â rolau cyfrifoldeb am rai agweddau ar yr agenda Cydraddoldeb ac Amrywiaeth ac mae hyn yn cynnwys rôl Llysgennad sy'n gyfrifol am y Gymraeg.

Nod cynllun Diwylliannol drafft yr Ymddiriedolaeth yw bod mor gynhwysol â phosibl a bydd Llysgennad y Gymraeg yn hyrwyddo ethos y cynllun hwn drwy gydol gwaith y Bwrdd Gweithredol.

**Cydymffurfio â Safonau'r Gymraeg:**

O fis Tachwedd 2021 ymlaen, mae cydymffurfiad ein Hymddiriedolaeth â Safonau'r Gymraeg dros 50%. Cesglir y dystiolaeth hon trwy ein gweithgorau is-adrannol mewnol a bydd y dystiolaeth yn cael ei hadrodd i'n grŵp datblygu'r Gymraeg ar draws yr Ymddiriedolaeth. Dyma'n ffordd ni o sicrhau y gallwn ddatblygu ar y cydymffurfedd a reoleiddir flwyddyn ar ôl blwyddyn a rhoi prosiectau ar waith i sicrhau ein bod yn canolbwyntio ein darpariaeth mewn ffordd gynhyrchiol.

**Gohebiaeth cleifion a rhoddwyr:**

Gwnaethom adrodd yn flaenorol ar ddull systematig o sicrhau bod gohebiaeth cleifion yn ddwyieithog. Ers y llynedd, mae hyn wedi cael ei ohirio mewn nifer o adrannau gan fod yr hen system sy'n cynhyrchu'r llythyrau yn dal i weithredu. Daeth yr holl fentrau datblygu i ben oherwydd y pandemig ac mae cyflwyno'r system cleifion newydd hefyd wedi bod yn arafach na'r disgwyl.

Fel Ymddiriedolaeth, rydym yn benderfynol o sicrhau bod ein gohebiaeth ddwyieithog yn hygyrch ac er bod hyn yng Ngwasanaeth Gwaed Cymru yn broses a ddilynwyd yn hanesyddol mae gennym beth ffordd i fynd i sicrhau bod Canolfan Ganser Felindre yn cyd-fynd â'n huchelgeisiau.

Mae un o'n hadrannau yn arwain y ffordd yn hyn o beth. Mae radiotherapi wedi cyfieithu llythyrau dwyieithog fel safon ac yn eu defnyddio, ac maent hefyd wedi sicrhau bod staff brysbennu sy'n siarad Cymraeg yn cefnogi'r dderbynfa gan fod nifer staff y dderbynfa sy'n siarad Cymraeg yn parhau i fod yn isel. Mae hon yn ffordd gadarnhaol o sicrhau bod adran yn cael ei chefnogi pan fo angen gan aelodau eraill o staff, sef yr ethos sy'n sail i'r fframwaith 'mwy na geiriau'.

Mae monitro galwadau ffôn i'r Ymddiriedolaeth ac oddi yno yn heriol dros ben. Yng Ngwasanaeth Gwaed Cymru, mae hyn yn fwy cyraeddadwy. Yn y flwyddyn adrodd

hon, nifer y galwadau [Cymraeg] i'r tîm Casglu Rhoddwyr oedd 1004. Mae hyn yn 2% o'r galwadau cyffredinol i'r ganolfan gyswllt rhoddwyr.

Bydd y Gweithgor Cymraeg yng Nghanolfan Ganser Felindre yn ystyried y gwaith o fonitro hyn fel mater o frys yn ystod y flwyddyn adrodd hon.

**Cyfarfodydd:**

Yng ngoleuni'r newid parhaus i drefniadau gweithio o dan y pandemig bu'n rhaid meddwl am ffyrdd y gallwn gefnogi staff dwyieithog yn fewnol mewn cyfarfodydd os ydynt yn dymuno defnyddio'r Gymraeg.

Ar gyfer cyfarfodydd allanol rydym yn parhau i fod yn ymwybodol o'r gwaith sy'n mynd rhagddo gan Lywodraeth Cymru gyda Microsoft ac edrychwn ymlaen at glywed sut mae hyn yn mynd rhagddo dros y misoedd nesaf. Yn fewnol rydym yn treialu dull adnabod iaith o fewn Teams (yng Ngwasanaeth Gwaed Cymru) a byddwn yn monitro'r defnydd o hyn. Bydd y broses wedyn yn cael ei dosbarthu ar draws yr Ymddiriedolaeth fel opsiwn ar gyfer adnabod iaith mewn cyfarfodydd mewnol.

**Recriwtio Siaradwyr Cymraeg:**

Fel y dywedasom yn yr adroddiad diwethaf, ein nod yn y flwyddyn adrodd hon oedd cwblhau ein proses recriwtio ac asesu iaith. Rydym wedi cwblhau hyn ac yn awr rydym yn sicrhau bod POB swydd sy'n mynd allan i recriwtio yn cwblhau tabl asesu iaith sy'n cael ei drafod gyda'r rheolwr iaith pe bai cwestiynau'n codi. Mae wedi cymryd peth amser i integreiddio'r broses hon ond rydym yn hyderus y bydd hyn yn newid y ffordd yr ydym yn asesu'r angen am sgiliau iaith, nid yn unig fel rhan o'r swydd unigol ond ar gyfer y timau ehangach ar draws yr Ymddiriedolaeth.

Mae'r broses yn ei babandod ond dros amser bydd yn rhoi'r data sydd ei angen arnom i werthuso ei llwyddiant.

Fel y gwelwch o'r ffigurau isod mae'r pandemig wedi gosod blaenoriaethau clinigol dros anghenion iaith a byddwn yn monitro'r cynnydd yn nifer y rolau 'hanfodol' unwaith y bydd y broses recriwtio wedi ymwreiddio.

Wrth symud ymlaen byddwn hefyd yn edrych ar gyfieithu ein hysbysebion a'n deunyddiau ategol. Bydd hyn yn dechrau yn 2022.

## YMDDIRIEDOLAETH GIG PRIFYSGOL FELINDRE

| Cyfanswm nifer y swyddi gwag a hysbysebwyd fel: | |
|---|---|
| Mae sgiliau Cymraeg yn hanfodol | 1 |
| Mae sgiliau Cymraeg yn ddymunol | 98 |
| Bydd angen dysgu sgiliau Cymraeg pan benodir rhywun i'r swydd; | 0 |
| Nid yw sgiliau Cymraeg yn angenrheidiol. | 6 |

| | |
|---|---|
| Cyfanswm nifer y swyddi gwag a hysbysebwyd 01/04/2021 i 31/03/2022 | 105 |

## Gwasanaeth Gwaed Cymru 2021-2022

| Cyfanswm nifer y swyddi gwag a hysbysebwyd fel: | |
|---|---|
| Mae sgiliau Cymraeg yn hanfodol | 0 |
| Mae sgiliau Cymraeg yn ddymunol | 97 |
| Bydd angen dysgu sgiliau Cymraeg pan benodir rhywun i'r swydd | 0 |
| Nid yw sgiliau Cymraeg yn angenrheidiol. | 1 |

| | |
|---|---|
| Cyfanswm nifer y swyddi gwag a hysbysebwyd 01/04/2021 i 31/03/2022 | 98 |

## Canolfan Ganser Felindre 2021-2022

| Cyfanswm nifer y swyddi gwag a hysbysebwyd fel: | |
|---|---|
| Mae sgiliau Cymraeg yn hanfodol | 0 |
| Mae sgiliau Cymraeg yn ddymunol | 269 |
| Bydd angen dysgu sgiliau Cymraeg pan benodir rhywun i'r swydd | 0 |
| Nid yw sgiliau Cymraeg yn angenrheidiol. | 23 |

| | |
|---|---|
| Cyfanswm nifer y swyddi gwag a hysbysebwyd 01/04/2021 i 31/03/2022 | 292 |

## Cyfathrebu

### Cyfieithu:

Mae'r Ymddiriedolaeth wedi ymrwymo cymorth ariannol ychwanegol i gyfieithu a bellach mae gennym ddau gyfieithydd penodol i gefnogi ein gwaith. Mae gennym hefyd gytundeb cyfieithu gydag un o'n sefydliadau a letyir i gael cymorth ychwanegol pan fo angen.

Mae hyn wedi golygu y gallwn ganolbwyntio ein blaenoriaethau cyfieithu yn fwy ac mae wedi ein galluogi i ddechrau cyfieithu dogfennau pwysig fel swydd ddisgrifiadau a datblygu cronfa o ddisgrifiadau dwyieithog pwrpasol i'w defnyddio yn y dyfodol.

Mae ffigurau cyfieithu yn parhau i ddangos ymrwymiad yr Ymddiriedolaeth i ddarparu gwybodaeth a gwasanaethau mewnol ac allanol dwyieithog. Y flwyddyn adrodd hon rydym wedi symud ymlaen gyda phrynu meddalwedd cof cyfieithu ac rydym yn y broses o ddefnyddio hwn i sicrhau cysondeb gyda chyfieithu ac fel adnodd i arbed amser. Drwy gysylltu â'n cydweithwyr cyfieithu ar draws y GIG, gallwn symud hyn ymlaen eto eleni a rhannu adnodd defnyddiol gyda thimau cyfieithu eraill.

### Gwefannau:

Mae'r gwaith yn parhau ar Wefan yr Ymddiriedolaeth ac mae Gwasanaeth Gwaed Cymru wedi diweddaru eu safle yn unol â blaenoriaethau a gofynion dwyieithog. Eleni maent hefyd wedi datblygu tudalen Gymraeg sy'n adlewyrchu gofynion yr Ymddiriedolaeth ond sy'n benodol i ofynion lleol. Bu hyrwyddo hyn yn hynod lwyddiannus ar Ddydd Gŵyl Dewi yn ogystal â dathlu ei gweithgor Cymraeg.

Mae gan 1.12% (3,390) o ddefnyddwyr porth archebu gwefan Gwasanaeth Gwaed Cymru (Ebrill 2021 i Fawrth 2022) eu porwyr wedi'u gosod yn y Gymraeg.

Yn gyffredinol, mae prif wefan yr Ymddiriedolaeth wedi derbyn 3,200 o ymweliadau Cymraeg yn y flwyddyn adrodd.

### Addysg Gymraeg:

Eleni rydym wedi bod wrthi'n hyrwyddo darparu hyfforddiant Cymraeg yn y gweithle. Yn ogystal â hysbysebu'r cyfleoedd a ddarperir gan 'laith Gwaith' yn rheolaidd, rydym wedi cael cefnogaeth gan Brifysgol Caerdydd i gynnal dau gwrs i'n staff.

Nid yw darparu hyfforddiant mewnol mor syml â sicrhau cymorth ariannol, mae'n hanfodol fod staff yn gallu mynychu dosbarthiadau ac yn cael eu cefnogi i wneud hynny. Yn anffodus, mewn lleoliad clinigol, nid yw hyn mor llwyddiannus ag yr hoffem, fodd bynnag, rydym yn falch o gyhoeddi bod wyth o'n staff wedi cwblhau eu blwyddyn gyntaf yn llwyddiannus ac y byddant yn cael cefnogaeth bellach gennym i symud ymlaen i'r lefel nesaf o hyfforddiant.

Mae darparu hyfforddiant a chymorth parhaus i nifer fach o staff yn fwy cynhyrchiol iddynt hwy ac i anghenion y gwasanaethau a ddarparwn. Ein ffocws yn y flwyddyn i ddod yw hyrwyddo cyfleoedd e-ddysgu ymhellach a chefnogaeth fewnol gryfach i'r rhai sy'n dymuno ymarfer a dod yn fwy hyderus yn y gweithle.

Rydym yn falch o nodi bod y pecyn ymwybyddiaeth o'r Gymraeg newydd a gefnogir gan Lywodraeth Cymru bellach wedi'i gwblhau. Mae'r Ymddiriedolaeth wedi bod yn awyddus i dderbyn hyn a bydd nawr yn integreiddio hwn fel rhan o'i hyfforddiant rheolaidd ledled yr Ymddiriedolaeth.

**Sgiliau Cymraeg:**

Rydym wedi cynyddu ein cydymffurfedd cofnodi data eleni ac rydym bellach yn dangos cydymffurfedd o 84.5% o fewn ESR.

Mae casglu'r data iaith yn hynod bwysig, ond rydym yn ymwybodol, er bod ein proses recriwtio yn defnyddio'r wybodaeth hon i sicrhau anghenion recriwtio yn y dyfodol, bod angen i ni nawr ddefnyddio'r data hwn i'n galluogi i gryfhau ein gwasanaethau ymhellach.

Mae cynllunio'r gweithlu a'n Strategaeth Pobl yn ganolog i hyn, a fydd yn cael ei drafftio gyda

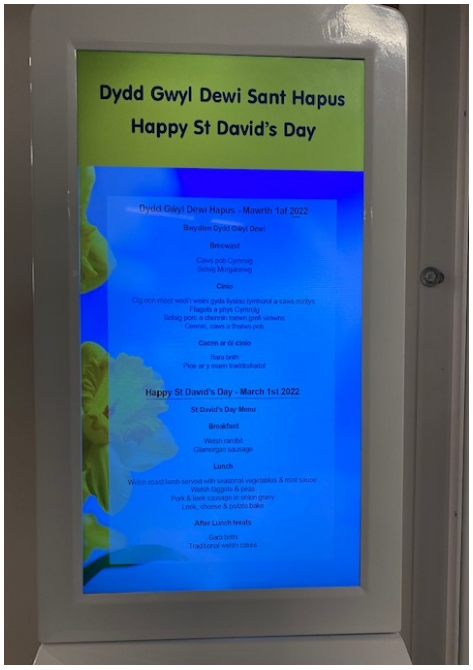
*'Gweithlu Iach ac Ymgysylltiedig: o fewn Diwylliant o wir gynwysoldeb, tegwch a chydraddoldeb ar draws y gweithlu. Gweithlu sy'n adlewyrchu amrywiaeth a hunaniaeth poblogaeth Cymru o ran y Gymraeg a'i diwylliant'*

Mae'r Ymddiriedolaeth yn dangos ei hymrwymiad i sicrhau bod anghenion dwyieithog ei staff a'i gwasanaethau yn ganolog i gynllunio ar bob lefel a bydd yn parhau eleni i integreiddio'r nodau hyn ar draws yr Ymddiriedolaeth.

| | Nifer yr Aseiniadau | Angenrheidiol | Wedi'i gyflawni | Cydymffurfedd % |
|---|---|---|---|---|
| | 1587 | 4761 | 4027 | 84.58% |
| **Org L4** | **Nifer yr Aseiniadau** | **Angenrheidiol** | **Wedi'i gyflawni** | **Cydymffurfedd %** |
| 120 Is-adran Gorfforaethol | 172 | 516 | 442 | 85.66% |
| Is-adran Ymchwil, Datblygu ac Arloesi | 51 | 153 | 137 | 89.54% |
| Is-adran Trawsnewid Gwasanaethau Canser | 25 | 75 | 54 | 72.00% |
| 120 Canolfan Ganser Felindre | 860 | 2580 | 2193 | 85.00% |
| 120 Gwasanaeth Gwaed Cymru | 479 | 1437 | 1201 | 83.58% |

**Hyrwyddo:**

Mae ein gwaith hyrwyddo ar draws yr Ymddiriedolaeth yn parhau gyda dathliadau megis 'Diwrnod Shwmae /Sumae' a Dydd Gŵyl Dewi. Eleni cawsom ddiwrnod lliwgar ardderchog yn y Ganolfan Ganser gyda bwydlen thematig yn y bwyty a chyfle i staff i gyd alw heibio.




Yng Ngwasanaeth Gwaed Cymru lansio tudalen benodol ar y Fewnrwyd i gynorthwyo staff oedd y brif thema ac roedd yn gyfle unwaith eto i staff glywed am waith y gweithgor Cymraeg. Roedd hefyd yn gyfle gwych i longyfarch y dysgwyr Cymraeg sydd wedi cwblhau blwyddyn gyntaf eu cyrsiau.

Byddant yn symud ymlaen y flwyddyn nesaf i ail lefel gan roi cyfle iddynt ddatblygu eu sgiliau Cymraeg ymhellach.

## Pryderon a Chwynion

**Gwasanaeth Gwaed Cymru:**

Cafodd tair cwyn gan roddwyr eu derbyn gan Wasanaeth Gwaed Cymru yn ystod y flwyddyn adrodd hon.

Roedd y ddwy gyntaf yn ymwneud â gwallau mewn negeseuon testun a safon y Gymraeg a anfonwyd, a'r llall yn ymwneud â gwall ar y wefan. Yn anffodus roedd hen neges wedi'i defnyddio ac nid oedd yn neges wedi'i chyfieithu'n broffesiynol ond cafodd hyn ei gywiro. Ymchwiliwyd yn drylwyr i'r tair cwyn ac o ganlyniad gwnaed newidiadau i'r gwasanaeth a'r prosesau gwirio.

Nid oedd yr un o'r cwynion wedi arwain at ymchwiliad ffurfiol gan Gomisiynydd y Gymraeg.

**Canolfan Ganser Felindre: Profiad y Cleifion:**

Yn ystod y cyfnod adrodd hwn, rydym wedi cyflwyno system adborth ddigidol newydd yng Nghanolfan Ganser Felindre. Mae CIVICA Experience yn blatfform mewnwelediadau yn y cwmwl sy'n cefnogi casglu data arolwg aml-sianel, adrodd mewn amser real, dadansoddeg testun craff, offer llif gwaith, rhybuddion sy'n cael eu

gyrru gan ddigwyddiadau a *push reporting.* Cafodd ei gaffael yn 2021 fel rhan o ymarferiad Unwaith i Gymru i gefnogi gwelliannau ar draws GIG Cymru.

Gall casglu adborth gan gleifion a'u teuluoedd yn unol â'r Fframwaith Cenedlaethol ar gyfer Sicrhau Profiad Defnyddwyr Gwasanaeth gael ei wneud yn ddigidol ac mewn amser real, gan ein galluogi i gasglu mwy o ddata mewn system amserol ac ymatebol. Mae gweithredu CIVICA Experience wedi gweld cynnydd yn nifer yr ymatebion i'r arolwg ac yn benodol Cwestiwn 3 sy'n cyfeirio at y Gymraeg.

Atebodd cyfanswm o 592 o bobl y cwestiwn "*Oeddech chi'n gallu siarad Cymraeg â staff os oedd angen i chi*? " gyda 5% o'r ymatebwyr yn dweud "Byth". Mae hyn yn cyfateb i 30 o gleifion sy'n teimlo nad oeddent fyth yn gallu defnyddio'r Gymraeg yn Felindre. Mae'r data pwerus hwn bellach yn llywio ein cynlluniau gwella lleol a bydd yn cael ei ddefnyddio i fonitro effaith a chynnydd datblygiadau gwasanaeth yn barhaus.

**Sefydliadau a Letyir:**

Mae'r Ymddiriedolaeth yn parhau i letya Technoleg Iechyd Cymru (HTW) a'r Bartneriaeth Cydwasanaethau (NWSSP). Mae'r ddau sefydliad wedi ymrwymo i sicrhau bod safonau'r Gymraeg yn flaenoriaeth uchel.

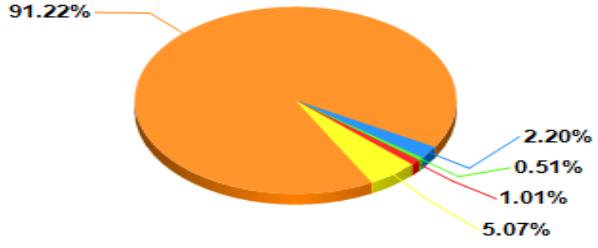
Mae Technoleg Iechyd Cymru wedi bod wrthi'n cyfieithu swydd ddisgrifiadau yn unol â gofynion Safonau'r Gymraeg.

Mae Partneriaeth Cydwasanaethau GIG Cymru (NWSSP) wedi sicrhau bod staff ar draws y GIG bellach yn gallu cael mynediad at dudalen agoriadol y system Cofnod Staff Electronig yn Gymraeg ac yn Saesneg. Mae hwn yn gam cadarnhaol iawn ymlaen gan fod y system wedi bod yn uniaith ers ei sefydlu. Mae gallu cael gafael ar wybodaeth bersonol cyflogeion yn yr iaith o ddewis yn dangos ymrwymiad i anghenion iaith gweithwyr y GIG ac mae Partneriaeth Cydwasanaethau GIG Cymru wedi darparu hyn.

Mae meysydd datblygu eraill wedi cynnwys:

- **Gwasanaethau Cymorth Cyfieithu:**

  Mae Uned y Gymraeg, ym Mhartneriaeth Cydwasanaethau GIG Cymru wedi darparu gwasanaethau cyfieithu ar gyfer y sefydliadau GIG canlynol yn ystod 2021/22:




- Is-adrannau a rhaglenni a letyir gan Bartneriaeth Cydwasanaethau GIG Cymru
- Ymddiriedolaeth GIG Iechyd Cyhoeddus Cymru
- Iechyd a Gofal Digidol Cymru

- Ymddiriedolaeth GIG Prifysgol Felindre
- Addysg a Gwella Iechyd Cymru
- Ymddiriedolaeth Gwasanaeth Ambiwlans Cymru o ran cyfieithu Gwefan 111
- Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
- Rhaglen Gwerth mewn Gofal Iechyd Cymru
- Cefnogwyd Cyflogwyr y GIG i gyfieithu Swydd Ddisgrifiadau a Manylebau'r Person

Cyfieithwyd cyfanswm o dros 3.7 miliwn o eiriau yn ystod 2021/22.

- **Banc Cyfieithu:**
  Mae'r GIG yn wynebu galw digynsail am wasanaethau cyfieithu. Mae hyn mewn ymateb i fodloni gofynion Safonau'r Gymraeg yn bennaf, ond hefyd i ymateb i'r angen/galw ymysg cleifion a'r cyhoedd.
  Mae'n dod yn fwyfwy anodd recriwtio cyfieithwyr cymwys a phrofiadol i swyddi gwag parhaol llawn amser, ac mae cadw staff yn mynd yn heriol hefyd, oherwydd bod y farchnad recriwtio yn hynod gystadleuol.
  Er mwyn gallu ymateb i'r sefyllfa hon rydym wedi sefydlu banc o gyfieithwyr sy'n gallu gweithio'n hyblyg i ni wrth i ni fod angen eu gwasanaeth.
  Sefydlwyd y banc yn hydref 2021, ac mae ein trefniadau presennol yn gweithio'n dda hyd yma. Mae ein dull o weithio'n ystwyth hefyd yn golygu y gallwn recriwtio cyfieithwyr o wahanol rannau o Gymru a thu hwnt i'n cynorthwyo gyda'n gallu i ymateb i'r galw am wasanaethau cyfieithu.

- **Y Cynllun Symleiddio i Fyfyrwyr:**
  Mae Cydwasanaethau GIG Cymru wedi gwella taith y cwsmer drwy Wasanaeth Symleiddio i Fyfyrwyr drwy sicrhau bod y system yn darparu taith Gymraeg drwy gydol y broses.
  Gwnaethom archwilio ac adolygu ein prosesau, ein gwasanaethau awtomataidd a'n templedi er mwyn sicrhau bod cynnig Cymraeg di-dor bellach ar gael i fyfyrwyr sy'n ymgysylltu â'n gwasanaeth.
  Fel rhan o'r prosiect hwn, gwnaethom hefyd gyfieithu hysbysebion a swydd ddisgrifiadau i alluogi Byrddau Iechyd i hysbysebu'r cyfleoedd drwy'r rhaglen Symleiddio i Fyfyrwyr drwy gyfrwng y Gymraeg a'r Saesneg.

- **Taflenni Gwybodaeth i Gleifion Cymru Gyfan:**
  Gwnaethom gynnal archwiliad ac adolygiad cynhwysfawr o dros 350 o Daflenni Gwybodaeth i Gleifion yn ystod 2021/22. Mae'r taflenni yn cael eu rhoi i gleifion fel rhan o'r broses gydsynio. Galluogodd yr archwiliad a'r adolygiad i ni wneud gwelliannau i'r iaith a ddefnyddir yn y taflenni, sicrhau cysondeb o ran terminoleg yn ogystal â gwneud y taflenni yn gwbl ddwyieithog i gleifion yng Nghymru. Cyn hynny roedd fersiynau Cymraeg a Saesneg ar gael ar wahân. Bydd hyn yn parhau yn 2022/23 gyda gwaith yn cael ei wneud mewn partneriaeth ag Eido Healthcare i gyfieithu fersiynau hawdd eu deall o'r taflenni.

- ***Portlets* ESR ar gael yn Gymraeg:**
  Gweithiodd Uned y Gymraeg a thîm Systemau Gwybodaeth y Gweithlu ar y cyd ag Awdurdod Gwasanaethau Busnes y GIG ac IBM ar ddatblygu *Portlets* Cymraeg ar ESR yn hydref 2021. Mae hyn bellach yn golygu bod y *portlets* ar ESR ar gael i Staff y GIG yn Gymraeg ac yn Saesneg i fodloni gofynion Safon 81 y Safonau Gweithredol.

- **Prosiect Adolygu'r Ganolfan Gyswllt:**
  Diben y prosiect adolygu hwn oedd archwilio gwasanaethau ein canolfannau presennol, sefydlu sut mae ein cwsmeriaid yn ymgysylltu â ni ar hyn o bryd, nodi gwelliannau, a chynyddu a gwella elfen hunanwasanaethu'r gwasanaethau a ddarparwn.
  Fel rhan o'r gwaith hwn, craffwyd hefyd ar y gwasanaethau Cymraeg a ddarperir, a nododd arolwg a ddosbarthwyd i staff y GIG fod rhwng 10% ac 20% o staff y GIG yn dymuno ymgysylltu â ni drwy gyfrwng y Gymraeg.
  Bydd rhagor o waith yn cael ei wneud gyda chanolfannau cyswllt trwy bob rhan o PCGC dros y blynyddoedd nesaf.

- **Diweddariadau i System Recriwtio TRAC:**
  Rydym wedi parhau i weithio gyda datblygwyr system TRAC i sicrhau bod y rhyngwyneb ar gyfer y system yn parhau i fod yn gyfoes ac yn gyson yn y Gymraeg a'r Saesneg.

**Symud Ymlaen:**

Dros y flwyddyn i ddod bydd yr Ymddiriedolaeth yn ailedrych ar ei Gwerthoedd ac yn ymgynghori'n ymarferol â'i staff. Mae diwylliant yn ganolog i'r gwerthoedd hyn ac fel y gwyddom mae diwylliant cadarnhaol yn arwain at well gofal. Byddwn yn ystyried sut y gallwn integreiddio ein Cymraeg ymhellach a bydd ein grwpiau is-adrannol yn datblygu nodau ac amcanion penodol er mwyn cryfhau'r ddarpariaeth yn lleol.

Yn genedlaethol, byddwn yn parhau i weithio gyda'n partneriaid, Byrddau Iechyd Lleol a Llywodraeth Cymru. Mae iaith a Diwylliant Cymru yn eiddo i ni i gyd ac fel Ymddiriedolaeth rydym yn ymdrechu i ddarparu'r gofal dwyieithog gorau y gallwn.

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Cymraeg

# WELSH LANGUAGE ANNUAL REPORT 2021/22


**Welsh language Annual Report**

**2021-2022**

## Introduction

This report will focus on the importance the Trust gives to enhancing bilingual provision. It will demonstrate a commitment to the Welsh language standards but also highlight the work we are currently doing on our Welsh language Cultural plan, which is our platform for celebrating and recognising the cultural importance of Wales.

We continue to to provide support for the needs of our bilingual patients and donors. We are keen to ensure the services we provide are even more visible than previously especially at a time where the pandemic has made it difficult to communicate face to face.

We continue to strenthen the Governance around this area and recognise the importance of the Welsh language Standards but are also eager to do more than is required of us. We have began a Trust wide converstation this year on the meaning of Culture and have recognised that our values need to emulate what it means for our staff to provide a bilingual service under continued pressures that the pandemic has brought to us.

We value the work of our staff and at a time of continued change we seek to support them with all that they need to belong to an organisation with true values of Welsh language and Culture. The ethos of our new Cultural plan was accepted by the Executive Board and moving forward we will embace its aims and objectives and seek to further integrate our support for staff, patients and donors who need or chose to use the Welsh language.

Steve Ham

Chief Executive

**Celebrating Welsh culture**

The Trust continues to actively seek ways in which to engage its staff in the culture of Wales as well as its languages. We recognise the need to comply with its legal obligations but we aim to do more than is needed as this celebrates the diversity of our staff and services.

This reporting year we have drafted a Cultural Plan that aims to strengthen our engagement with staff around the language and Culture of Wales and promote a value of inclusion that encompasses all that we believe. The Executive management board have taken on roles of responsibility for certain aspects of the Equality and Diverstity agenda and this includes an Ambasador role responsible for the Welsh language.

The Trusts draft Cultural plan aims to be as inclusive as possible and the Welsh language Ambasador will drive the ethos of this plan throughout the work of the Executive Board.

**Strengthening the Governance**

**Welsh language Standards Compliance**

As of November 2021 our Trust compliane of the Welsh language Standards stands at over 50%. This evidence is collected through our internal divisional working groups and reported to our Trust wide Welsh language development group. It is our way of ensuring we can build on the regulated compliance year on year and put projects in place to ensure we focus our provision productively.

**Patient and donor correspondence**

We previosuly reported on a systematic approach to ensuring out patient correspondence was bilingual. Since last year this has been put on hold in a number of areas as the old system generating the letters has been put on hold. All development initiatives were ceased due to the pandemic and the roll out of the new new patient system has also been slower than anticipated.

As a Trust we are determined to ensure our bilingual correspondence is accessible and although at the Welsh Blood Service this is a process historically followed we have some way to go to ensure Velindre Cancer Centre are in line with our ambitions.

One of our departments are leading the way in this. Radiotherapy have translated and are using biligual letters as standard and they have also ensured that reception is supported by Welsh speaking triage staff as the number of Welsh speaking reception staff continues to be low. This is a positive way to ensure a department is supported when needed by other members of staff which is the ethos that underpins the 'more than just words' framework.

Monitoring telephone calls to and from the Trust is extremely challenging. At the Welsh Blood Service this is more achievable. In this reporting year, calls to the Donor Collection team was 1004. This is 2% of the overall calls into the donor contact centre.

Our Welsh language Working group at Velindre Cancer Centre will take the monitoring of this on board as a matter of urgency this reporting year.

**Meetings**

In light of the continued change to working arrangements under the pandemic it has been necessary to think of ways in which we can internally support bilingual staff at meetings if they wish to use the Welsh language.

For external meetings we continue to be mindful of the ongoing work underway by Welsh Government with Microsoft and look forward to hearing how this progresses over the coming months. Internally we are piloting a method of language identification within Teams (at the Welsh Blood Service) and will monitor the take up of this. The process will then be diseminated Trust wide as an option for language identification at internal meetings.

**Recruiting Welsh speakers**

As we stated in last's years report our aim in this reporting year was to finalise our recruitment and language assessment process. We have completed this and are now ensuring that ALL posts going out for recruitment complete a language assessment table that is discussed with the Welsh language manager should questions arise. It has taken some time to integrate this process but we are confident that this will change the way in which we assess the need for language skills, not only as part of the individual post but for the wider teams across the Trust.

The process is in its infancy but will over time give us the data we need to evaluate its success.

As you will see from the figures below the pandemic has placed clinical priorities over language needs and we will be monitoring the increase in the number of 'essential' roles once the recruitment process has embedded.

Moving forward we will also be looking at the translation of our adverts and supporting materials. This will begin in 2022.

**Velindre University NHS Trust 2021-2022**

| Total number of vacancies advertised as: | |
|---|---|
| Welsh language skills are essential | 1 |
| Welsh language skills are desirable | 98 |
| Welsh language skills need to be learnt when appointed to the post | 0 |
| Welsh language skills are not necessary | 6 |

| | |
|---|---|
| Total Number of vacancies advertised 01/04/2021 to 31/03/2022 | 105 |

**Welsh Blood Service 2021-2022**

| Total number of vacancies advertised as: | |
|---|---|
| Welsh language skills are essential | 0 |
| Welsh language skills are desirable | 97 |

| | |
|---|---|
| Welsh language skills need to be learnt when appointed to the post | 0 |
| Welsh language skills are not necessary | 1 |

| | |
|---|---|
| Total Number of vacancies advertised 01/04/2021 to 31/03/2022 | 98 |

| **Velindre Cancer Centre 2021-2022** | |
|---|---|

| Total number of vacancies advertised as: | |
|---|---|
| Welsh language skills are essential | 0 |
| Welsh language skills are desirable | 269 |
| Welsh language skills need to be learnt when appointed to the post | 0 |
| Welsh language skills are not necessary | 23 |

| | |
|---|---|
| Total Number of vacancies advertised 01/04/2021 to 31/03/2022 | 292 |

**Communication**

**Translation**

The Trust has committed additional financial support to translation and we now have two dedicated translators to support our work. We also have a translation agreement with one of our hosted organiations for additional support when needed.

This has meant that we can focus our translation priorities more and has enabled us to begin to translate important documentation such as Job descriptions and build a bank of dedicated bilingual descriptions for future use.

Translation figures continue to demonstrate the commitment given by the Trust to provide bilingual internal and external information and services. This reporting year we have progressed with the purchase of a memory software and are in the process of using this to ensure consistency with translaton and as a time saving of resource. Liaising with our translation colleagues across the NHS we can move this forward again this year and share a productice reasource with other translation teams.

**Websites**

Work continues on the Trust Website and the Welsh Blood Service have updated their site in line with priorities and bilingual requirements. This year they have also developed a dedicated Welsh langauge page mirroring that of the Trust's but specific to local requirements. The Promotion of this was extremely successful on St David's day as was the celebration of its dedicated Welsh language working group.

1.12% (3,390) of the Welsh Blood Service website booking portal users (April 2021 to March 2022) have their browsers set in Welsh.

Overall, the Trust main website has received 3,200 Welsh language hits in the reporting year.

**Welsh language Education**

This year we have been actively promoting providing Welsh language training in the workplace. In addition to regularly advertising the opportunities provided by 'Iaith Gwaith' we have been supported by Cardiff University to run two courses for our staff.

Providing in house training is not as simple as ensuring financial support it is crucial that staff are able to attend classes and are supported to do so. Unfortunately within a clinical setting this is not as successful as we would like, however, we are proud to announce that eight of our staff have successfully completed their first year and will be further supported by us to proceed to the next level of training.

Providing continued training and support to a small number of staff is more productive for the them and the needs of the services we provide. Our focus in the coming year is to further promote e-learning opportunities and a stronger in house support for those who wish to pracice and become more confident in the work place.

We are pleased to note that the new Welsh language awareness package supported by the Welsh Government is now completed. The Trust has been eager to recieve this and will now be integrating this as part of its regular training Trust wide initiatives.

**Welsh language Skills**

We have increased our data entry compliance this year and are now showing an 84.5% compliance within ESR.

Collecting the language data is extremely important, however we are aware that even though our recruitment processess use this information to ensure future recruitment needs, we now need to use this data to enable us to strengthen our services further.

Workforce planning and our People Strategy are central to this, being drafted with

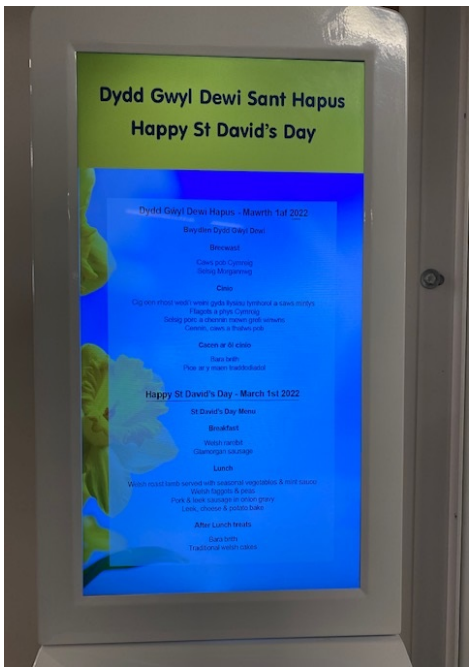
*'A Healthy and Engaged workforce, within a culture of true inclusivty, fairness and equality acoss the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and Cultural identity'*

The Trust is demonstrating its commitment to ensuring the bilingual needs of its staff and services are central to planning at all levels and will continue this year to integrate these aims across the Trust.

| | Assignment Count | Required | Achieved | Compliance % |
|---|---|---|---|---|
| | 1587 | 4761 | 4027 | 84.58% |
| **Org L4** | **Assignment Count** | **Required** | **Achieved** | **Compliance %** |
| 120 Corporate Division | 172 | 516 | 442 | 85.66% |
| 120 Research, Development and Innovation Division | 51 | 153 | 137 | 89.54% |
| 120 Transforming Cancer Services Division | 25 | 75 | 54 | 72.00% |
| 120 Velindre Cancer Centre | 860 | 2580 | 2193 | 85.00% |
| 120 Welsh Blood Service | 479 | 1437 | 1201 | 83.58% |

**Promotion**

Our Trust wide promotion continues with celebrations such as 'Diwrnod Shwmae / Sumae' and St David's day. This year we had an excellent colourfull day at the Cancer Centre with a themed menu at the restaurant and a drop in opportunity for staff.




At the Welsh Blood service the launch of a dedicated Intranet page to assist staff was the main theme and an opportunity once again for staff to hear about the work of the Welsh language working group. It was also a great opportunity to congratulate the Welsh language learners who have completed the first year of their courses.

They will progress this coming year to a second level giving them opportunity to further develop their Welsh language skills.

**Concerns and Complaints**

**The Welsh Blood Service**

Three donor complaints were recieved by the Welsh Blood Service this reporting year.

The first two were relating to text messaging errors and the standard of Welsh sent and the other relating to a website error. Unfortunately an old message had been used and not a professionally translated message but this was rectified.

All three complaints were investigated thoroughly and as a consequence changes have been made to the service and checking processes.

None of the complaints resulted in a formal investigation being undertaken by the Welsh language Commissioner.

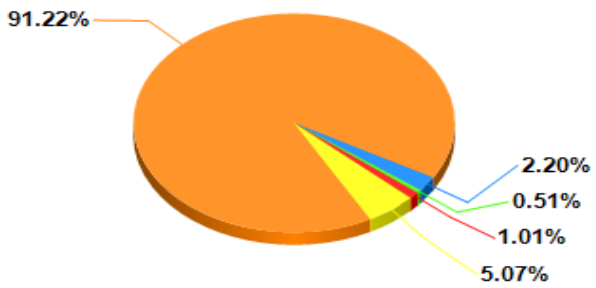
**Velindre Cancer Centre**

**Patient Experience**

During this reporting period, we have introduced a new digital feedback system at Velindre Cancer Centre. CIVICA Experience is a cloud-based insights platform which supports multi-channel survey data collection, real-time reporting, smart text analytics, workflow tools, event-driven alerts and push reporting. It was procured in 2021 as part of a Once for Wales exercise to support improvement across NHS Wales.

Capturing feedback from patients and their families in line with the National Framework for Assuring Service User Experience can now be conducted digitally and in real-time, enabling us to capture more data in a timely and responsive system. The CIVICA Experience implementation has seen an increase in survey responses and in particular Question 3 which references the Welsh language.

A total of 592 people answered the question "*Were you able to speak Welsh to staff if you needed to*?" with 5% of respondents saying "Never". This equates to 30 patients who feel they were never able to use Welsh in Velindre. This powerful data is now informing our local improvement plans and will be used to continually monitor the impact and progress of service developments.




**Hosted organisations**

The Trust continues to host Health Technology Wales (HTW) and the Shared Services Partnership (NWSSP). Both organisations are committed to ensuring the Welsh language standards are a high priority.

HTW have been actively translating Job descriptions in line with the requirements of the Welsh language standards.

NWSSP have ensured that staff across the NHS can now access the opening page of the Electronis Staff record system in Welsh and in English. This is a really positive step forward as the system has been monolingual since its inception. Being able to access personal employee information in the language of choice demonstrates a commitment to the language needs of the NHS employees and NWSSP have provided this.

Other areas of development have included:

- **Translation Support Services**
  The Welsh Language Unit, in NHS Wales Shared Services Partnership have provided translation services for the following NHS organisations during 2021/22:

- NHS Wales Shared Services Partnership's divisions and hosted programmes
- Public Health Wales NHS Trust
- Digital Health and Care Wales
- Velindre University NHS Trust
- Health Education Improvement Wales
- Wales Ambulance Service Trust in the translation of the 111 Website
- Welsh Health Specialised Services Committee
- The All Wales Value in Health Care programme
- Supported NHS Employers in the translation of Job Descriptions and Person Specifications

Totalling over 3.7 million words translated during 2021/22.

- **Translation Bank**
  The NHS is facing unprecedented demand for translation services, this is in response to meeting the requirements of the Welsh language standards in the most part, but also to respond to the need/demand amongst patients and the public.
  It is becoming increasingly difficult to recruit qualified and experienced translators to full-time permanent vacancies, and it is also becoming challenging to retain staff, due to the recruitment market being extremely competitive.
  To be able to respond to this situation we've established a bank of translators who can work flexibly for us as we require their services. The bank was established in autumn 2021, and our existing arrangements are working well to date. Our approach to agile working also means that we can recruit translators from different parts of Wales and beyond to assist us with our ability to respond to the demand for translation services.
- **Student Streamlining**
  NHS Wales Shared Services have improved the customer journey through Student Streamlining Service by ensuring the system provides a Welsh language journey throughout the process.
  We audited and reviewed our processes, automated services and templates to ensure that there is now a seamless Welsh language offer to students engaging with our service.
  As part of this project, we also translated adverts and job descriptions to enable Health Boards to be able to advertise the opportunities through the Student Streamlining programme through both the medium of Welsh and English.
- **All Wales Patient Information Leaflets**
  We undertook a comprehensive audit and review of over 350 Patient Information Leaflets during 2021/22. The leaflets are given to patients as part of the consent process. The audit and review enabled us to make improvements to the language used in the leaflets, to have consistency in terminology as well as making the leaflets wholly bilingual for patients in Wales. Previously Welsh and English versions were available separately. This work will continue in 2022/23 with work being undertaken in partnership with Eido Healthcare to translate easy read versions of the leaflets.
- **ESR Portlets available in Welsh**
  The Welsh Language Unit and the Workforce Information Systems team worked collaboratively with the NHS Business Services Authority and IBM on the development of Welsh Language Portlets on ESR in the autumn of 2021. This now means that the portals on ESR are available to NHS Staff in both Welsh and English to satisfy the requirements of Standard 81 of the Operational Standards.
- **Contact Centre Review Project**
  The purpose of this review project was to audit our existing centre services, establish how our customers currently engage with us, identify improvements, and to increase and improve the self-serve element of the services we provide.

As part of this work, the Welsh language provision of services was also scrutinised, and a survey circulated to NHS staff identified that between 10% and 20% of NHS staff wished to engage with us through the medium of Welsh.
Further work will be undertaken with contact centres throughout NWSSP over the coming years.

- **TRAC Recruitment system updates**
  We have continued to work with the developers of the TRAC system to ensure that the interface for the system continues to be up-to-date and consistent in both Welsh and English.

**Moving forward**

Over the coming year the Trust will revisit its Values and consult practively with its staff. Culture is central to these values and as we know a positive culture drives better care. We will be considering how we can further integrate our Welsh language and our divisional groups will take forward specific aims and objectives in order to strenghten provision locally.

Nationally we will continue to work with our partners, Local Health Boards and Welsh Government. The language and Culture of Wales belongs to us all and as a Trust we strive to provide the best bilingual care that we can.

# TRUST BOARD

# CAPITAL SCHEME FOR VENTILATION AT VELINDRE CANCER CENTRE

| | |
|---|---|
| **DATE OF MEETING** | 29/09/2022 |

| | |
|---|---|
| **PUBLIC OR PRIVATE REPORT** | Public |

| | |
|---|---|
| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |

| | |
|---|---|
| **PREPARED BY** | Jason Hoskins Assistant Director Estates Environment & Capital |
| **PRESENTED BY** | Carl James, Director of Strategic Transformation, Planning, Performance & Estates |
| **EXECUTIVE SPONSOR APPROVED** | Carl James, Director of Strategic Transformation, Planning, Performance & Estates |

| | |
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| **REPORT PURPOSE** | FOR APPROVAL |

**COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING (NOTE:**

| COMMITTEE OR GROUP | DATE | OUTCOME |
|---|---|---|
| Executive Management Board | 6th September 2021 | ENDORSED |
| Quality, Safety and Performance Committee | 16th September 2021 | ENDORSED |
| Trust Board | 30th September 2021 | APPROVED WITH CONDITIONS (SEE 1.1) |
| Ventilation Group | 6th September 2022 | ENDORSED |
| Executive Management Board | 1st September 2022 | ENDORSED |
| Quality Safety and Performance Committee | 15th September 2022 | ENDORSED |

| ACRONYMS | |
|---|---|
| N/A | Not Applicable |
| BJC | Business Justification Case |
| VCC | Velindre Cancer Centre |
| EMB | Executive Management Board |
| nVCC | New Velindre Cancer Centre |
| IP&C | Infection Prevention and Control |

## 1. SITUATION / BACKGROUND

1.1 A Business Justification Case (BJC) was presented to the Velindre University NHS Trust Board in September 2021. The BJC requested approval to submit a Business Justification Case to the Welsh Government for £2.2m of capital investment to support the implementation of compliant mechanical ventilation systems within the inpatient and outpatient areas at the Velindre Cancer Centre. The Board approved the BJC subject to the following two conditions being met:

- A solution which had minimal impact on capacity loss on the inpatient wards. The solution would need to include the required availability of single cubicles to support the care of COVID patients to support IP&C requirements,
- Certainty regarding forecast prevalence of COVID in the community, how it impacts our ability to treat patients in accordance with the national quality requirements.

1.2 Work was progressed in accordance with these conditions and a revised plan was developed to minimise the loss of capacity on the inpatient wards (with approximately 2 cubicles likely to be impacted as a minimum). However, the variability of COVID-19 over the past two years, together with the need to retain the maximum capacity (and cubicles) to treat patients as quickly as possible, in the context of the ongoing COVID-19 pandemic, has resulted in the second condition still not being able to be met.

1.3 During this period the Trust has deployed an interim ventilation solution at VCC which reduces the temperature and supports effective infection prevention control. This solution has received positive feedback from staff and patients and supports controlled environmental conditions through the summer months by the provision of clean, filtered, cooled air which is compliant with IP&C standards. During this period the IP&C data does not point to any increased levels of infection.

## 2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Executive Management Board received a paper on 1st September 2022 which revisited the position given the time between the Board decision in principle and the current position. The Executive Management Board considered the following information:

- Still no likely start date for the implementation of the Ventilation Scheme at VCC due to:
    - the continuing impact of COVID on service delivery i.e., backlog and increased waiting times,
    - the increasing demand for services. The SACT demand also impacts the potential decant options during the period of construction i.e., proposed decant areas will be required for the delivery of SACT treatments,
    - continued uncertainty surrounding future waves of COVID as we move out of the summer months into the winter season. This is likely to be see an increase in COVID prevalence together with seasonal flu.
- The proposed project programme for the delivery of the permanent ventilation scheme is 48 weeks. This will cause major disruption to the delivery of services at VCC during this period.
- The effectiveness of the interim ventilation solution which has improved patient and staff comfort through the provision of filtered, temperature-controlled air into the space.
- The continued progress of the nVCC with an expected opening date of 2025.

2.2 Given this position, the Executive Management Board concluded that the scheme would not proceed as there is still no likely start date given: the continuing prevalence of COVID and the priority to treat patients as quickly as possible; the stable nature of the interim solution; the likely significant impact of the scheme compared to the reduced likely benefits given the move to the nVCC in 2025, i.e., the completion of the planned ventilation scheme is not likely to be completed until 2024 given approvals, procurement and delivery of the scheme.

2.3 The Executive Management Board are committed to enhancing the current interim ventilation solution at VCC, ensuring that it meets required IPC standards by seeking to purchase the equipment permanently (currently leased) through any capital slippage in 2022/2023 or allocation of Trust discretionary capital in 2023/2024. A cost/benefit analysis will be undertaken to inform the optimum option (Annex 1).

**Discussion at the Quality, Safety and Performance Committee**

2.4 The Committee discussed the proposal at its meeting on the 15th September 2022 and were assured on the key matters set out relating to the recommendation:

- the inability to reduce the capacity on the inpatient ward for a prolonged period of time given the need to treat patients as quickly as possible in light of the delays caused/still being managed by the COVID-19 pandemic,
- the effectiveness of the existing solution in reducing air temperature and supporting improved ventilation,
- the data and information over the period which indicates that the current arrangements are robust in supporting effective infection prevention and control,
- the confidence that the new Velindre Cancer Centre project will go ahead.

2.5 The Committee also inquired about the cost benefit analysis of a revenue versus capital based solution regarding the current solution which will be deployed permanently if the decision not to progress the major capital scheme is supported. This appraisal will be undertaken to inform the way forward.

## 3. IMPACT ASSESSMENT

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| **QUALITY AND SAFETY IMPLICATIONS/IMPACT** | Yes (Please see detail below) |
| | The proposed investment be a betterment on the current position providing an element of compliance with HTM 03 (Healthcare Technical Memorandum) |
| **RELATED HEALTHCARE STANDARD** | Governance, Leadership and Accountability |
| | If more than one Healthcare Standard applies, please list below:<br>• Staff and Resources<br>• Safe Care<br>• Timely Care<br>• Effective Care |

| | |
|---|---|
| | • Staying Healthy |
| **EQUALITY IMPACT ASSESSMENT COMPLETED** | Not required |
| **LEGAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| **FINANCIAL IMPLICATIONS / IMPACT** | Yes (Include further detail below) |
| | 2022/23 Slippage Welsh Government Funding<br>Discretionary Capital 2023/24 |

## 4. RECOMMENDATION

4.1 The Board is asked to approve that:

i. the Business Justification Case and planned capital ventilation scheme is not progressed,

ii. the current solution is made permanent with the optimum option deployed following cost-benefit analysis.

## ANNEX 1 Development of Interim Ventilation Solution: initial inputs and indicative costs for the cost/benefit analysis

### The Solution

- The current interim solution is being explored to consider a number of potential options including:

    - Enhanced design on the previously used solution.
    - Hire of equipment.
    - Purchase of equipment.
    - Sell back or repurpose of equipment following closure of the existing site.
    - A variety of the above

- The solution will require consultation and sign off from the Trust Ventilation Group and Executive Management Board.

### Costs

- Initial capital costs to purchase the equipment range between £250K-£600K depending on complexity of the design.
- The revenue costs for hiring the equipment are estimated between £100K-£200K per annum.

### Benefits

- There are a range of benefits/dis-benefits associated with each option and the implementation approach and these will be included in the cost/benefit analysis

It should be noted that these are initial estimated costs, are subject to change and should not be used for any decision-making process at this stage.